

Statewide Collaborative Quality Improvement Project  
*Reducing Avoidable Emergency Room Visits*

Remeasurement Report: January 1, 2009 – December 31, 2009

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

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### Purpose and Scope of Report

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

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

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

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

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

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

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<sup>1</sup> Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 3, October 1, 2005.

<sup>2</sup> California Department of Health Services. May 2009. *Baseline Report: Statewide Collaborative QIP on Reducing Avoidable Emergency Room Visits*.

<sup>3</sup> Department of Health Care Services. *ER Collaborative Baseline Report*, August 2008. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>

<sup>4</sup> Department of Health Care Services. *ER Collaborative 2008–2009 Interim Report*, June 2010. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>

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

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

HSAG produced the first remeasurement report, and the DHCS released the report in November 2010.<sup>5</sup> The remeasurement report described collaborative activities since the interim report. The report displayed QIP validation findings and presented the first year of remeasurement data, covering the period of January 1, 2008, through December 31, 2008.

The purpose of this remeasurement report is to provide background information on the collaborative, update the progress of the collaborative statewide interventions, display QIP validation findings, present the second year of remeasurement data for the period of January 1, 2009, through December 31, 2009, discuss activity related to the first remeasurement report's recommendations, and present conclusions and recommendations for the remainder of the collaborative.

## Summary of Collaborative Quality Improvement Project Activities

Since the first remeasurement report, the collaborative:

- ◆ Continued implementation of its two targeted statewide interventions: a member health education campaign and a plan-hospital data collaboration pilot.
- ◆ Analyzed member survey data on the member health education campaign.
- ◆ Submitted second-year remeasurement data to the EQRO for QIP validation in October 2010.
- ◆ Submitted plan/hospital data collaboration intervention data to the EQRO in October 2010 to compile and analyze results.

## Summary of Overall Findings

HSAG reviewed a total of 24 statewide collaborative QIP submissions, which represented 20 plans, using a validation protocol to ensure that plans designed, conducted, and reported QIPs in a methodologically sound manner. The EQRO uses validation as the method to determine the credibility of the reported results. HSAG provided each QIP submission with an overall validation

<sup>5</sup> Department of Health Care Services. *Statewide Collaborative Improvement Project – Reducing Avoidable Emergency Room Visits Remeasurement Report*: January 1, 2008 through December 31, 2009, November 2010. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>

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

Of the 24 QIP submissions, five required resubmission. As of February 2011, all collaborative QIP submissions received an overall *Met* validation status with the exception of one QIP that remained as a *Partially Met* validation status.

Within the QIP submissions, plans operating in multiple counties reported county-level results. Of the 37 county-level results that had Remeasurement 1 and Remeasurement 2 rates, 13 showed a decrease in their avoidable ER visits rate. Seven of the 13 decreases were statistically significant. Conversely, the remeasurement data showed an increase in the avoidable ER visits rate for the other 24 county-level rates. Anthem Blue Cross–Stanislaus County was the only plan to achieve sustained improvement as defined by improvement between the baseline and remeasurement year without a statistically significant decline in the second remeasurement period.

Analysis by plan model type and county did not reveal patterns of improvement or decline. Plans that had statistically significant improvement between the remeasurement period used a combination of plan-specific interventions targeting members, providers, and systems.

## Conclusions and Recommendations

HSAG identified several strengths of the collaborative through QIP validation and documented activities. HSAG noted consistency with plans' QIP documentation and high rates of compliance for the study design and study implementation phases of the QIP.

The collaborative collected member health education campaign survey results, which showed that respondents who had a discussion with their provider about the appropriate use of the ER indicated they would be more likely to contact their provider or nurse advice line before going to the ER. These results suggest that increasing communication between provider and members on the appropriate use of the ER may be an effective strategy. While the campaign yielded some success, member survey data results suggest that the campaign had limited sustainability beyond the initial implementation if members were not exposed to campaign materials beyond six months after implementation and/or the campaign had limited message recall in which members could not remember receiving or seeing campaign materials.

Most all plans documented participation from a contracted hospital to work on a data collaboration intervention pilot. The purpose of the pilot was to improve health plan notification regarding members seen in the ER. Plans conducted analysis on the avoidable ER visits rates for their participating and non-participating pilot hospitals, and the results did not show a distinguishable pattern of difference between the participating and non-participating pilot hospitals' avoidable ER visit rates. While most plans had established routine notification from the

ER regarding members, follow-up communication with members as a result of receiving this information differed by plan and present a missed opportunity for many plans.

Thirty-five percent of county plans reporting Remeasurement 1 and Remeasurement 2 rates for avoidable ER visits experienced a decrease, which is consistent with the percentage of decrease in the prior review period between baseline and Remeasurement 1. Of those, approximately half showed a statistically significant decrease. Anthem Blue Cross–Stanislaus County was the only plan with sustained improvement.

Despite decreases in avoidable ER visits rates among some county plans, many counties showed an increase in their rates. Similar to the analysis of results in the prior year, analysis by plan model type revealed mixed results, with many model types showing relatively the same number of statistically significant increases as statistically significant decreases. Results also varied by county and size of county with no noted trends.

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

- ◆ Plans should consider strategies to increase discussion with providers and members about the appropriate use of the ER since this may be an effective strategy.
- ◆ Plans that did not initiate follow-up with members who had a recent avoidable ER visit need to implement a process to act upon the notification received from hospitals and outreach members who used the ER to determine if this strategy has an impact on the avoidable ER visits rate.
- ◆ The DHCS should survey collaborative partners related to the QIP process to get input for future QIP activities.



### **Medi-Cal Managed Care Background**

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

During the second remeasurement year, which reflects data from January 1, 2009, through December 31, 2009, 20 full-scope health plans were operating in 25 counties throughout California, providing comprehensive health services to approximately 3.8 million beneficiaries enrolled in Medi-Cal managed care as of December 31, 2009.<sup>6</sup>

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

### **County-Organized Health System**

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

During the measurement period for this report, January 1, 2009, through December 31, 2009, the DHCS had contracts with five COHS plans operating in 10 counties.

### **Geographic Managed Care**

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

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<sup>6</sup> *Medi-Cal Managed Care Enrollment Report, December 2009*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>



beneficiaries may either enroll in a managed care plan or receive services through the Medi-Cal fee-for-service program.

During the measurement period for this report, January 1, 2009, through December 31, 2009, the GMC model type was operating in San Diego and Sacramento counties.

### **Two-Plan**

In a Two-Plan model county, the DHCS contracts with two managed care plans to provide health care services to members. In most Two-Plan model counties, Medi-Cal beneficiaries in both mandatory and voluntary aid codes can choose between a local initiative plan and a nongovernmental commercial health plan.

During the measurement period for this report, January 1, 2009, through December 31, 2009, the Two-Plan model was operating in 12 counties.

## **Purpose of the Collaborative Quality Improvement Project**

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

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

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

## Collaborative Components and Process

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

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

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

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

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

### 3. QUALITY IMPROVEMENT PROJECT INDICATORS: SPECIFICATIONS AND METHODOLOGIES

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

#### ***Measure I—HEDIS Ambulatory Care—Emergency Department Visits***

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

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

*Measure I* reflects the plans' 2008, 2009 and 2010 *HEDIS Ambulatory Care—Emergency Department Visits* rate, which covers the measurement period of January 1, 2007, through December 31, 2007; January 1, 2008, through December 31, 2008; and January 1, 2009, through December 31, 2009, respectively.

