Statewide Collaborative Quality Improvement Project

Reducing Avoidable Emergency Room Visits

Final Remeasurement Report: January 1, 2010 – December 31, 2010

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

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Purpose and Scope of Report

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

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

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

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

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 an annual report during the duration of the statewide collaborative QIP.

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

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

Following the baseline report, the DHCS released an interim collaborative report in June 2010, available on the DHCS Web site,[4] which described the collaborative activities conducted since the baseline report. The interim report provided the status of statewide collaborative interventions, initial QIP validation findings, baseline data, collaborative successes and challenges, and recommendations.

HSAG produced the first remeasurement report, and the DHCS released the report in November 2010.[5] 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.

HSAG produced the second remeasurement report, and the DHCS released the report in November 2011.[6] The remeasurement report described collaborative activities since the first remeasurement report. The report displayed QIP validation findings and presented the second year of remeasurement data, covering the period of January 1, 2009, through December 31, 2009.

The purpose of this final remeasurement report is to provide a summary of the collaborative activities; provide QIP validation findings and final remeasurement data for the period of January 1, 2010, through December 31, 2010; discuss activity related to the second remeasurement report's recommendations; and present successes and lessons learned from the collaborative.

Summary of Collaborative Quality Improvement Project Activities

Since the second remeasurement report, the collaborative:

- Continued implementation of its plan-hospital data collaboration pilot.
- Submitted third-year remeasurement data to the EQRO for QIP validation in October 2011.
- Submitted plan/hospital data collaboration intervention data to the EQRO in October 2011 to compile and analyze results.

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

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

[6] Department of Health Care Services. *Statewide Collaborative Improvement Project – Reducing Avoidable Emergency Room Visits Remeasurement Report*: January 1, 2009 through December 31, 2009, November 2011. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

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. As a result of this validation, HSAG determined the credibility of the reported results. HSAG provided each QIP submission with an overall validation status of *Met*, *Partially Met*, or *Not Met*. The DHCS requires that QIPs receive an overall *Met* validation status; therefore, plans must resubmit a QIP until it achieves a *Met* validation status. Of the 24 QIP submissions, 2 required a resubmission. As of March 31, 2012, all collaborative QIP submissions received an overall *Met* validation status.

Within the QIP submissions, plans operating in multiple counties reported county-level results. Of the 38 county-specific results that had remeasurement rates, 55 percent showed statistically significant improvement (a decline) in their avoidable ER visits rate between the second and third remeasurement period. Conversely, the remeasurement data showed a statistically significant decline in performance of the avoidable ER visits rate for 11 percent of the county-specific plan rates. Twenty-six percent of the county-specific plans achieved sustained improvement from baseline to the final measurement period.

Analysis by plan model type showed differences. From Remeasurement 2 to Remeasurement 3, the Two-Plan models outperformed the County-Organized Health Systems and the Geographic Managed Care Plans. Fifty percent of the Two-Plan commercial plans and 81 percent of the Two-Plan local initiative plans demonstrated statistically significant improvement over the prior measurement period, and neither model reported a statistically significant decline in performance.

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

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

Successes

HSAG observed good cooperation and active participation from all 20 plans throughout the collaborative process. The DHCS was able to engage plans at all levels of plan leadership, which may have increased the plans' investment in the project and dedication of plan resources. The State and plans were successful in identifying an area of concern common to all plans and in need of improvement. In addition, the collaborative worked to review the literature and developed a performance measure that all plans would use over the course of the project.

One of the two statewide collaborative interventions was a member health education campaign aimed at increasing communication between members and PCPs on appropriate ER use and increasing members' knowledge of alternatives to the ER. Based on provider survey results collected in the second remeasurement period, overall, providers found the member health education campaign materials helpful in talking with patients about the ER. By providing these materials, the campaign may have increased how frequently providers and patients communicate regarding appropriate ER use. Additionally, member survey data collected during the first remeasurement period showed that, while only a small percentage (18 percent) of member respondents indicated that their doctor spent time explaining the campaign brochure and/or poster with them, 88 percent of those 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.

The second statewide collaborative intervention was a hospital/plan data exchange, which allowed for timely notification of members seen in the emergency room for an avoidable visit. Plans overcame early challenges and barriers related to identifying hospitals willing to participate in a data exchange, resulting in the implementation of provider and member interventions by all plans participating in the collaborative and the development of manual and electronic systems by health plans and participating hospitals to facilitate the timely exchange of ER data. During the last year of the QIP, plans had improved their QIP validation scores compared with the prior review period. Plans demonstrated high validation scores for study design and study implementation phases of the QIP. Additionally, for the outcomes stage, the plans improved the validation scores for all three activities as the project progressed.

The collaborative had some late outcome success with its project showing that fifty-five percent of the county-specific plans reporting final measurement rates for avoidable ER visits demonstrated statistically significant reductions in their avoidable ER visits rates over the prior measurement period. This percentage is higher than the two prior review periods. Additionally, twenty-six percent achieved sustained improvement from baseline through the final measurement period. Plans had greater success at the county-level than at the overall plan level.

Analysis by plan model type revealed that the Two-Plan models outperformed the County-Organized Health Systems and the Geographic Managed Care Plans. Fifty percent of the Two-Plan commercial plans and 81 percent of the Two-Plan local initiative plans demonstrated statistically significant improvement over the prior measurement period, and neither model reported a statistically significant decline in performance.

Lessons Learned

In addition to the collaborative successes, there were also many lessons learned. The collaborative experienced a longer than anticipated period for project planning and implementation of the QIP interventions, which resulted in an additional year of remeasurement to fully assess the impact of the collaborative interventions. Plans also provided feedback that the process for developing the avoidable ER visits measure was complicated and resource intensive. In future years, the DHCS and plans should allow adequate time for the startup of the next collaborative project to ensure the timing aligns with the measurement periods.

For this collaborative project, an evaluation plan was not initiated at the start of the project, which could have potentially alleviated some of the challenges with execution and planning of the collaborative activities. In future years, the collaborative should consider developing an evaluation plan at the inception of the project to help lay the groundwork for a project theory which in turn would direct the collaborative toward interventions that directly align with identified barriers. Additionally, the DHCS should consider allowing plans to customize interventions that are specific to their plans and county-specific barriers to help increase the likelihood of success.

While the Member Health Education Campaign survey results showed success with some members indicating that they would contact their PCP or use a plan nurse advice line in the future, the survey results also showed that only a very small percentage of respondents had a discussion about the campaign materials and appropriate use of the ER with their provider. Although plans had an ongoing opportunity to increase this interaction and discussion between providers and members, some plans were unable to provide campaign materials and support to providers beyond the initial implementation phase of the campaign. Additionally, since the member survey was conducted approximately a year after the initial implementation phase, it is unclear whether the member survey results suggested poor sustainability of the campaign after initial implementation or poor message recognition. These issues should be addressed before future educational campaigns are initiated to promote success over time.

While nearly all plans documented partnership with a hospital to improve data exchange, and most plans documented routinely receiving member information from the hospital, the plans demonstrated differing efforts to outreach members as a result of receiving this information. This variance continued to be a missed opportunity for plans. Additionally, while the collaborative identified standardized outcomes measures, further consideration should be given to future projects to ensure that plans' self-reported rates are audited and validated to reduce errors and strengthen the reliability of the results as HSAG noted potential issues with plans' self-reported data.

Finally, plans continued to report challenges with collaborative efforts to reduce avoidable ER visits given many hospitals' direct marketing efforts to increase use of the ER and the length of

time required to change patient behaviors related to the appropriate use of emergency rooms. Many collaborative partners voiced concerns that the financial arrangements with hospitals and providers would need to change before they could achieve a true reduction in avoidable ER visits. Other states have initiated or are in the design phases of similar collaborative approaches to reduce avoidable ER visits. Many of these collaboratives include interventions that facilitate participation of hospitals as collaborative partners. The results from these efforts are pending but once available may provide additional information on the effectiveness of alternate strategies.

Despite the numerous challenges encountered throughout the collaborative, overall, the topic and ultimate goal to reduce avoidable ER visits was of value to the health plans. The Medi-Cal Managed Care Division surveyed all health plans at the completion of the collaborative to obtain the health plans' perception of the successes, challenges, value of the collaborative, and whether the health plans would continue the collaborative interventions. Health plans reported that the collaborative improved communication and coordination with hospitals, improved communication with providers, raised member awareness of alternate options other than the ER, and raised provider awareness of their members' ER usage. The collaborative also served to raise public awareness of avoidable ER visits through one health plan's presentation of the collaborative at a national quality conference. Also, three other health plans shared the campaign materials and additional collaborative resources with hospitals, clinics, medical groups, and other State agencies.

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 third and final remeasurement year, which reflects data from January 1, 2010, through December 31, 2010, 20 full-scope health plans were operating in 24 counties throughout California, providing comprehensive health services to approximately 4.1 million beneficiaries enrolled in Medi-Cal managed care as of December 31, 2010.[7]

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.

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" 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, 2010, through December 31, 2010, the GMC model type was operating in San Diego and Sacramento counties.

[7] *Medi-Cal Managed Care Enrollment Report, December 2010.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Two-Plan

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

Quality Improvement Project (QIP) Requirements

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.

Purpose of the Collaborative QIP

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 the continuity of care between the member and his or her primary care provider, improve access to the primary care provider, as well as encourage 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 analyses. 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.

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, 2010, and 2011 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; January 1, 2009, through December 31, 2009; and January 1, 2010, through December 31, 2010, 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.