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

Per HSAG's recommendation in the interim report, the DHCS notified plans to follow HEDIS specifications for reporting this measure prior to submitting their QIPs in October 2010. In addition, HSAG implemented a process to check plans' reported QIP remeasurement rates against the HEDIS reported rates prior to conducting validation to address data discrepancies.

HSAG found that six of the 20 plans had inconsistent rates. This was a decrease from the prior year in which 12 of 21 plans had inconsistent rates. Six plans could not fully resolve the data discrepancy because they refreshed their data after HEDIS reporting and were unable to revert to the previous data set.

## ***Measure II—Avoidable ER Visits***

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

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

The collaborative used ***Measure II*** as the QIP indicator to measure the success of the collaborative. As part of the validation process, HSAG assessed whether plans achieved real, statistically significant improvement between the Remeasurement 1 and Remeasurement 2 years using this measure.

## Collaborative Statewide Interventions

The collaborative implemented two statewide interventions and completed development of outcome measures for each intervention.

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

### **Member Health Education Campaign**

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

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

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

The collaborative identified two objectives for the campaign:

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

Campaign materials, available on the DHCS Web site,<sup>7</sup> included an English and Spanish brochure and poster, and a provider tool kit. Plans disseminated initial campaign materials to providers in May 2009 with completion in October 2009.

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

## **Member Health Education Campaign Outcome Measures**

One of the two objectives of the member health education campaign was to increase communication between members and PCPs on appropriate ER use. The collaborative developed both a provider and member survey to measure the success of the campaign.

### **Provider Survey Results**

The provider survey results showed that providers found the member health education campaign materials helpful in talking with patients about the ER. Detailed results from the provider survey were included in the ER Collaborative Remeasurement Report, available on the DHCS Web site.<sup>8</sup>

### **Member Survey**

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

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

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

While it was not feasible for the collaborative to administer pre- and post-tests and to administer surveys using statistically valid sampling techniques due to limited time and resources, the survey results can provide the collaborative with data on process outcomes and short-term outcomes of those surveyed.

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<sup>8</sup> Department of Health Care Services. *ER Collaborative Remeasurement Report: January 1, 2008 – December 31, 2008*. November 2010. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx>

## Member Survey Results

MMCD collected and aggregated provider survey results for 875 respondents. Appendix B includes the member survey and detailed survey results.

The survey included several questions that each health plan populated regarding information on the member's county, how the survey was administered, and time between a PCP visit and the administration of the survey. Member questions focused on the member's awareness of the campaign, communication between provider and the member regarding the campaign, and whether the member would be more likely to contact his or her provider or nurse advice line if unsure about going to the ER.

Most members were contacted via telephone member outreach. Only 18.3 percent of respondents indicated that they received a campaign brochure and 24.9 percent responded that they saw the campaign poster in their providers' offices. DHCS staff noted that plans encountered challenges with verifying that members who received the survey were actually exposed to the campaign because the member survey was administered between six months to a year after the initial implementation of the campaign. This suggests that either the members did not receive the campaign materials or that the members did not remember seeing or receiving the materials.

Although only 17.9 percent of respondents indicated that their doctor spent time explaining the campaign brochure and/or poster with them, of those an overwhelming 88.2 percent of respondents indicated that they would be more likely to call their doctor or nurse advice line when unsure about visiting the ER; and 90 percent answered that they were more likely to call their doctor or nurse advise line if worried about their child's earache, sore throat, cough, cold, or flu.

## Member Health Education Campaign Challenges and Successes

The collaborative has experienced several successes with the member health education campaign. All 20 plans participating in the collaborative implemented the member health education campaign. An estimated 7,000 providers across Medi-Cal managed care counties received campaign materials, which represents approximately 67 percent of Medi-Cal managed care providers who see members 1 to 19 years of age.<sup>9</sup> This demonstrates an ongoing commitment from the DHCS and participating plans despite limited resources.

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

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<sup>9</sup> Department of Health Care Services. Health Plan Survey Provider Sample Responses. November 2, 2009.



respondents indicated they would be more likely to contact their provider or nurse advice line before visiting the ER as a result of a discussion with their provider. This suggests that increasing communication between provider and members on the appropriate use of the ER may be an effective strategy.

While the campaign yielded some success, member survey data results suggest that the campaign had limited sustainability beyond the initial implementation if members were not exposed to campaign materials beyond six months after implementation and/or the campaign had limited message recall in which members could not remember receiving or seeing campaign materials.

### ***Plan-Hospital Data Collaboration***

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

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

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

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

The collaborative was interested in learning what impact timely notification has on the health plans' ability to intervene with members to reduce avoidable ER visits. Each participating plan had a goal of targeting one hospital. Implementation began in August 2008 with the expectation that all plans had a data exchange in place by June 1, 2009.

### ***Plan-Hospital Data Collaboration Outcome Measures***

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

Plans collected and reported information on data frequency, data timeliness, data volume, and data completeness for the first time in October 2010. HSAG used this information to assess whether the collaborative met its first objective by measuring if there was an increase in the timely exchange of information from the hospital to the plan.

Table 4.1 documents the timeliness of the exchange of information between the plans and the participating hospital(s).

**Table 4.1—Hospital Data Collaboration Timeliness<sup>‡</sup>**  
January 1, 2009, through December 31, 2009

Plan Name	Percentage of ER Visits Data Received from the Participating Hospital(s) from the Service Date <sup>^</sup>		
	Within 5 Days	Within 10 Days	Within 15 Days
Alameda Alliance for Health	NR	NR	NR
Anthem Blue Cross*	66.7%	31.7%	0.1%
CalOptima	NR	NR	NR
Care 1st	NR	NR	NR
CenCal Health	100.0%	0.0%	0.0%
Central California Alliance for Health	100.0%	0.0%	0.0%
Community Health Group	0.0%	0.0%	100.0%
Contra Costa Health Plan	100.0%	0.0%	0.0%
Health Net	0.0%	48.5%	70.5%
Health Plan of San Joaquin	98.9%	0.4%	0.7%
Health Plan of San Mateo	0.0%	99.3%	0.1%
Inland Empire Health Plan	0.0%	0.0%	9.8%
Kaiser Permanente—North	100.0%	0.0%	0.0%
Kaiser Permanente—South	100.0%	0.0%	0.0%
Kern Family Health Care	NR	NR	NR
L.A. Care Health Plan	0.0%	12.6%	67.6%
Molina Healthcare	88.7%	9.5%	1.8%
Partnership Health Plan	NR	NR	NR
San Francisco Health Plan	83.3%	16.7%	0.0%
Santa Clara Family Health	NR	NR	NR
<sup>‡</sup> Table data reflect plan-reported rates via Hospital Data Collaboration Outcomes Measures Form. <sup>^</sup> Time period percentages are mutually exclusive and not cumulative. NR Data not reported. * Plan reported 0, 6, and 11 days instead of 5, 10, and 15 days.			

Five of the 14 plans reporting timeliness reported that they received all of the ER visit data within 5 days from the date of service. Conversely, Community Health Group did not receive any of the data until 15 days after service. Inland Empire Health Plan had only received 9.8 percent of the data within 15 days.

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

Table 4.2 documents the percentage of members that the plan communicated with within 14 days of receiving notice of their first ER visit. Qualifying communication includes, but is not limited to: letters sent, group instruction, and individual instruction in person or via telephone. Returned letters (undelivered) and calls to disconnected phone lines do not constitute qualifying communication with the member.