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 2 and Remeasurement 3 years using this measure.

Collaborative Statewide Interventions

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

While development and implementation of intervention outcome measures are not standardized components of a QIP, they were necessary to evaluate the efficacy of the interventions. The efforts of the collaborative to collect information on the two statewide interventions allowed evaluation of the interventions' short-term and/or intermediate impact on the targeted causal barriers. This information was used by the collaborative partners to determine allocation of resources for ongoing and future interventions.

Member Health Education Campaign

All 20 plans participating in the collaborative implemented the member health education campaign. One of the two objectives of the member health education campaign was to increase communication between members and PCPs on appropriate ER use. The second objective was to increase members' knowledge/awareness of alternatives to using the ER. The collaborative developed both a provider and member survey to measure the success of the campaign.

An estimated 7,000 providers across Medi-Cal managed care counties received campaign materials, which represents approximately 67 percent of Medi-Cal managed care providers who see members 1 to 19 years of age.[8] The MMCD collected and aggregated provider survey results for 519 providers and 875 respondents for the member survey.

Provider Survey Results

The provider survey results showed that approximately 74 percent of 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.[9]

[8] Department of Health Care Services. Health Plan Survey Provider Sample Responses. November 2, 2009.
[9] 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

Most members were contacted via telephone member outreach. Only 18 percent of respondents indicated that they received a campaign brochure and 25 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.

Only 18 percent of respondents indicated that their doctor spent time explaining the campaign brochure and/or poster with them; however, 88 percent of those 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. Detailed results from the member survey were included in the ER Collaborative Remeasurement Report, available on the DHCS Web site.[10]

Member Health Education Campaign Successes and Lessons Learned

The collaborative 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.[11] 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 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.

[10] Department of Health Care Services. *ER Collaborative Remeasurement Report: January 1, 2009 – December 31, 2009.* September 2011. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

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

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. However, survey results are difficult to interpret because the member survey was conducted a year after the initial implementation of the campaign. Many plans reported limited funding to continue to reprint the campaign materials and inadequate staff time to provide ongoing PCP support for the campaign after the initial implementation. Since the member survey was conducted well after the initial implementation, it is unclear whether the majority of the members surveyed had limited recall of the message or whether they were exposed to the message at all. The most important finding of the member survey involved changing members' attitude and behavior toward ER use. After speaking with their PCP, members gain a better understanding of the appropriate use of the ER and modify their behavior accordingly.

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 B 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. In October of 2011, the plans submitted the plan-hospital data for the CY 2010 information.

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¥
January 1, 2010, through December 31, 2010

Plan Name	Percentage of ER Visits Data Received From the Participating Hospital(s) From the Service Date^		
	Within 5 Days	Within 10 Days	Within 15 Days
Alameda Alliance for Health	99.6%	0.2%	0.1%
Anthem Blue Cross*	60.7%	24.9%	1.0%
CalOptima	100.0%	0.0%	0.0%
Care 1st	NR	NR	NR
CenCal Health	94.9%	2.4%	2.7%
Central California Alliance for Health	NR	NR	NR
Community Health Group	0.0%	0.0%	100.0%
Contra Costa Health Plan	100.0%	0.0%	0.0%
Health Net	0.0%	77.6%	11.4%
Health Plan of San Joaquin	75.3%	18.3%	4.0%
Health Plan of San Mateo	1.5%	98.0%	0.2%
Inland Empire Health Plan	0.0%	0.0%	11.9%
Kaiser Permanente—Sacramento	100.0%	0.0%	0.0%
Kaiser Permanente—San Diego	NR	NR	NR
Kern Family Health Care	100.0%	0.0%	0.0%
L.A. Care Health Plan	0.0%	0.8%	10.3%
Molina Healthcare	94.0%	6.0%	0.1%
Partnership Health Plan¥	NR	NR	NR
San Francisco Health Plan	75.8%	24.2%	0.0%
Santa Clara Family Health Plan	1.8%	53.4%	43.1%

¥ Table data reflect plan-reported rates via the Hospital Data Collaboration Outcomes Measures Form.
^ Time period percentages are mutually exclusive and not cumulative.
NR—Data not reported although the plan participated in the collaborative intervention.
* Plan reported 0, 6, and 11 days instead of 5, 10, and 15 days.
¥ The data were sent directly to the providers instead of to the health plan.

Seven of the 16 plans (44 percent) reporting the timeliness data documented that 94 percent or more of the ER visit data were received from the participating hospital within 5 days. Nine of the 16 plans (56 percent) reported receiving 100 percent of the data within 15 days. Both Inland

Empire Health Plan and L.A. Care Health Plan reported that only about 11 percent of the ER visit data was received from the hospital within 15 days.

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 telephone lines do not constitute qualifying communication with the member.

Table 4.2—Hospital Data Collaboration Member Communication[¥]
January 1, 2010, through December 31, 2010

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	64.7%	75.7%
CalOptima	NR	48.9%
Care 1st	NR	NR
CenCal Health	77.8%	79.6%
Central California Alliance for Health	NR	NR
Community Health Group	50.0%	50.0%
Contra Costa Health Plan	100.0%	100.0%
Health Net	89.5%	93.6%
Health Plan of San Joaquin	97.9%	98.5%
Health Plan of San Mateo	NR	93.6%
Inland Empire Health Plan	0.0%	0.0%
Kaiser Permanente—Sacramento	77.0%	77.8%
Kaiser Permanente—San Diego	NR	NR
Kern Family Health Care	92.3%	91.6%
L.A. Care Health Plan	41.9%	16.0%
Molina Healthcare	62.4%	64.5%
Partnership Health Plan	NR	NR
San Francisco Health Plan	NR	NR
Santa Clara Family Health Plan	11.1%	8.1%

[¥] Table data reflect plan-reported rates via the Hospital Data Collaboration Outcomes Measures Form.
NR—Data not reported.

Twelve plans reported member communication percentages for both halves of CY 2010. Eight plans (67 percent) reported contacting over 50 percent of the members within 14 days of their

first ER visit for both halves of the year. Inland Empire Health Plan reported contacting 0.0 percent of their members while Santa Clara Health Plan contacted 11.1 percent in the first half of the year and 8.1 percent in the second half of the year.

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, 2010, through December 31, 2010.

Table 4.3—Hospital Data Collaboration Participating and Non-Participating Hospital Avoidable ER Visits Rate—January 1, 2010, through December 31, 2010

Plan Name	Avoidable ER Visits Rate¥		
	Participating Hospitals	Non-Participating Hospitals	Total Plan
Alameda Alliance for Health*	6.5%	20.0%	17.6%
Anthem Blue Cross	26.6%	20.7%	20.7%
CalOptima	19.8%	17.8%	18.0%
Care 1st	NR	NR	NR
CenCal Health	20.0%	22.6%	20.6%
Central California Alliance for Health	NR	NR	NR
Community Health Group	36.1%	13.2%	15.2%
Contra Costa Health Plan	16.1%	19.5%	19.3%
Health Net*	14.6%	21.1%	21.0%
Health Plan of San Joaquin*	16.7%	17.1%	18.6%
Health Plan of San Mateo	25.3%	16.5%	17.5%
Inland Empire Health Plan	21.6%	19.9%	20.0%
Kaiser Permanente—Sacramento*	12.6%	13.8%	15.5%
Kaiser Permanente—San Diego	NR	NR	NR
Kern Family Health Care*	11.7%	14.9%	13.3%
L.A. Care Health Plan	21.0%	19.4%	19.4%
Molina Healthcare*	18.5%	19.2%	22.0%
Partnership Health Plan	26.6%	17.1%	19.1%
San Francisco Health Plan	20.4%	16.8%	17.8%
Santa Clara Family Health Plan	23.1%	24.0%	23.8%

¥ Table data reflect plan-reported rates via the Hospital Data Collaboration Outcomes Measures Form.
* Reported rates may not be accurate.
NR—Data not reported.

Nine of the 17 plans (53 percent) reporting avoidable ER visit rates reported that the participating hospital had lower avoidable ER visit rates than that of the non-participating hospitals. With only one participating hospital per plan, the effect on the overall avoidable ER visits was limited.

Plan-Hospital Data Collaboration Successes and Lessons Learned

Most plans successfully implemented the hospital data exchange intervention, with 56 percent of reporting plans receiving notification of all members accessing the ER within 15 days. Despite over half of the plans receiving complete notification, not all plans initiated outreach communication to members. For plans that did outreach members, two of these plans implemented communication to members only 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.

For the nine plans that reported lower avoidable ER visits for the participating hospital than the non-participating hospitals, seven plans (78 percent) had reported communication percentages of 62.4 percent to 100.0 percent for each half of the year. The mixed notification and communication percentages may have contributed to the mixed results seen among participating and non-participating hospitals' avoidable ER visit rates.

Overall Collaborative Successes and Lessons Learned

Despite the numerous challenges encountered throughout the collaborative, overall, the topic and ultimate goal to reduce avoidable ER visits was of value to the health plans. The Medi-Cal Managed Care Division surveyed all health plans at the completion of the collaborative to obtain the health plans' perception of the successes, challenges, value of the collaborative, and whether the health plans would continue the collaborative interventions. The survey results are included in Appendix D. As a result of the collaborative, 15 health plans (83 percent of the respondents) continued to collaborate with hospitals for the timely exchange of ER data and 13 health plans (72 percent of respondents) continued to use the ER brochures. In addition, health plans reported that the collaborative improved communication and coordination with hospitals, improved communication with providers, raised member awareness of alternate options other than the ER, and raised provider awareness of their members' ER usage. The collaborative also served to raise public awareness of avoidable ER visits through one health plan's presentation of the collaborative at a national quality conference. Also, three other health plans shared the campaign materials and additional collaborative resources with hospitals, clinics, medical groups, and other State agencies.