**Table 4.2—Hospital Data Collaboration Member Communication<sup>‡</sup>  
January 1, 2009, through December 31, 2009**

Plan Name	Percentage of Members the Plan Contacted after Receiving the ER Visit Data	
	January through June	July through December
Alameda Alliance for Health	NR	NR
Anthem Blue Cross*	21.5%	42.5%
CalOptima	NR	NR
Care 1st	NR	NR
CenCal Health	74.7%	NR
Central California Alliance for Health	NR	NR
Community Health Group	49.9%	75.0%
Contra Costa Health Plan	NR	100.0%
Health Net	90.1%	90.0%
Health Plan of San Joaquin	99.5%	96.7%
Health Plan of San Mateo	NR	NR
Inland Empire Health Plan	NR	61.0%
Kaiser Permanente—North	NR	69.9%
Kaiser Permanente—South	57.8%	94.8%
Kern Family Health Care	NR	NR
L.A. Care Health Plan	100.0%	95.1%
Molina Healthcare	67.0%	61.3%
Partnership Health Plan	NR	NR
San Francisco Health Plan	NR	NR
Santa Clara Family Health	NR	NR
<sup>‡</sup> Table data reflect plan-reported rates via Hospital Data Collaboration Outcomes Measures Form. NR Data not reported.		

Eleven plans reported communicating with members who had visited the ER according to the protocol. Health Net, Health Plan of San Joaquin, and L.A. Care Health Plan reported communicating with over 90 percent of the members for both six month time periods, while Contra Costa Health Plan and Kaiser Permanente—South reported over 90 percent for one of the two time periods.

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

Table 4.3 displays each plan's self-reported avoidable ER visits rates between its participating and non-participating hospital for the measurement year January 1, 2009, through December 31, 2009.

**Table 4.3—Hospital Data Collaboration Participating and Non-Participating Hospital Avoidable ER Visits Rate – January 1, 2009, through December 31, 2009**

Plan Name	Avoidable ER Visits Rate <sup>‡</sup>		
	Participating Hospitals	Non-Participating Hospitals	Total Plan
Alameda Alliance for Health*	19.4%	20.1%	19.9%
Anthem Blue Cross	26.9%	22.1%	22.2%
CalOptima	15.6%	17.6%	17.2%
Care 1st	NR	NR	NR
CenCal Health	19.0%	22.9%	19.8%
Central California Alliance for Health*	22.8%	23.1%	22.2%
Community Health Group	45.1%	15.0%	17.2%
Contra Costa Health Plan	22.6%	19.9%	20.0%
Health Net*	14.1%	22.6%	22.5%
Health Plan of San Joaquin*	7.6%	21.5%	21.5%
Health Plan of San Mateo	26.8%	15.7%	17.0%
Inland Empire Health Plan	21.7%	21.3%	21.3%
Kaiser Permanente—North*	12.5%	11.0%	4.9%
Kaiser Permanente—South*	21.2%	16.3%	NR
Kern Family Health Care	NR	NR	NR
L.A. Care Health Plan	23.0%	22.4%	22.4%
Molina Healthcare*	17.9%	20.7%	18.0%
Partnership Health Plan	NR	NR	NR
San Francisco Health Plan	21.2%	18.5%	19.3%
Santa Clara Family Health	23.7%	21.7%	22.5%
<sup>‡</sup> Table data reflect plan-reported rates via Hospital Data Collaboration Outcomes Measures Form. * Reported rates may not be accurate.			

Plan reported data for this measure should be used with caution. HSAG could not replicate the total plan avoidable ER visits rate using plan reported numerators and denominators for participating and non-participating plans.

Plan reported data showed mixed results with seven of 17 plans showing lower rates of their participating hospitals when compared to non-participating hospitals, while 10 plans showed lower rates for their non-participating hospitals compared to participating hospitals.

Based on these results, the mere collaboration with hospitals for data collaboration exchange did not result in decreased avoidable ER visits rates when compared to non-collaborating hospitals.

### **Plan-Hospital Data Collaboration Challenges and Successes**

Most plans successfully implemented the hospital data exchange intervention, with a very high percentage receiving notification of members accessing the ER within 15 days. Despite most plans receiving notification, not all plans initiated outreach communication to members. Appendix E displays what outreach actions were completed by each of the plans. For plans that did outreach members, several of these plans implemented communication to members in the second half of the year, and this outreach may not have been in place long enough to have an impact on the avoidable ER visits rate in the measurement period. This may also have contributed to the mixed results seen among participating and non-participating hospitals' avoidable ER visit rates.

### **Plan-Specific Interventions**

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

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

## 5. QUALITY IMPROVEMENT PROJECT VALIDATION FINDINGS

### Project Timeline

In October 2010, all plans submitted QIPs for validation and reported second-year remeasurement data, which reflect the measurement period of January 1, 2009, through December 31, 2009.

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

### Quality Improvement Project Validation Description

CMS produced protocols for plans to use when conducting QIPs<sup>10</sup> and for EQROs to use when validating QIPs.<sup>11</sup>

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

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

<sup>10</sup> U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Managed Care Organization Protocol. *Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 2002.*

Available at: [http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/07\\_Tools\\_Tips\\_and\\_Protocols.asp](http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/07_Tools_Tips_and_Protocols.asp)

<sup>11</sup> U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Managed Care Organization Protocol. *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 2002.*

Available at: [http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/07\\_Tools\\_Tips\\_and\\_Protocols.asp](http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/07_Tools_Tips_and_Protocols.asp)

With October 2010 QIP submissions, plans completed Activities I–X, which involved statistical testing for a real, statistically significant decrease in avoidable ER visits rates and whether the improvement has been sustained across measurement periods.

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

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

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

### **Evaluating the Overall Validity and Reliability of Study Results**

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

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

## **Quality Improvement Project Validation Findings**

HSAG reviewed a total of 24 statewide collaborative QIP submissions which represented 20 plans. HSAG provided each QIP submission with an overall validation status of *Met*, *Partially Met*, or *Not Met*. The DHCS requires that QIPs receive an overall *Met* validation status; therefore, plans must resubmit a QIP until it achieves a *Met* validation status.

Of the 24 QIP submissions, five required a resubmission. As of March 31, 2011, all collaborative QIP submissions received an overall *Met* validation status except for Partnership Health Plan in Napa, Solano, and Yolo counties. This plan received a *Partially Met* status; however, HSAG did not recommend a resubmission as the overall structure of the QIP was sufficient to produce valid and reliable results. HSAG recommended that the plan address outstanding issues as part of its final project submission in October 2011.



HSAG presents a summary of the validation results for baseline through Remeasurement 2 data in Table 5.1. Validation results presented in the table include all plans' final QIP submissions. All plans included their entire eligible population (i.e., they did not use sampling techniques); however, two plans did not address prior *Points of Clarification* for Activity V by including the necessary documentation specifying that sampling was not used and were scored down for this activity as a result.