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 the health care delivery system.

While many plans achieved statistically significant improvement between measurement periods, six plans achieved sustained improvement from baseline through Remeasurement 3. All six plans that achieved sustained improvement provided outreach to members after ER visits. Additionally, the six plans implemented the following plan-specific interventions:

Anthem Blue Cross

- Evaluated all interventions at the county level.
- Concentrated on access to after-hours care.

Community Health Group

- Established the Multiple Admitter's Program (MAP) as a permanent, focused case management project to provide intensive follow-up for members with multiple hospital inpatient and/or emergency department admissions.
- Contracted with retail Minute Clinic to provide an alternative setting for urgent care visits.
- Contracted with Palomar Express to provide an alternative setting for urgent care visits in the northern portion of San Diego County.

Central California Alliance for Health

- Providers receive quarterly mailings of members who have been to the ER three or more times during the last quarter. Reports are modified to include an indicator to let the provider know if the visit met the criteria of an avoidable visit.
- PCPs participate in an incentive program where 10 percent of the money allocated is aimed at reducing ER utilizations. Providers are compared against their peer groups.

Health Plan of San Joaquin

- Expanded or established working relationships with three different hospitals.
- Established the Nurse Practitioner program to visit members in their homes, addressing issues including ER visits.

Inland Empire Health Plan

- Nine health navigators worked to educate members on a variety of health care topics including ER utilization during home visits.
  - An additional navigator in the ER, hired by the hospital, assisted members with their follow-up care and making the necessary appointments after an ER visit.
- A comprehensive provider profile report is distributed monthly.

Kern Family Health Care

- Emphasized timely communication with all members seen in the ED.

Project Timeline

In October 2011, all plans submitted QIPs for validation and reported third-year remeasurement data, which reflect the measurement period of January 1, 2010, through December 31, 2010.

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

QIP Validation Description

CMS produced protocols for plans to use when conducting QIPs[12] and for EQROs to use when validating QIPs.[13]

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

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

[12] 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*.

[13] 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*.

With October 2011 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.

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

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

Quality Improvement Project Validation Findings

HSAG reviewed a total of 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, 2 required a resubmission. As of March 31, 2012, all collaborative QIP submissions received an overall *Met* validation status.

HSAG presents a summary of the validation results for baseline through Remeasurement 3 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). For Anthem and Health Net, the validation was for an overall plan rate and was not county-specific, which was consistent with the DHCS requirements at the time the collaborative QIP was developed.

Table 5.1—Remeasurement 3 Validation Results for 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)
Design Total		**100% (406/408)**	**0% (1/408)**	**0% (1/408)**
Implementation	V. Valid Sampling Techniques (if sampling was used)	Not Applicable	Not Applicable	Not Applicable
	VI. Accurate/Complete Data Collection	95% (114/120)	1% (1/120)	4% (5/120)
	VII. Appropriate Improvement Strategies	96% (81/84)	4% (3/84)	0% (0/84)
Implementation Total		**96% (195/204)**	**2% (4/204)**	**2% (5/204)**
Outcomes	VIII. Sufficient Data Analysis and Interpretation	92% (176/192)	5% (10/192)	3% (6/192)
	IX. Real Improvement Achieved	75% (71/95)	0% (0/95)	25% (24/95)
	X. Sustained Improvement Achieved	26% (6/23)	0% (0/23)	74% (17/23)
Outcomes Total		**82% (253/310)**	**3% (10/310)**	**15% (47/310)**
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**93% (854/922)**		
Percentage of QIPs With a Validation Status of *Met*		**100%**		

*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 scored *Met* across activities improved compared with the prior-year validation results from the plans' October 2010 submissions.

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 increased the percentage of elements scored *Met* for Activity VIII by two percentage points. 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 75 percent of the elements within Activity IX for the October 2011 QIP submission which was an increase of 29 percentage points from the October 2010 submissions. Six of the 20 plans demonstrated sustained improvement at the overall plan level compared to none of the plans for the October 2010 submissions.

Plans significantly increased their compliance with the CMS protocol for conducting QIPs in their October 2011 submissions compared to October 2010 submissions. Ninety-three percent of all applicable evaluation elements were scored *Met* for QIPs submitted in October 2011 compared to 88 percent in October 2010. 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 displays 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 non-avoidable ER visits.

Table 6.1—*Measure I—HEDIS Ambulatory Care—Emergency Department Visits*[¥]
January 1, 2007, through December 31, 2010

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	Remeasurement 3 1/1/10–12/31/10
Alameda Alliance for Health	Alameda	Two-Plan: LI	47.6 †	39.6 †	44.3	37.9
Anthem Blue Cross	Alameda	Two-Plan: CP	55.5 †	56.7 †	64.2	43.9
Anthem Blue Cross	Contra Costa	Two-Plan: CP	51.8 †	52.8 †	59.0	33.1
Anthem Blue Cross	Fresno	Two-Plan: CP	37.3 †	38.9 †	46.9	39.5
Anthem Blue Cross	Sacramento	GMC: CP	33.3 †	34.2 †	42.5	31.7
Anthem Blue Cross	San Francisco	Two-Plan: CP	29.8 †	29.9 †	38.3	37.4
Anthem Blue Cross	San Joaquin	Two-Plan: CP	35.1 †	36.9 †	49.0	45.7
Anthem Blue Cross	Santa Clara	Two-Plan: CP	30.3 †	32.6 †	39.8	38.5
Anthem Blue Cross	Stanislaus	Two-Plan: LI	50.6 †	53.0 †	64.4	59.2
Anthem Blue Cross	Tulare	Two-Plan: LI	44.0 †	40.0 †	45.2	39.9
CalOptima	Orange	COHS	36.3	37.4	40.0	36.7
Care 1st	San Diego	GMC: CP	44.1	39.3	52.0	45.8
CenCal Health	Santa Barbara	COHS	50.3 †	51.9 †	55.9	51.3
CenCal Health	San Luis Obispo	COHS	68.5^	70.4^	65.0^	Δ
Central California Alliance for Health	Monterey, Santa Cruz	COHS	60.9	62.1	59.3	53.5
Community Health Group	San Diego	GMC: CP	23.3	27.0	32.5	30.5
Contra Costa Health Plan	Contra Costa	Two-Plan: LI	55.1	57.1	59.2	58.3
Health Net	Fresno	Two-Plan: CP	35.4	39.2	48.0	44.8
Health Net	Kern	Two-Plan: CP	38.6	41.5	48.9	46.1
Health Net	Los Angeles	Two-Plan: CP	27.4	29.0	35.1	32.3
Health Net	Sacramento	GMC: CP	26.6	26.4	35.3	36.5
Health Net	San Diego	GMC: CP	41.5	43.7	45.9	47.6

Table 6.1—*Measure I—HEDIS Ambulatory Care—Emergency Department Visits*[¥]
January 1, 2007, through December 31, 2010

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	Remeasurement 3 1/1/10–12/31/10
Health Net	Stanislaus	Two-Plan: CP	50.8	53.2	57.1	51.4
Health Net	Tulare	Two-Plan: CP	42.9	41.1	44.9	39.2
Health Plan of San Joaquin	San Joaquin	Two-Plan: LI	42.3	34.7	40.5	35.2
Health Plan of San Mateo	San Mateo	COHS	48.1	52.7	57.5	50.9
Inland Empire Health Plan	Riverside/San Bernardino	Two-Plan: LI	47.4	48.0	53.3	49.3
Kaiser Permanente—Sacramento	Sacramento	GMC: CP	38.9 †	40.2 †	48.9	52.9
Kaiser Permanente—San Diego	San Diego	GMC: CP	41.7 †	39.5 †	40.8	37.4
Kern Family Health Care	Kern	Two-Plan: LI	38.9	40.3	45.8	42.5
L.A. Care Health Plan	Los Angeles	Two-Plan: LI	31.6	33.1	33.7	31.2
Molina Healthcare	Riverside/San Bernardino	Two-Plan: CP	36.1	39.9	42.9	42.9
Molina Healthcare	Sacramento	GMC: CP	33.3	31.9	41.6	43.2
Molina Healthcare	San Diego	GMC: CP	40.6	39.1	44.7	44.8
Partnership Health Plan	Napa, Solano, Yolo	COHS	45.0 †	46.8 †	48.8	47.0
San Francisco Health Plan	San Francisco	Two-Plan: LI	22.8	22.5†	26.4	24.6
Santa Clara Family Health Plan	Santa Clara	Two-Plan: LI	36.1	35.0	31.7	28.6

[¥] Table data reflect plan-reported rates via 2011 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, Remeasurement 1 is 1/1/2009–12/31/2009, and Remeasurement 2 is 1/1/2010–12/31/2010.
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 county-specific plans that reported a third remeasurement period, 30 showed a decrease in their ED visit rate (83 percent) from Remeasurement 2 to Remeasurement 3 while 6 (17 percent) demonstrated an increase in the rate. CenCal Health—San Luis Obispo reported a decrease in the ED visits rate from Remeasurement 1 to Remeasurement 2.

Table 6.2 includes baseline through Remeasurement 3 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 when plans demonstrate improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

All county-specific plans reported Remeasurement 3 data as the final measurement period for the collaborative, except for CenCal Health—San Luis Obispo, whose final measurement period was Remeasurement 2.