**Table 5.1—Remeasurement 2 Validation Results for the Statewide ER Collaborative QIP (20 Plans, 24 QIPs)**

QIP Study Stage	Activity	Percentage of Applicable Elements		
		Met	Partially Met	Not Met
Design	I. Appropriate Study Topic*	99% (142/144)	1% (1/144)	1% (1/144)
	II. Clearly Defined, Answerable Study Question(s)*	100% (48/48)	0% (0/48)	0% (0/48)
	III. Clearly Defined Study Indicator(s)	100% (168/168)	0% (0/168)	0% (0/168)
	IV. Correctly Identified Study Population*	100% (48/48)	0% (0/48)	0% (0/48)
<b>Design Total</b>		<b>100%</b> <b>(406/408)</b>	<b>0%</b> <b>(1/408)</b>	<b>0%</b> <b>(1/408)</b>
Implementation	V. Valid Sampling Techniques (if sampling was used)	0% (0/2)	100% (2/2)	0% (0/2)
	VI. Accurate/Complete Data Collection	94% (114/121)	6% (7/121)	0% (0/121)
	VII. Appropriate Improvement Strategies	94% (72/77)	5% (4/77)	1% (1/77)
<b>Implementation Total*</b>		<b>93%</b> <b>(186/200)</b>	<b>7%</b> <b>(13/200)</b>	<b>1%</b> <b>(1/200)</b>
Outcomes	VIII. Sufficient Data Analysis and Interpretation	90% (173/192)	7% (14/192)	3% (5/192)
	IX. Real Improvement Achieved	46% (44/95)	0% (0/95)	54% (51/95)
	X. Sustained Improvement Achieved*	0% (0/23)	4% (1/23)	95% (22/23)
<b>Outcomes Total</b>		<b>70%</b> <b>(217/310)</b>	<b>5%</b> <b>(15/310)</b>	<b>25%</b> <b>(78/310)</b>
<b>Overall Percentage of Applicable Evaluation Elements Scored Met</b>		<b>88%</b> <b>(809/918)</b>		
<b>Percentage of QIPs with Validation Status of Met</b>		<b>96%</b> <b>(23/24)</b>		
*The activity or stage total may not equal 100 percent due to rounding.				

Based on the final QIP validation results, the plans demonstrated a strong understanding of both the study design and study implementation phases. The percentage of elements *Met* across activities improved compared with the prior-year validation results from the plans' October 2009 submissions, except for Activity VI, which decreased from 98 percent to 94 percent.

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

For the Outcomes stage, plans decreased the percentage of elements scored *Met* for Activity VIII by one percentage point. Plans can achieve full compliance in this stage only by demonstrating statistically significant improvement in Activity IX and sustained improvement in Activity X. Plans achieved *Met* scores for only 46 percent of the elements within Activity IX for the October 2010 QIP submission which was an increase of three percentage points from the October 2009 submissions. None of the 20 plans demonstrated sustained improvement at the overall plan level.

Plans significantly increased their compliance with the CMS protocol for conducting QIPs in their October 2010 submissions compared to October 2009 submissions. Ninety-six percent of QIPs submitted in October 2010 achieved an initial overall *Met* validation status compared to 60 percent in October 2009. This suggests that actions taken by the DHCS and the plans have resulted in greater compliance with HSAG's validation requirements. Detailed validation findings are available on the DHCS Web Site at:

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx>.

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

**Table 6.1—Measure I—HEDIS Ambulatory Care—Emergency Department Visits<sup>‡</sup>**  
January 1, 2009, through December 31, 2009

Plan Name	County	Model and Plan Type*	ER Visits/1,000 Member Months		
			Baseline 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09
Alameda Alliance for Health	Alameda	Two-Plan: LI	47.6 †	39.6 †	44.3
Anthem Blue Cross	Alameda	Two-Plan: CP	55.5 †	56.7 †	64.2
Anthem Blue Cross	Contra Costa	Two-Plan: CP	51.8 †	52.8 †	59.0
Anthem Blue Cross	Fresno	Two-Plan: CP	37.3 †	38.9 †	46.9
Anthem Blue Cross	Sacramento	GMC: CP	33.3 †	34.2 †	42.5
Anthem Blue Cross	San Francisco	Two-Plan: CP	29.8 †	29.9 †	38.3
Anthem Blue Cross	San Joaquin	Two-Plan: CP	35.1 †	36.9 †	49.0
Anthem Blue Cross	Santa Clara	Two-Plan: CP	30.3 †	32.6 †	39.8
Anthem Blue Cross	Stanislaus	Two-Plan: LI	50.6 †	53.0 †	64.4
Anthem Blue Cross	Tulare	Two-Plan: LI	44.0 †	40.0 †	45.2
CalOptima	Orange	COHS	36.3	37.4	40.0
Care 1st	San Diego	GMC: CP	44.1	39.3	52.0
CenCal Health	Santa Barbara	COHS	50.3 †	51.9 †	55.9
CenCal Health	San Luis Obispo	COHS	68.5^	70.4^	Δ
Central California Alliance for Health	Monterey, Santa Cruz	COHS	60.9	62.1	59.3
Community Health Group	San Diego	GMC: CP	23.3	27.0	32.5
Contra Costa Health Plan	Contra Costa	Two-Plan: LI	55.1	57.1	59.2
Health Net	Fresno	Two-Plan: CP	35.4	39.2	48.0
Health Net	Kern	Two-Plan: CP	38.6	41.5	48.9
Health Net	Los Angeles	Two-Plan: CP	27.4	29.0	35.1
Health Net	Sacramento	GMC: CP	26.6	26.4	35.3
Health Net	San Diego	GMC: CP	41.5	43.7	45.9
Health Net	Stanislaus	Two-Plan: CP	50.8	53.2	57.1

**Table 6.1—Measure I—HEDIS Ambulatory Care—Emergency Department Visits<sup>‡</sup>**  
**January 1, 2009, through December 31, 2009**

Plan Name	County	Model and Plan Type*	ER Visits/1,000 Member Months		Remeasurement 2 1/1/09–12/31/09
			Baseline 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	
Health Net	Tulare	Two-Plan: CP	42.9	41.1	44.9
Health Plan of San Joaquin	San Joaquin	Two-Plan: LI	42.3	34.7	40.5
Health Plan of San Mateo	San Mateo	COHS	48.1	52.7	57.5
Inland Empire Health Plan	Riverside/San Bernardino	Two-Plan: LI	47.4	48.0	53.3
Kaiser Permanente—North	Sacramento	GMC: CP	38.9 †	40.2 †	48.9
Kaiser Permanente—South	San Diego	GMC: CP	41.7 †	39.5 †	40.8
Kern Family Health Care	Kern	Two-Plan: LI	38.9	40.3	38.9
L.A. Care Health Plan	Los Angeles	Two-Plan: LI	31.6	33.1	33.7
Molina Healthcare	Riverside/San Bernardino	Two-Plan: CP	36.1	39.9	42.9
Molina Healthcare	Sacramento	GMC: CP	33.3	31.9	41.6
Molina Healthcare	San Diego	GMC: CP	40.6	39.1	44.7
Partnership Health Plan	Napa, Solano, Yolo	COHS	45.0 †	46.8 †	48.8
San Francisco Health Plan	San Francisco	Two-Plan: LI	22.8	22.5†	26.4
Santa Clara Family Health	Santa Clara	Two-Plan: LI	36.1	35.0	31.7

<sup>‡</sup> Table data reflect plan-reported rates via 2010 QIP submissions.

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

^ CenCal Health—San Luis Obispo County added in March 2008; therefore, baseline is 3/1/2008–12/31/2008 and Remeasurement 1 is 1/1/2009–12/31/2009.

Δ Data not reported in QIP submission.

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

Of the 36 counties that reported a second remeasurement period, three showed a decrease in their ED visits rate while 33 showed an increase. CenCal Health—San Luis Obispo demonstrated an increase from baseline to Remeasurement 1.