Table 6.2—*Measure II—Avoidable ER Visits*[1]
January 1, 2007, through December 31, 2010

Plan Name[2]	County	Model and Plan Type[3]	Avoidable ER Visits as a Percentage of Overall ER Visits				Sustained Improvement[4]
				Remeasurement			
			Baseline	1	2	3	
			1/1/07–12/31/07	1/1/08–12/31/08	1/1/09–12/31/09	1/1/10–12/31/10	
Alameda Alliance for Health	Alameda	Two-Plan: LI	12.1%^	15.0%^†	19.9%†	17.6%*	No
Anthem Blue Cross	Alameda	Two-Plan: CP	18.7%	16.3%*	21.0%†	21.03	No
Anthem Blue Cross	Contra Costa	Two-Plan: CP	20.9%	17.7%*	19.5%†	17.0%*	Yes
Anthem Blue Cross	Fresno	Two-Plan: CP	16.4%	16.6%	18.0%†	17.5%	No
Anthem Blue Cross	Sacramento	GMC: CP	17.0%	15.7%*	18.0%†	14.8%*	Yes
Anthem Blue Cross	San Francisco	Two-Plan: CP	16.4%	16.3%	18.5%†	15.7%*	Yes
Anthem Blue Cross	San Joaquin	Two-Plan: CP	18.5%	18.3%	20.1%†	18.6%*	No
Anthem Blue Cross	Santa Clara	Two-Plan: LI	17.6%	17.7%	22.3%†	21.9%	No
Anthem Blue Cross	Stanislaus	Two-Plan: LI	22.2%	21.1%*	18.4%*	15.0%*	Yes
Anthem Blue Cross	Tulare	Two-Plan: LI	21.3%	19.8%*	20.5%†	21.1%	Yes
CalOptima	Orange	COHS	16.1%	16.7%†	16.6%	18.0%†	No
Care 1st	San Diego	GMC: CP	13.8%	17.7%†	12.2%*	29.0%†	No
CenCal Health	Santa Barbara	COHS	19.2%	19.6%	18.8%*	20.2%†	No
CenCal Health	San Luis Obispo	COHS	18.8%‡	22.0%‡†	21.3%‡*	Δ	No

Table 6.2—*Measure II—Avoidable ER Visits*[1]
January 1, 2007, through December 31, 2010

Plan Name[2]	County	Model and Plan Type[3]	Avoidable ER Visits as a Percentage of Overall ER Visits				Sustained Improvement[4]
				Remeasurement			
			Baseline	1	2	3	
			1/1/07–12/31/07	1/1/08–12/31/08	1/1/09–12/31/09	1/1/10–12/31/10	
Central California Alliance for Health	Monterey, Santa Cruz	COHS	23.2%	19.0%*	22.2%†	18.5%*	Yes
Community Health Group	San Diego	GMC: CP	17.9%	16.5%*	21.6%†	15.2%*	Yes
Contra Costa Health Plan	Contra Costa	Two-Plan: LI	16.6%	20.9%†	20.0%*	19.3%*	No
Health Net	Fresno	Two-Plan: CP	17.4%	22.2%†	19.8%*	19.0%*	No
Health Net	Kern	Two-Plan: CP	15.3%	21.5%†	21.7%	20.4%*	No
Health Net	Los Angeles	Two-Plan: CP	15.5%	21.7%†	21.7%	20.2%*	No
Health Net	Sacramento	GMC: CP	15.9%	19.0%†	18.8%	17.6%*	No
Health Net	San Diego	GMC: CP	16.2%	20.5%†	17.8%*	18.1%	No
Health Net	Stanislaus	Two-Plan: CP	14.5%	23.5%†	23.3%	23.5%	No
Health Net	Tulare	Two-Plan: CP	19.4%	22.5%†	22.1%	21.4%	No
Health Plan of San Joaquin	San Joaquin	Two-Plan: LI	21.3%	16.7%*	21.5%†	18.6%*	Yes
Health Plan of San Mateo	San Mateo	COHS	15.0%	16.2%†	17.2%†	17.5%	No
Inland Empire Health Plan	Riverside/ San Bernardino	Two-Plan: LI	22.8%	20.3%*	23.0%†	21.5%*	Yes
Kaiser Permanente —Sacramento	Sacramento	GMC: CP	11.6%	10.8%	14.3%†	15.5%†	No
Kaiser Permanente —San Diego	San Diego	GMC: CP	11.5%	13.1%†	15.9%†	15.4%	No
Kern Family Health Care	Kern	Two-Plan: LI	15.9%	16.9%†	14.7%*	13.3%*	Yes
L.A. Care Health Plan	Los Angeles	Two-Plan: LI	16.0%	15.9%	22.4%†	19.4%*	No
Molina Healthcare	Riverside	Two-Plan: CP	19.6%	21.6%†	21.8%	22.2%	No
Molina Healthcare	San Bernardino	Two-Plan: CP	19.1%	20.9%†	21.5%	21.8%	No
Molina Healthcare	Sacramento	GMC: CP	14.5%	16.7%†	16.1%	15.7%	No
Molina Healthcare	San Diego	GMC: CP	15.3%	16.2%†	15.9%	16.0%	No

Table 6.2—*Measure II—Avoidable ER Visits*[1]
January 1, 2007, through December 31, 2010

Plan Name[2]	County	Model and Plan Type[3]	Avoidable ER Visits as a Percentage of Overall ER Visits				Sustained Improvement[4]
			Baseline	Remeasurement			
				1	2	3	
			1/1/07–12/31/07	1/1/08–12/31/08	1/1/09–12/31/09	1/1/10–12/31/10	
Partnership Health Plan	Napa, Solano, Yolo	COHS	17.7%	18.9%†	21.5%†	19.1%*	No
San Francisco Health Plan	San Francisco	Two-Plan: LI	16.3%^	17.0%^	20.3%†	18.2%*	No
Santa Clara Family Health Plan	Santa Clara	Two-Plan: LI	17.1%^	18.5%^†	24.8%†	23.8%*	No

Note: Sustained improvement from baseline to Remeasurement 3 is indicated by either "Yes" or "No."

[1] Table data reflect plan-reported rates via 2011 QIP submissions.

[2] Anthem and Health Net were validated at the overall plan level; county results are provided for informational purposes.

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

[4] Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

* Statistically significant improvement between measurement periods (p value ≤ 0.05).

† Statistically significant decline in performance between measurement periods (p value ≤ 0.05).

‡ CenCal Health—San Luis Obispo County added in March 2008; therefore, baseline is 3/1/2008–12/31/2008, Remeasurement 1 is 1/1/2009–12/31/2009, and Remeasurement 2 is 1/1/2010–12/31/2010.

Δ Data not reported in November 2011 QIP submission.

^ Rate may have been calculated incorrectly.

Twenty-one of the 38 county-specific rates for avoidable ER visits (55 percent) demonstrated statistically significant improvement over the prior measurement period. Conversely, only 4 of the 38 county-specific rates (11 percent) demonstrated a statistically significant decline in performance. Ten of the 38 county-specific results (26 percent) demonstrated sustained improvement from baseline to the final measurement period.

Table 6.3 indicates the plans that demonstrated statistically significant improvement in the overall plan rates from Remeasurement 2 to Remeasurement 3. Additionally, the table reports which of the plans also achieved sustained improvement from baseline to Remeasurement 3.

Table 6.3—*Measure II—Avoidable ER Visits*—Plans With Improvement From Remeasurement 2 to Remeasurement 3
January 1, 2010, through December 31, 2010

Plan Name	Statistically Significant Improvement	Sustained Improvement¥
Alameda Alliance for Health	✓	
Anthem Blue Cross	✓	✓
CenCal Health—Santa Barbara	✓	
Central California Alliance for Health	✓	✓
Community Health Group	✓	✓
Contra Costa Health Plan	✓	
Health Net	✓	
Health Plan of San Joaquin	✓	✓
Inland Empire Health Plan	✓	✓
Kern Family Health Care	✓	✓
L.A. Care Health Plan	✓	
Partnership Health Plan	✓	
San Francisco Health Plan	✓	
Santa Clara Family Health Plan	✓	
¥Sustained improvement is evaluated from baseline to Remeasurement 3.		

Six of the 14 plans that demonstrated statistically significant improvement in the plans' overall avoidable ER visits also achieved sustained improvement from baseline to the third remeasurement period.

Table 6.4 presents the results for ***Measure II*** by model type.

Table 6.4—*Measure II—Avoidable ER Visits* by Model Type¥
January 1, 2010, through December 31, 2010

Change in Avoidable ER Visits From Remeasurement 2 to Remeasurement 3	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	33.3%	50.0%	81.8%	33.3%
No Statistically Significant Change	33.3%	50.0%	18.2%	44.4%
Statistically Significant Decline in Performance	33.3%	0.0%	0.0%	22.2%
Total*	**99.9%**	**100.0%**	**100.0%**	**99.9%**

¥Table data reflect plan-reported rates via 2011 QIP submissions.
*The total may not equal 100 percent due to rounding.
CP = Commercial Plan

From Remeasurement 2 to Remeasurement 3, the Two-Plan models outperformed the County-Organized Health Systems and the Geographic Managed Care Plans. Fifty percent of the Two-Plan commercial plans and 81 percent of the Two-Plan local initiative plans demonstrated statistically significant improvement over the prior measurement period, and neither model reported a statistically significant decline in performance.