Table 6.2 includes baseline through Remeasurement 2 results for *Measure II—Avoidable ER Visits*. HSAG compared each measurement period with the prior measurement period and evaluated the QIP for statistically significant improvement. For this measure, a statistically significant decrease in the rate demonstrates improvement. Sustained improvement is achieved for plans that had a statistically significant decrease during the first remeasurement period and sustained the increase by not showing a statistically significant decline or decline below the baseline rate.

**Table 6.2—Measure II—Avoidable ER Visits<sup>1</sup>**  
January 1, 2009, through December 31, 2009

Plan Name	County	Model and Plan Type <sup>2</sup>	Avoidable ER Visits as a Percentage of Overall ER Visits			Sustained Improvement
			Baseline 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09	
Alameda Alliance for Health	Alameda	Two-Plan: LI	12.1%^	15.0%^†	19.9%†	No
Anthem Blue Cross	Alameda	Two-Plan: CP	18.7%	16.3%*	21.0%†	No
Anthem Blue Cross	Contra Costa	Two-Plan: CP	20.9%	17.7%*	19.5%†	No
Anthem Blue Cross	Fresno	Two-Plan: CP	16.4%	16.6%	18.0%†	No
Anthem Blue Cross	Sacramento	GMC: CP	17.0%	15.7%*	18.0%†	No
Anthem Blue Cross	San Francisco	Two-Plan: CP	16.4%	16.3%	18.5%†	No
Anthem Blue Cross	San Joaquin	Two-Plan: CP	18.5%	18.3%	20.1%†	No
Anthem Blue Cross	Santa Clara	Two-Plan: LI	17.6%	17.7%	22.3%†	No
Anthem Blue Cross	Stanislaus	Two-Plan: LI	22.2%	21.1%*	18.4%*	Yes
Anthem Blue Cross	Tulare	Two-Plan: LI	21.3%	19.8%*	20.5%†	No
CalOptima	Orange	COHS	16.1%	16.7%†	16.6%	No
Care 1st	San Diego	GMC: CP	13.8%	17.7%†	12.2%*	No
CenCal Health	Santa Barbara	COHS	19.2%	19.6%	18.8%*	No
CenCal Health	San Luis Obispo	COHS	18.8%‡	22.0%‡†	Δ	
Central Coast Alliance for Health	Monterey, Santa Cruz	COHS	23.2%	19.0%*	22.2%†	No
Community Health Group	San Diego	GMC: CP	17.9%	16.5%*	21.6%†	No
Contra Costa Health Plan	Contra Costa	Two-Plan: LI	16.6%	20.9%†	20.0%*	No
Health Net	Fresno	Two-Plan: CP	17.4%	22.2%†	19.8%*	No
Health Net	Kern	Two-Plan: CP	15.3%	21.5%†	21.7%	No
Health Net	Los Angeles	Two-Plan: CP	15.5%	21.7%†	21.7%	No
Health Net	Sacramento	GMC: CP	15.9%	19.0%†	18.8%	No
Health Net	San Diego	GMC: CP	16.2%	20.5%†	17.8%*	No
Health Net	Stanislaus	Two-Plan: CP	14.5%	23.5%†	23.3%	No
Health Net	Tulare	Two-Plan: CP	19.4%	22.5%†	22.1%	No

**Table 6.2—Measure II—Avoidable ER Visits<sup>1</sup>  
January 1, 2009, through December 31, 2009**

Plan Name	County	Model and Plan Type <sup>2</sup>	Avoidable ER Visits as a Percentage of Overall ER Visits			Sustained Improvement
			Baseline 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09	
Health Plan of San Joaquin	San Joaquin	Two-Plan: LI	21.3%	16.7%*	21.5%†	No
Health Plan of San Mateo	San Mateo	COHS	15.0%	16.2%†	17.2%†	No
Inland Empire Health Plan	Riverside/ San Bernardino	Two-Plan: LI	22.8%	20.3%*	23.0%†	No
Kaiser Permanente – North	Sacramento	GMC: CP	11.6%	10.8%	14.3%†	No
Kaiser Permanente – South	San Diego	GMC: CP	11.5%	13.1%†	15.9%†	No
Kern Family Health Care	Kern	Two-Plan: LI	15.9%	16.9%†	14.7%*	No
L.A. Care Health Plan	Los Angeles	Two-Plan: LI	16.0%	15.9%	22.4%†	No
Molina Healthcare	Riverside	Two-Plan: CP	19.6%	21.6%†	21.8%	No
Molina Healthcare	San Bernardino	Two-Plan: CP	19.1%	20.9%†	21.5%	No
Molina Healthcare	Sacramento	GMC: CP	14.5%	16.7%†	16.1%	No
Molina Healthcare	San Diego	GMC: CP	15.3%	16.2%†	15.9%	No
Partnership Health Plan	Napa, Solano, Yolo	COHS	17.7%	18.9%†	21.5%†	No
San Francisco Health Plan	San Francisco	Two-Plan: LI	16.3%^	17.0%^	20.3%†	No
Santa Clara Family Health	Santa Clara	Two-Plan: LI	17.1%^	18.5%^†	24.8%†	No

Note: Sustained improvement from baseline to Remeasurement 2 is indicated by either “Yes” or “No.”

<sup>1</sup> Table data reflect plan-reported rates via 2009 QIP submissions.

<sup>2</sup> Model Types: COHS=County-Operated Health System, GMC=Geographic Managed Care, Two-Plan Plan Types: CP=Commercial Plan, LI=Local Initiative

\* Statistically significant improvement between measurement periods ( $p$  value  $\leq 0.05$ ).

† Statistically significant decline in performance between measurement periods ( $p$  value  $\leq 0.05$ ).

‡ CenCal Health—San Luis Obispo County added in March 2008; therefore, baseline is 3/1/2008–12/31/2008 and Remeasurement 1 is 1/1/2009–12/31/2009.

Δ Data not reported in November 2010 QIP submission.

^ Rate may have been calculated incorrectly.

Thirteen of 37 counties demonstrated a decrease in the rate of avoidable ER visits between the first remeasurement period and the second remeasurement period. For seven of the 13 counties, the improvement was statistically significant. Conversely, 24 counties reported an increase in the rate of avoidable ER visits; and for 20 counties, the decline in performance was statistically significant.

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

Anthem Blue Cross—Stanislaus County was the only county that achieved statistically significant improvement between the baseline and Remeasurement 1 periods and sustained that improvement during the second remeasurement period. No plans achieved sustained improvement at the overall plan level.

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

**Table 6.3—Measure II—Avoidable ER Visits by Model Type<sup>‡</sup>  
January 1, 2009, through December 31, 2009**

Change in Avoidable ER Visits From Remeasurement 1 to Remeasurement 2	Model and Plan Type			
	County- Organized Health System N = 6	Two-Plan: CP N = 12	Two-Plan: Local Initiative N = 11	Geographic Managed Care: CP N = 9
Statistically Significant Improvement	16.7%	8.3%	27.3%	22.2%
No Statistically Significant Change	33.3%	50.0%	0.0%	33.3%
Statistically Significant Decline in Performance	50.0%	41.7%	72.7%	44.4%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>99.9%*</b>
<sup>‡</sup> Table data reflect plan-reported rates via 2009 QIP submissions. *The total is not 100 percent due to rounding. CP=Commercial Plan				

HSAG assessed differences in improvement from Remeasurement 1 to Remeasurement 2 by model type. Over 22 percent of GMC county plans showed statistically significant improvement compared to 27.3 percent for the Two-Plan local initiative county plans, 8.3 percent for the Two-Plan commercial plans and 16.7 percent for the COHS county plans. Conversely, 72.7 percent of



the Two-Plan local initiative county plans reported a statistically significant decline in performance. HSAG did not identify a meaningful pattern of improvement by model type.