Table 6.5 presents the results for ***Measure II*** by county.

Table 6.5—*Measure II—Avoidable ER Visits* by County¥
January 1, 2010, through December 31, 2010

	Change in Avoidable ER Visits From Remeasurement 2 to Remeasurement 3			
County	**Statistically Significant* Improvement**	**Statistically Significant* Decline in Performance**	**No Statistically Significant* Change**	**Total Number of Plans Per County**
Alameda	1	0	1	2
Contra Costa	2	0	0	2
Fresno	1	0	1	2
Kern	2	0	0	2
Los Angeles	2	0	0	2
Monterey/Santa Cruz	1	0	0	1
Napa, Solano, Yolo	1	0	0	1
Orange	0	1	0	1
Riverside	0	0	1	1
Riverside/ San Bernardino	1	0	0	1
Sacramento	2	1	1	4
San Bernardino	0	0	1	1
San Diego	1	1	3	5
San Francisco	2	0	0	2
San Joaquin	2	0	0	2
San Mateo	0	0	1	1
San Obispo	1	0	0	1
Santa Barbara	0	1	0	1
Santa Clara	1	0	1	2
Stanislaus	1	0	1	2
Tulare	0	0	2	2
Total	**21**	**4**	**13**	**38**

¥ Table data reflect plan-reported rates via 2011 QIP submissions.
* Statistically significant change (*p* value ≤ 0.05).

For 9 counties, all of the plans operating in those counties demonstrated statistically significant improvement in the avoidable ER visits. Conversely, for 4 counties, all plans within the county reported statistically significant declines in performance. For multi-plan counties, 5 of the 12 counties (41.7 percent) demonstrated only statistically significant improvement, while none of the multi-plan counties only demonstrated a significantly significant decline in performance.

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

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

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

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

The Baseline Measurement Period:

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

Numerator:

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

Denominator:

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

Rate:

- The percentage of all ER visits defined as avoidable

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

ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

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

ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

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

ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

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

ER Collaborative Avoidable Visits ICD-9 Diagnosis Codes

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

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

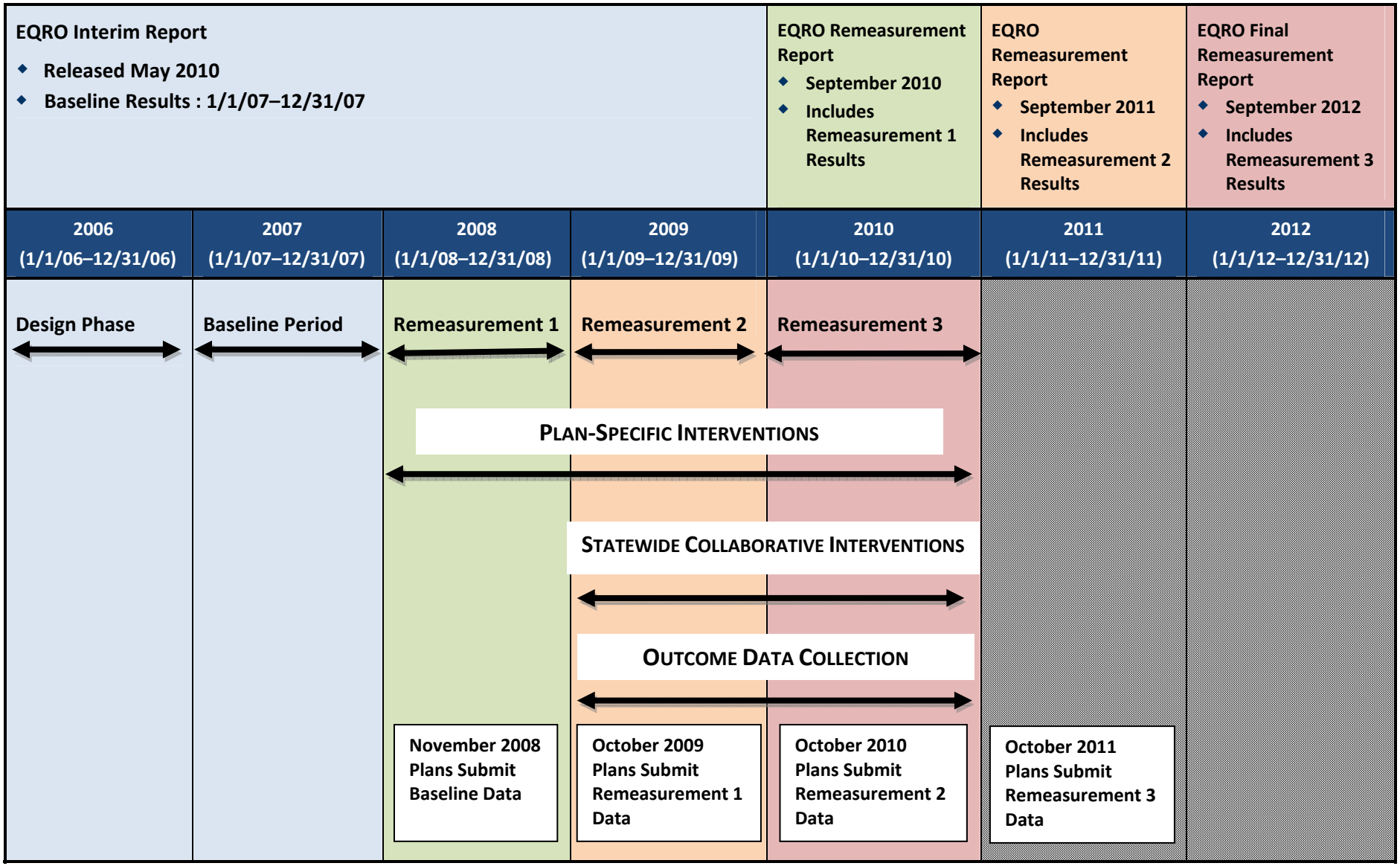
Outcome Evaluation

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 C presents the ER statewide collaborative QIP timeline.

Timeline for the ER Statewide Collaborative QIP



Introduction

Medi-Cal managed care plans were surveyed between July 13, 2011, and August 15, 2011. The purpose of this final ER Collaborative survey was to obtain the plans' perspectives on lessons learned throughout the life of the ER Collaborative and to identify successful strategies that could be shared with other plans. All results were self-reported.

Question 1

Medi-Cal managed care plan name: The response rate was 95 percent, with 18 out of 19 eligible plans responding. The following plans responded to the survey:

- Alameda Alliance for Health
- Anthem Blue Cross
- CalOptima
- Care 1st
- CenCal Health
- Community Health Group
- Contra Cost Health Plan
- Health Net
- Health Plan of San Joaquin
- Health Plan of San Mateo
- Inland Empire Health Plan
- Kaiser Permanente (represents Kaiser Permanente–Sacramento and San Diego)
- Kern Family Health Care
- L.A. Care Health Plan
- Molina Healthcare
- Partnership Health Plan
- San Francisco Health Plan
- Santa Clara Family Health Plan

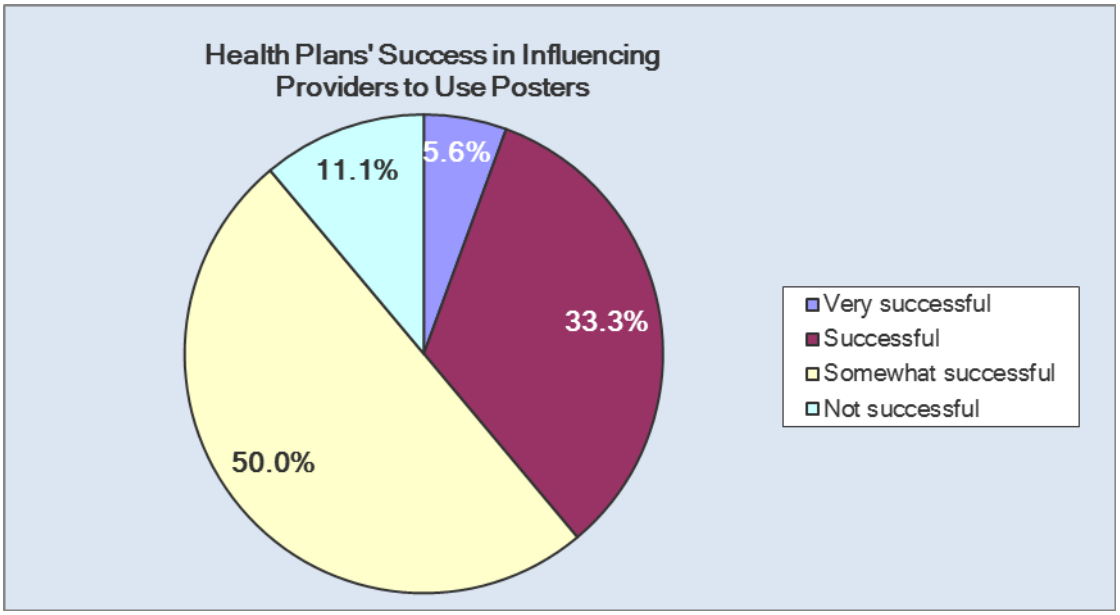
(Central California Alliance for Health is the only plan that did not respond to the survey.)

CalViva and Gold Coast, the newest Medi-Cal managed care health plans, were not required to submit surveys because their managed care contracts were not operational during the implementation phase of the Collaborative.

Question 2

Posters: Almost 90 percent of plans indicated that they were at least somewhat successful in influencing providers to use the posters, while only 11 percent were not successful.