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

**Table 6.4—Measure II—Avoidable ER Visits by County\***  
January 1, 2009, through December 31, 2009

County	Change in Avoidable ER Visits From Remeasurement 1 to Remeasurement 1			Total Number of Plans Per County
	Statistically Significant* Improvement	Statistically Significant* Decline in Performance	No Statistically Significant* Change	
Alameda		2		2
Contra Costa	1	1		2
Fresno	1	1		2
Kern	1		1	2
Los Angeles		1	1	2
Monterey/Santa Cruz		1		1
Napa, Solano, Yolo		1		1
Orange			1	1
Riverside			1	1
Riverside/San Bernardino		1		1
Sacramento		2	3	5
San Bernardino			1	1
San Diego	2	2	1	5
San Francisco		2		2
San Joaquin		2		2
San Mateo		1		1
Santa Barbara	1			1
Santa Clara		2		2
Stanislaus	1		1	2
Tulare		1	1	2
<b>Total</b>	<b>7</b>	<b>20</b>	<b>11</b>	<b>38</b>

\* Table data reflect plan-reported rates via 2010 QIP submissions.  
\* Statistically significant change ( $p$  value  $\leq 0.05$ ).

HSAG also assessed change in avoidable ER visit rates by county. Eight counties, or combined counties, were represented by only one plan. For these single-plan counties, only Santa Barbara reduced its rate of avoidable ER visits. In counties with five plans, only two plans in San Diego reported a decrease in the rate of avoidable ER visits.

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

**Table 6.5—Measure II—Avoidable ER Visits—Plans With Improvement Between Remeasurement 1 and Remeasurement 2 January 1, 2009, through December 31, 2009**

Plan Name and County	Statistically Significant Improvement	Sustained Improvement
Anthem Blue Cross—Stanislaus	✓	✓
Care 1st	✓	
CenCal Health—Santa Barbara	✓	
Contra Costa Health Plan	✓	
Health Net—Fresno	✓	
Health Net—San Diego	✓	
Kern Family Health Care	✓	

For the seven county-level plans showing statistically significant improvement between Remeasurement 1 and Remeasurement 2, only one plan demonstrated sustained improvement. All plans that showed statistically significant improvement implemented a variety of plan-specific interventions. Most of these plans implemented a combination of member, provider, and system interventions.

## Strengths/Opportunities for Improvement

Plans improved their compliance with the CMS protocol for conducting QIPs compared with the prior review period. Plans demonstrated high validation scores for study design and study implementation phases of the QIP. Despite the high validation scores, plans still had challenges similar to the prior review period with providing consistent rates within the QIP submission and the HEDIS reported rate. The DHCS should strongly consider having the EQRO audit collaborative QIP rates in future projects to ensure valid rates and promote greater confidence to comparability among plans and between remeasurement periods.

The DHCS and the plans had good success with evaluating their statewide collaborative interventions. The resulting information is valuable in terms of identifying factors that may be promising moving forward as well as factors that may have prevented the collaborative from achieving targeted results.

The Member Health Education Campaign survey results indicated that, after having a discussion with their provider about the appropriate use of the ER, respondents were more likely to contact their provider or plan's nurse advice line before visiting the ER. The survey results also showed that a very small percentage of respondents had a discussion about the campaign materials and appropriate use of the ER with their provider. Therefore, plans have an opportunity to increase this interaction and discussion between providers and members. Member survey results also suggested poor sustainability of the campaign after initial implementation and/or poor message recognition. Plans have an opportunity to assess this further.

While nearly all plans documented partnership with a hospital to improve data exchange, and most plans documented receiving member information from the hospital on a routine basis, the plans demonstrate differing efforts to outreach members who had a recent visit to the ER. This presents a missed opportunity for plans. Additionally, while the collaborative identified outcomes measures, HSAG noted potential errors in the plans' self-reported rates.

Thirty-five percent of county plans reporting Remeasurement 1 and Remeasurement 2 rates for avoidable ER visits experienced a decrease. This is consistent with the percentage of decrease in the prior review period between baseline and Remeasurement 1. Of those, approximately half showed a statistically significant decrease. Anthem Blue Cross–Stanislaus County was the only plan with sustained improvement.

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

## Next Steps

The collaborative's next steps include the following:

- ◆ Collect and report Remeasurement 3 data and submit QIPs to the EQRO for validation by October 29, 2011.
- ◆ Collect and report plan-hospital data collaboration outcome measures data for January 1, 2010–June 30, 2010.
- ◆ Gather feedback from participants regarding the collaborative QIP process to be used as input for future collaborative projects.

HSAG will complete the next statewide collaborative QIP report, including the third and final remeasurement year data and analysis, in July 2012. The DHCS's public release of that report is targeted for September 2012.

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

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

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

**The Baseline Measurement Period:**

- ◆ The 12-month calendar year (January 1, 2007, through December 31, 2007)<sup>A-1</sup>

**Numerator:**

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

**Denominator:**

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

**Rate:**

- ◆ The percentage of all ER visits defined as avoidable

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<sup>A-1</sup> The baseline measurement period is based on the revised collaborative time frame.

ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

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

ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

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

ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

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



ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

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

Appendix B contains the following materials:

- ◆ Member survey in English
- ◆ Member survey in Spanish
- ◆ Member survey responses

# Member Survey

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

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

**Yes**

**No**

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

**Yes**

**No**

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

**Yes**

**No**

***If you answered “No” to question 3, you are done with this survey!***

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

4. After talking with your doctor:

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

**Yes**

**No**

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

**Yes**

**No**

## Thank you!

### For Office Use Only

Survey  
Number :

Administered in:  English  Spanish  Chinese  Vietnamese  Other (please specify) \_\_\_\_\_

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

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

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

# ENCUESTA PARA MIEMBROS

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

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

**Sí**

**No**

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

**Sí**

**No**

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

**Sí**

**No**

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

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

4. Después de hablar con su doctor:

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

**Sí**

**No**

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

**Sí**

**No**

## ¡Gracias!

**For Office Use Only**

Survey  
Number :

Administered in:  English  Spanish  Chinese  Vietnamese  Other (please specify) \_\_\_\_\_

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

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

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

## ER Collaborative Member Survey Report

### January 2011

The online survey was set up in two parts. The first part was for the purpose of obtaining demographic information from the plans and information about their survey methodology. The second part consisted of the member survey questions. The survey questions and response summaries are included below:

<b>1. Please enter Member Survey #:</b>	
<i>answered question</i>	<b>875</b>

<b>2. Please enter the name of the staff person and e-mail address of the person who entered survey responses.</b>		
Answer Options	Response Percent	Response Count
Name	100.0%	875
E-mail Address	100.0%	875
Health Plan	100.0%	875
<i>answered question</i>		<b>875</b>

<b>3. Please enter the name of the city where member received services?</b>	
<i>answered question</i>	<b>875</b>

4. Please enter the county where member received services?		
Answer Options	Response Percent	Response Count
Alameda	3.7%	32
Contra Costa	3.4%	30
Fresno	3.5%	31
Kern	4.8%	42
Los Angeles	32.7%	286
Marin	0.0%	0
Monterey	0.0%	0
Napa	0.8%	7
Orange	9.9%	87
Riverside	5.1%	45
Sacramento	4.9%	43
San Bernardino	4.6%	40
San Diego	4.1%	36
San Francisco	2.9%	25
San Joaquin	2.4%	21
San Luis Obispo	1.1%	10
San Mateo	1.3%	11
Santa Barbara	1.1%	10
Santa Clara	4.8%	42
Santa Cruz	0.0%	0
Solano	1.5%	13
Sonoma	0.0%	0
Stanislaus	2.1%	18
Tulare	3.3%	29
Yolo	1.9%	17
<i>answered question</i>		<b>875</b>
<i>skipped question</i>		<b>0</b>