2. How successful was your health plan in influencing providers to use the posters?		
Answer Options	**Response Percent**	**Response Totals**
Very successful	5.6%	1
Successful	33.3%	6
Somewhat successful	50.0%	9
Not successful	11.1%	2
	Answered question	18

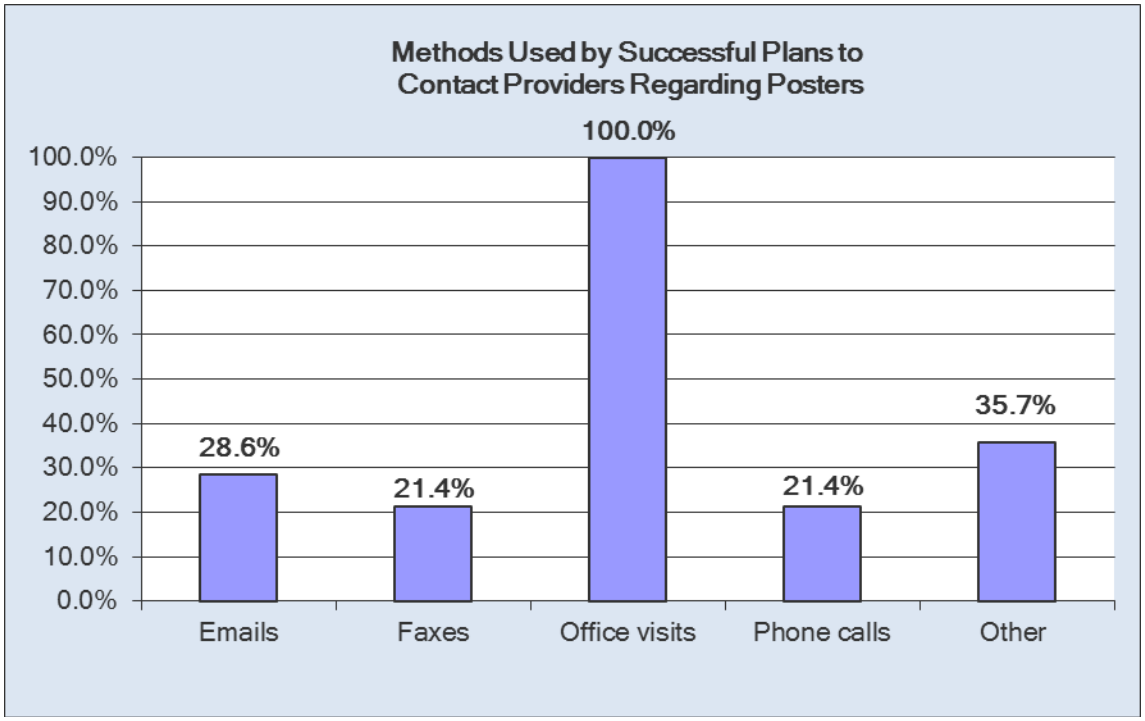


Question 2.1

Posters: Fourteen plans indicated success in influencing providers to use the posters. The most popular method of contacting providers was with office visits.

2.1 If successful, what methods did you use to contact providers?			
Answer Options	**Response Percent**	**Responses**	**Comments***
Emails	28.6%	4	◆ Mailed poster to providers. ◆ Offices that participated best were physically visited by staff. ◆ Regular provider newsletters reinforced their role and participation. ◆ Presentations to providers to discuss their role in the campaign.
Faxes	21.4%	3	
Office visits	100.0%	14	
Phone calls	21.4%	3	
Other (please specify)	35.7%	5	
Answered question		14	
Skipped question		2	

*Comments summarized



Question 2.2

Posters: Successful plans were asked to indicate the frequency of their contacts for each method used. For office visits, the most popular contact method, the majority of plans that responded made two office visits per year, followed by one per quarter and one per month.

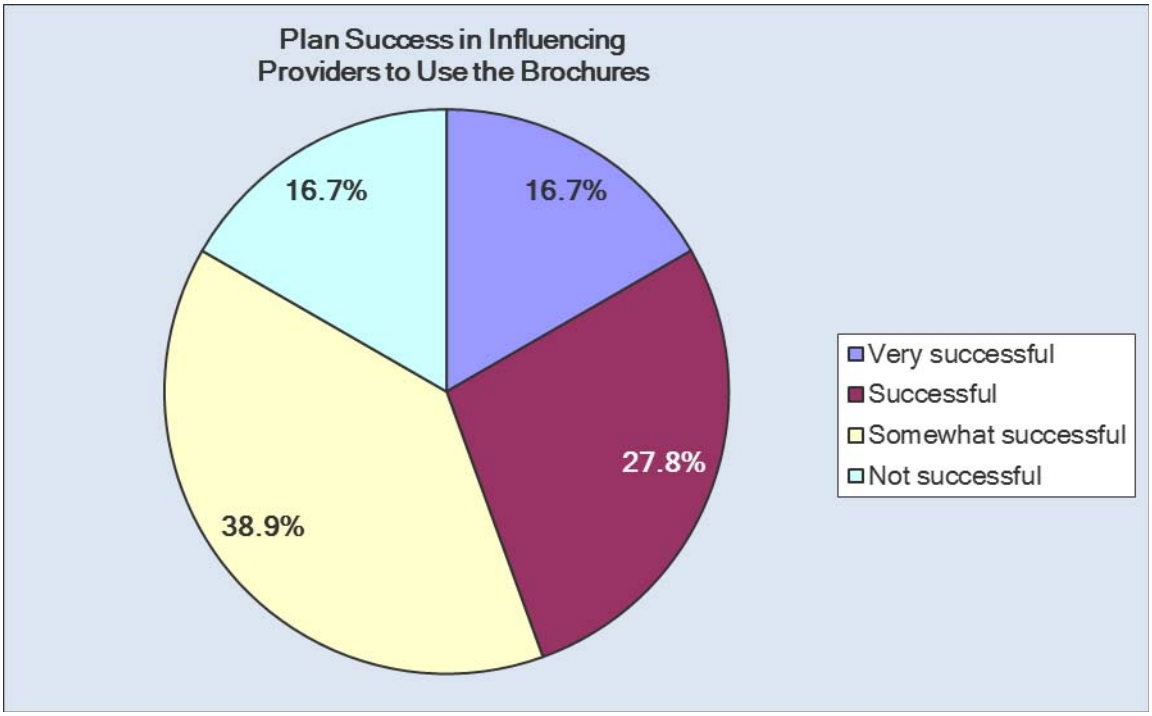
2.2. If successful, please indicate the number of contacts per method used:							
Answer Options	**1 per wk.**	**1 per mo.**	**2 per mo.**	**3 per mo.**	**1 per qtr.**	**2 per year**	**Responses**
Emails	0	1	0	0	1	2	4
Faxes	0	0	0	0	2	1	3
Office visits	1	2	1	1	2	5	12
Phone calls	0	1	0	0	1	0	2
Other	0	0	0	0	0	2	2
Other contact schedule: "Two visits per week."							2
						Answered question	14
						Skipped question	2

Question 3

Brochures: Slightly more than 83 percent of the plans indicated that they were at least somewhat successful in influencing providers to use the brochures. Nearly 17 percent were not successful.

3. How successful was your health plan in influencing providers to use the brochures?		
Answer Options	**Response Percent***	**Responses**
Very successful	16.7%	3
Successful	27.8%	5
Somewhat successful	38.9%	7
Not successful	16.7%	3
Answered question		18

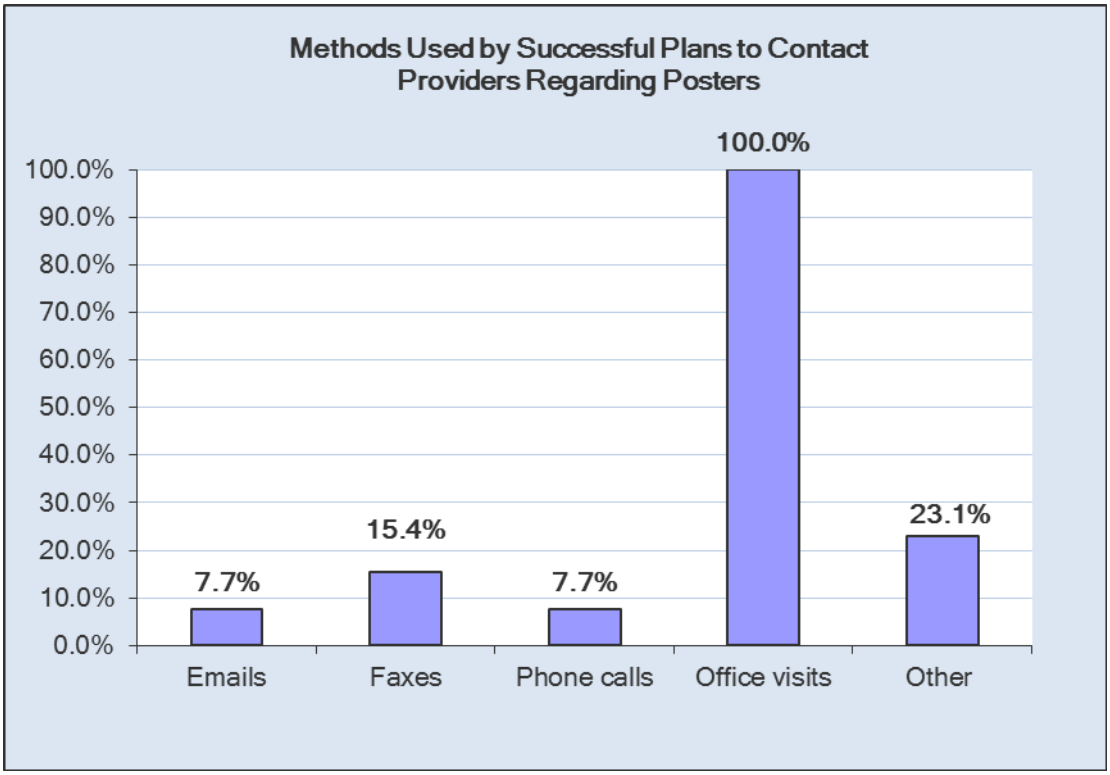
*Percentages do not total 100 percent due to rounding.