5. How was this member survey administered?		
Answer Options	Response Percent	Response Count
Interactive voice response	0.1%	1
Telephone member outreach (phone call)	52.5%	459
At the PCP office (after office visit)	6.7%	59
Other (please specify)	40.7%	356
<i>answered question</i>		<b>875</b>

**6. Length of time between Member's visit to the PCP and the administration of this survey?**

Answer Options	Response Percent	Response Count
Same day	0.5%	4
1 week or less	0.1%	1
2 - 3 weeks	0.0%	0
4 - 6 weeks	5.6%	49
More than six weeks	88.0%	770
Do not know	5.8%	51
Other (please specify)	0.0%	0
<i>answered question</i>		<b>875</b>

**7. Length of time between PCP receiving the campaign materials (poster and brochure) and member's office visit.**

Answer Options	Response Percent	Response Count
1 week or less	0.6%	5
2 - 3 weeks	0.6%	5
4 - 6 weeks	2.7%	24
More than 6 weeks	56.5%	494
Do not know	39.7%	347
Other (please specify)		0
<i>answered question</i>		<b>875</b>

**Member Survey Questions (1 through 5)****1) Did you receive a brochure titled "Not Sure It's An Emergency" at your doctor's office?**

Answer Options	Response Percent	Response Count
Yes	18.3%	157
No	81.7%	703
*Other (please specify)		78
<i>answered question</i>		<b>860</b>
<i>skipped question</i>		<b>15</b>

"Other" responses were all mailed surveys

2) Did you see a <u>poster</u> titled, "Not Sure It's and Emergency" at your doctor's office		
Answer Options	Response Percent	Response Count
Yes	24.9%	214
No	75.1%	646
Comments (please specify)		36
<i>answered question</i>		<b>860</b>
<i>skipped question</i>		<b>15</b>

3) Did your doctor spend time with you explaining the brochure and/or poster?		
Answer Options	Response Percent	Response Count
Yes	17.9%	154
No	82.1%	706
Comments (please specify)		25
<i>answered question</i>		<b>860</b>
<i>skipped question</i>		<b>15</b>

The member survey included the following statement after question 3:

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

4) <i>After talking with you doctor</i> , will you be more likely to call your doctor (or nurse advice line) when you are not sure about going to the emergency room?		
Answer Options	Response Percent	Response Count
Yes	88.2%	142
No	11.8%	19
Comments (please specify)		3
<i>answered question</i>		<b>161</b>
<i>skipped question</i>		<b>714</b>

5) <i>After talking with your doctor</i> , will you be more likely to call your doctor (or nurse advice line) if you are worried about your child's earache, sore throat, cough, cold, or flu?		
Answer Options	Response Percent	Response Count
Yes	90.0%	144
No	10.0%	16
Other (please specify)		3
<i>answered question</i>		<b>160</b>
<i>skipped question</i>		<b>715</b>



**Problem:**

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

**Goal:**

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

**Barriers:**

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

## **Basic Information Required of Health Plans**

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

## **Process to Measure Success of Collaboration between Health Plans and Hospitals**

1. **Data Frequency** – the percentage of health plans that receive regular ER data feeds from at least one participating hospital during the measurement period.
  - ◆ Plans report the frequency of reporting standard that they have arranged with a hospital.
  - ◆ Plans report the actual frequency that they receive data feeds during the measurement period (percentage of late reports).
2. **Data Timeliness** – the percentage of ER visits received from the participating hospital(s) within 5, 10 and 15 days of the service date during the measurement period. Plans report a percentage for each time period.

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

Measurement Period: annually; submit with annual QIP status report

\* Total number of ER visits, all ages for the participating hospital.

3. **Data Volume** – the percentage of total plan visits received by the health plan from the participating hospital(s) through the regular data feeds compared to total ER visits for all hospitals.

- ◆ Numerator = total number of ER visits received from the participating hospital(s) through regular data feeds during the measurement period
- ◆ Denominator = total ER visits from the HEDIS ER\* measure denominator for the measurement period

Measurement period: annually, submit with annual QIP status report

\*Total ER Visits for all ages.

4. **Data Completeness** – the percentage of total ER visits received through the regular data feeds compared to ER visits from claims/encounter data received from the participating hospital(s).

- ◆ Numerator = total number of ER visit records received from the participating hospital(s) through the regular data feeds
- ◆ Denominator = total number of ER visit records received from the participating hospital(s) through claim/encounter data

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

5. **Member Communications** – the percentage of member outreach attempts/communications originating from the data feeds during the measurement period

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

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

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

## Outcome Measures

### 6. Avoidable ER Visit Rate (AER Rate) for Participating Hospital(s)

- ◆ Numerator = total number of avoidable ER visits from claims/encounter data for the participating hospital(s) for the measurement period
  - ◆ Denominator = total number of ER visits from claim/encounter data for the participating hospital(s) for the measurement period derived from the denominator for Measure II Avoidable Emergency Room Visits
- Measurement period: annually, submit with annual QIP status report

### 7. Avoidable ER Visit Rate (AER Rate) for Non-Participating Hospital(s)

- ◆ Numerator = total number of avoidable ER visits from claim/encounter data for the non-participating hospital(s) for the measurement period
  - ◆ Denominator = number of total ER visits from claim/encounter data for the non-participating hospital(s) for the measurement period derived from the denominator for Measure II Avoidable Emergency Room Visits
- Measurement period: annually, submit with annual QIP status report

### 8. Total Plan AER Rate

- ◆ Numerator = number of total avoidable ER visits from claim/encounter data for the measurement period
  - ◆ Denominator = number of total ER visits from claim/encounter data for the measurement period (from the HEDIS measure)
- Measurement period: annually, submit with annual QIP status report