Questions 3.1

Brochures: Thirteen plans indicated success in influencing providers to use the brochures. The most popular method of contacting providers was with office visits.

3.1. If successful, what methods did your health plan use to contact providers?		
Answer Options	**Response Percent**	**Response Totals**
Emails	7.7%	1
Faxes	15.4%	2
Phone calls	7.7%	1
Office visits	100.0%	13
Other (please specify)	23.1%	3
Answered question		13
Skipped question		2



Question 3.2

Brochures: Successful plans were asked to indicate the frequency of their contacts per method used. For office visits, the most popular contact method, the majority of plans that responded made two office visits per year, followed by one per month, then one per quarter.

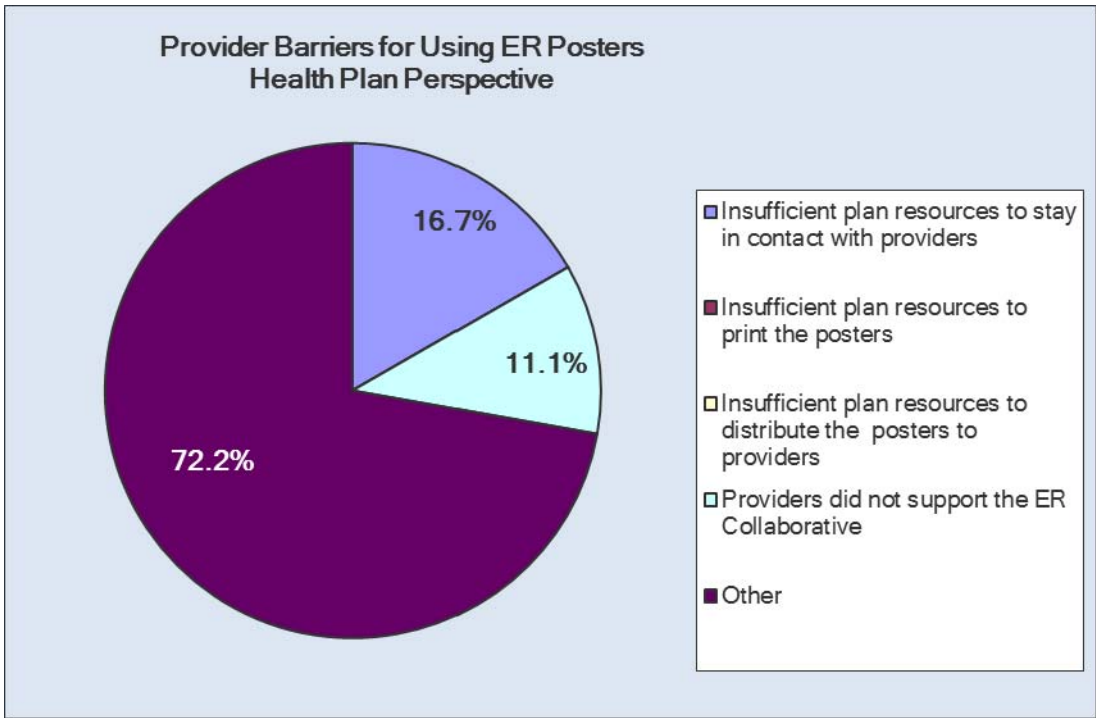
3.2. If successful, what methods did you use to contact providers?							
Answer Options	**1 per wk.**	**1 per mo.**	**2 per mo.**	**3 per mo.**	**1 per qtr.**	**2 per year**	**Response Count**
Emails	0	1	0	0	0	0	1
Faxes	0	0	0	0	1	1	2
Office visits	1	3	0	1	2	4	11
Phone calls	0	1	0	0	0	0	1
Other	0	0	0	0	0	1	1
Other contact schedule: "Two per week."							2
						Answered question	12
						Skipped question	3

Question 4

Posters: More than 72 percent of the plans indicated "Other" as their response because this option allowed plans to include comments. A majority of the comments were about the lack of resources to print and to keep providers supplied with the posters, followed by limited wall space. Nearly 17 percent indicated "insufficient plan resources to stay in contact with providers." Only 11 percent of plans indicated the providers did not support the ER Collaborative.

4. From the health plan's perspective, what was the greatest barrier for providers using the posters?			
Answer Options	**Response Percent**	**Responses**	**Comments***
Insufficient plan resources to stay in contact with providers	16.7%	3	◆ Lack of resources to print and to keep providers supplied with posters. ◆ Posters did not last long on provider walls because members would take them or kids would tear them. ◆ Limited wall space.
Insufficient plan resources to print the posters	0.0%	0	
Insufficient plan resources to distribute posters to providers	0.0%	0	
Providers did not support the ER Collaborative	11.1%	2	
Other	72.2%	13	
Answered question		18	

*Comments summarized

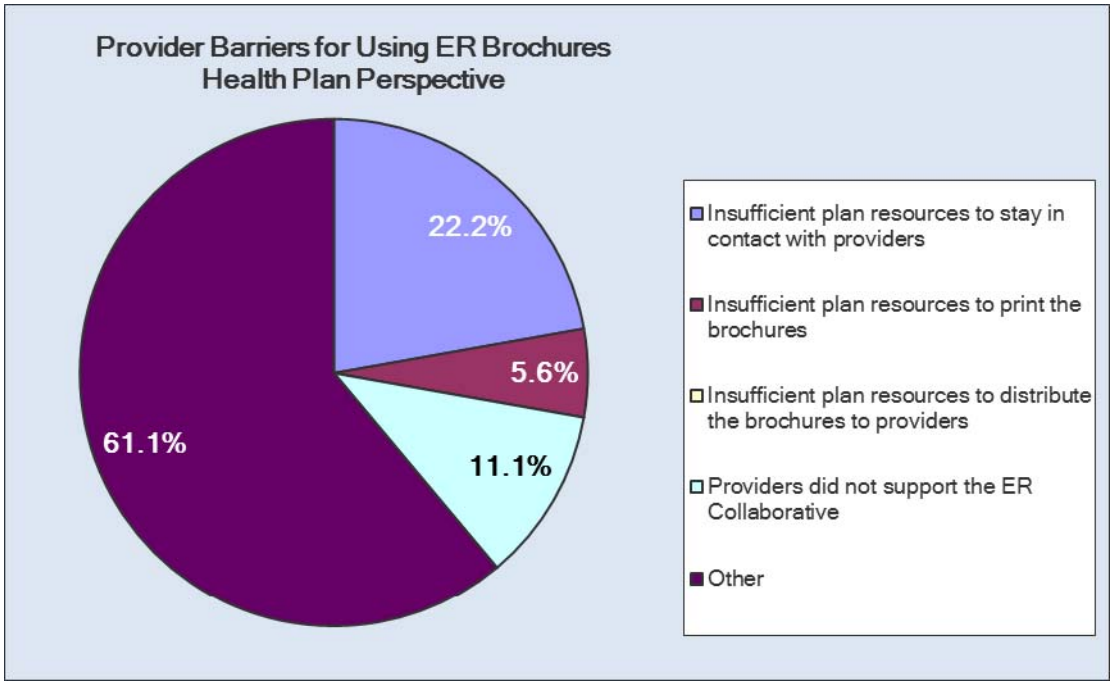


Question 5

Brochures: Plans were asked about barriers for using the ER brochure. Sixty-one percent of the plans indicated "Other" and included numerous comments about limited provider time to discuss the brochure, followed by challenges associated with restocking and printing the brochure, limited provider space for the brochures, and the unavailability of the brochures in all threshold languages. Twenty-two percent indicated insufficient plan resources to stay in contact with providers.

5. From the health plan's perspective, what was the greatest barrier for using ER brochures?			
Answer Options	**Response Percent**	**Response Totals**	**Comments***
Insufficient plan resources to stay in contact with providers	22.2%	4	◆ Provider time limited to discuss brochure. ◆ Restocking and printing the brochure. ◆ Limited provider space. ◆ Brochure available only in English and Spanish.
Insufficient plan resources to print the brochures	5.6%	1	
Insufficient plan resources to distribute brochures to providers	0.0%	0	
Providers did not support the ER Collaborative	11.1%	2	
Other	61.1%	11	
Answered question		18	

*Comments summarized



Question 6

Brochures: Here are the responses received for open-ended Question 6: "If the provider did not support the ER Collaborative, please provide an explanation below."

Summarized comments:

- Not enough time to educate members on appropriate use of ER.
- No incentive to keep members away from the ER.
- No opportunity for providers to see the patients prior to visiting the ER.
- Some members who visit the ER have never been seen by their PCP.
- Members do not follow advice from the PCP.
- Not clear why provider participation was not better after extensive outreach (office site visits, educational mailings, phone calls, etc.).
- ER Collaborative not a priority because of other health plan requirements.
- Some provider offices did not want to hang the posters.
- Most providers supported and appreciated the collaborative but were overwhelmed with paperwork from the health plan.