## Outcome Evaluation

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

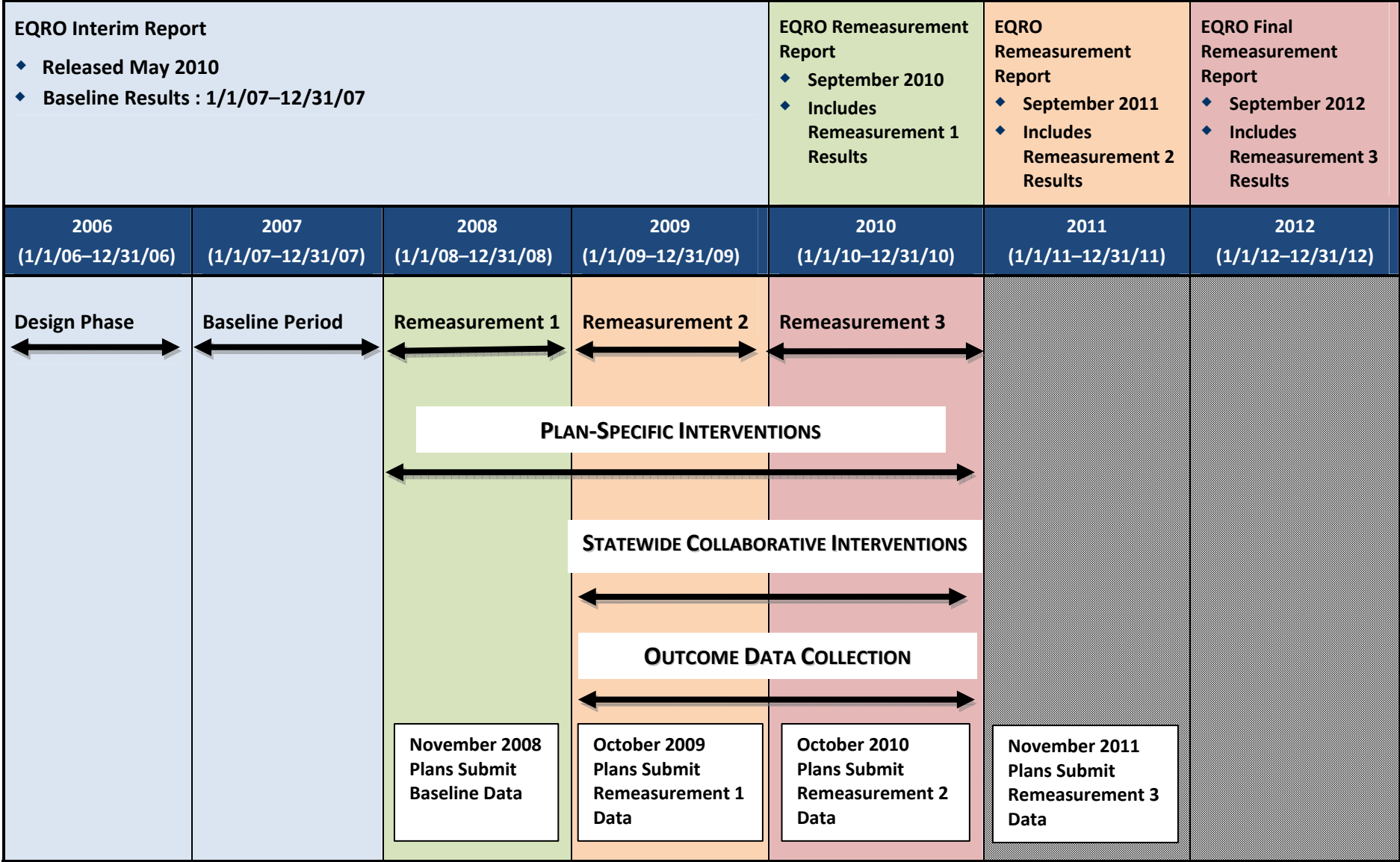
- ◆ AER Rate for participating vs. non-participating hospital(s)
- ◆ AER Rate for participating hospital(s) pre and post intervention
- ◆ AER Rate for non-participating hospitals pre and post intervention
- ◆ Total AER Rate pre and post intervention
- ◆ AER Rate for participating hospital(s) vs. Total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

*Appendix D.* **TIMELINE FOR THE ER STATEWIDE COLLABORATIVE QIP**

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Appendix D presents the ER statewide collaborative QIP timeline.

Timeline for the ER Statewide Collaborative QIP



*Appendix E.* **2009 MEMBER COMMUNICATION INTERVENTIONS**

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The DHCS collected information from each participating plan through QIP documentation and plan responses documented in the *Hospital Collaboration Outcomes Measures* forms and compiled the information into the grid on the following page.

Health Plan	Letter	Phone Call	Postcard	Advice Line	Misc Written Materials/ Brochures	Eval Relationship with PCP	Self Care Guide	Other	Comments
Alameda Alliance									Not implemented due to budget constraints and sustainability of intervention.
Anthem Blue Cross		X		X		X	X		Health service call staff contacted members and conducted screening questions for chronic health care conditions and PCP, and provided information related to the nurse advice line; offered a copy of Healthwise handbook, <i>A Self-Care Guide for You and Your Family</i> ; referred to CM as appropriate.
Cal Optima	X								Intervention delayed due to data challenges; distributed Medical Home Guide; health plan and providers received list of members seen in the ER and encouraged follow-up contact.
Care 1st									No report.
CenCal	X				X				Sent PCP after-hours availability brochure to members after each avoidable ER visit; brochure focused on network PCP extended office hours for avoidable conditions.
Central Ca. Alliance for Health									Not implemented due to data challenges.
Community Health Group	X	X		X	X				Promoted PCP and urgent care use.
Contra Costa Health Plan	X			X	X		X		Provided information on the Advice Nurse services and also encouraged members to contact their PCP; created a resource tip sheet helping members determine if it is necessary to go to the emergency room; provided a free copy of the book, <i>What to Do When Your Child Gets Sick</i> upon member request; children with multiple ER visits automatically received a copy of this book and a follow-up phone call from a nurse.

Health Plan	Letter	Phone Call	Postcard	Advice Line	Misc Written Materials/ Brochures	Eval Relationship with PCP	Self Care Guide	Other	Comments
Health Plan of San Joaquin	X			X	X				Expanded outreach to members with frequent visits to the ER; placed case manager telephone calls regarding alternatives to use instead of the ER; faxed ER face sheets with cover letter to PCPs.
Health Plan of San Mateo									Not implemented due to data challenges.
Health Net			X	X					Sent postcards weekly reminding members to contact their PCP or the advice line; sent providers a list of their patients with avoidable ER visits. Sent PCPs a list of members seen in the ER.
Inland Empire HP								X	Health Navigator Project—Health plan staff visited the hospital ER Monday–Fridays to verify member eligibility; faxed member triage and eligibility information to PCP; assisted member with follow-up visits; conducted brief survey of members’ knowledge of managed care and health plan. Expanded service to include fracture care—timely consultation with members in the ER who have a possible fracture; facilitated care through health plan staff in the ER.
Kaiser Permanente		X		X		X			Provided information on how to access the Appointment and Advice Call Center to obtain urgent care appointments and/or medical advice from an RN or MD.
Kern Family Health Care	X	X		X					Contacted members initially via telephone; mailed letter and materials if unable to reach member; sent letter to ER director advising of inappropriate instruction to members to return to the ER for recheck/follow-up care and that members should be referred to PCP or instructed to contact the health plan.



Health Plan	Letter	Phone Call	Postcard	Advice Line	Misc Written Materials/ Brochures	Eval Relationship with PCP	Self Care Guide	Other	Comments
LA Care	X			X	X		X		Sent member an information packet including ER campaign materials within 14 days of an avoidable ER visit.
Molina Healthcare	X	X		X	X		X		Advised member of urgent care and reinforced medical home; ER faxed face sheets to PCP; referred member to CM if three or more visits within four months; CM called member to conduct initial assessment.
Partnership Health Plan								X	Hospital sent member ER information directly to PCPs. Hospital conducted face-to-face interventions with frequent users when seen in the ER for an avoidable visit. Hospital scheduled follow-up visits with PCP for member. Referred members to Urgent Care/Diversion Clinic in lieu of the ER for an avoidable visit.
San Francisco Health Plan		X					X		Patient Advocate Program: contacted members within one week of an ER visit; arranged visit with PCP within one month, educated members regarding appropriate use of the ER; sent resource book, <i>What to Do When Your Child Is Sick</i> to children with upper respiratory infections; sent PCP member information including overdue health maintenance interventions and member ER data.
Santa Clara Family Health		X							Used part-time case manager.

**Note:** Interventions are limited to member communication and provider communication as a result of the data received from hospitals. Additional interventions can be found in the individual plan-specific QIP reports.