Question 6.1

Brochures: Here are the responses received for the open-ended follow-up Question 6.1: "What could have been done differently to get provider support?"

Summarized comments:

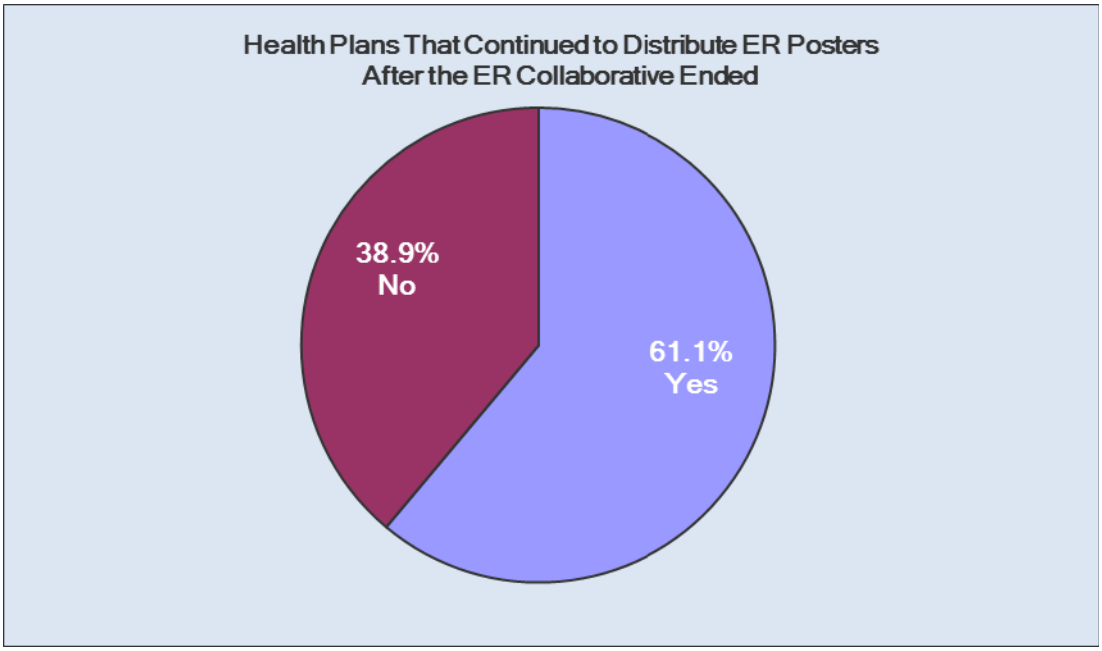
- Encourage members to have more responsibility.
- Offer an incentive for participation.
- Increase financial incentives for providers.
- Use evidence-based interventions.

Question 7

Posters: Plans were asked if they continued to distribute ER posters after the ER Collaborative had ended. Just over 61 percent indicated that they continued to distribute the posters, while almost 40 percent indicated that they did not.

7. Does the health plan continue to distribute the posters even though the ER Collaborative has ended?			
Answer Options	**Response Percent**	**Response Totals**	**Comments***
Yes	61.1%	11	◆ No provisions to print additional posters. ◆ Expensive to print materials. ◆ Cost, priorities, and budget constraints. ◆ Provided PDF version for offices to print. ◆ Distributing ER information through personalized letters to members.
No	38.9%	7	
Explanations/comments		9	
Answered question		18	

*Comments summarized

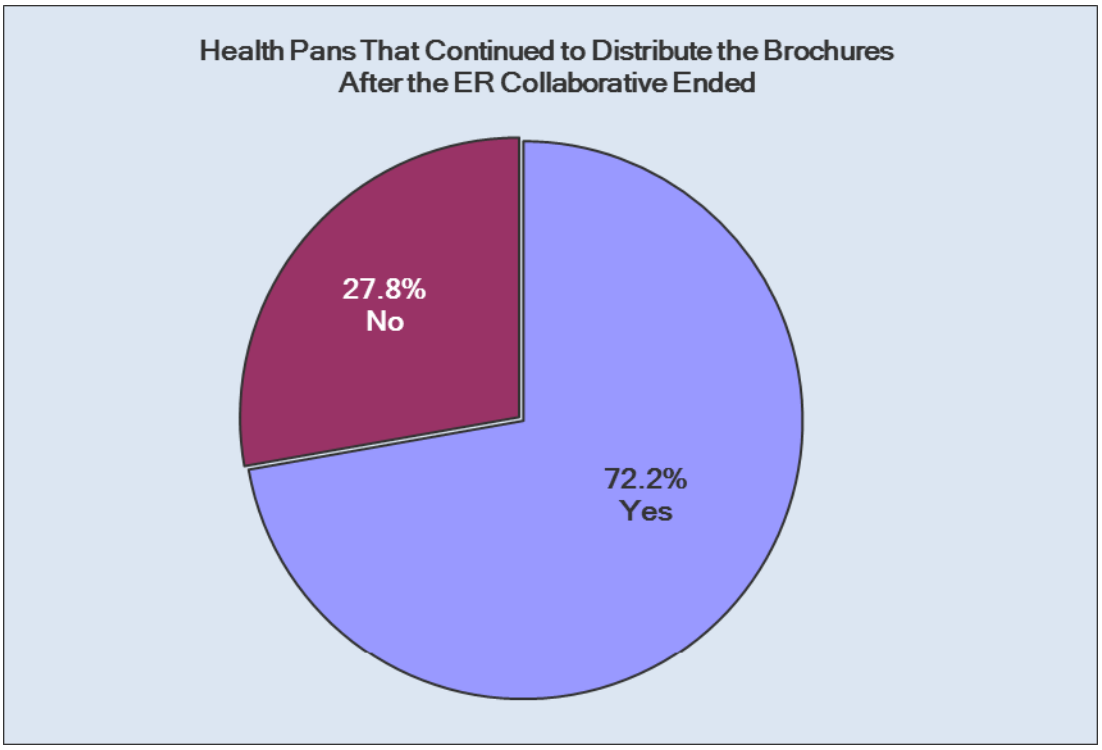


Question 8

Brochures: Plans were asked if they continued to distribute ER brochures after the ER Collaborative ended. Just over 72 percent indicated that they continued to distribute the ER brochures, while nearly 28 percent indicated that they did not.

8. Does the health plan continue to distribute the brochures even though the ER Collaborative has ended?			
Answer Options	**Response Percent**	**Response Totals**	**Comments***
Yes	72.2%	13	◆ Upon request. ◆ Plan continues to print and distribute brochures as needed. ◆ Plan uses brochure information for educational efforts. ◆ PDF version available for provider offices to print.
No	27.8%	5	
Explanations/comments		9	
Answered question		18	

*Comments summarized

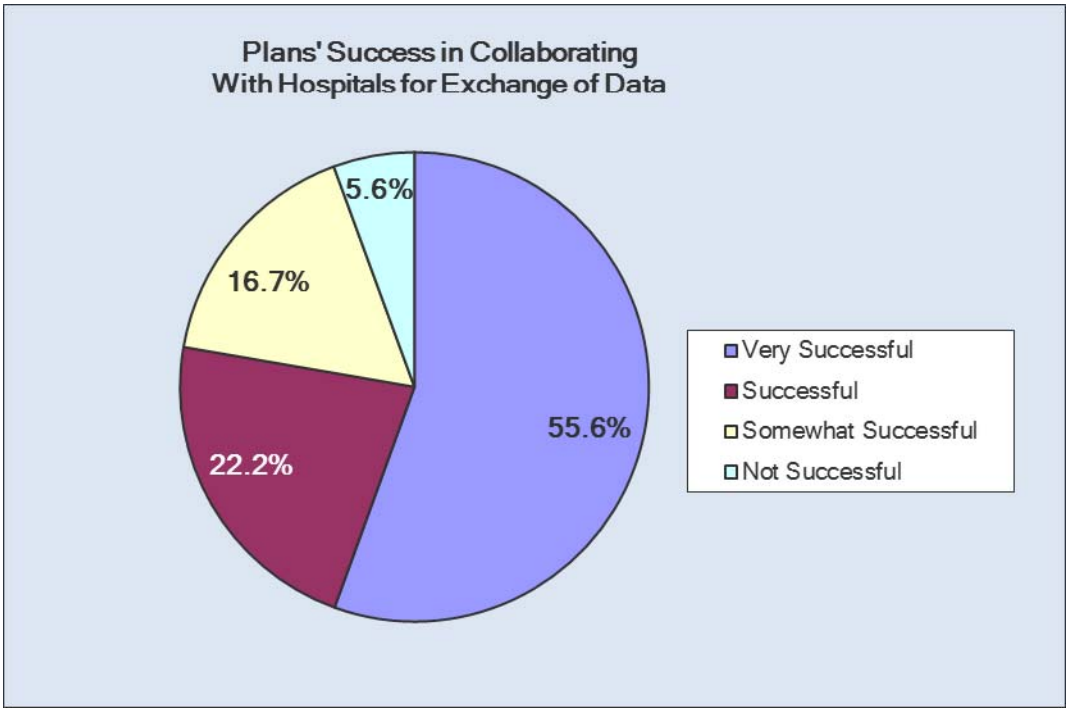


Question 9

Hospital Collaboration: Plans were asked how successful they were in collaborating with hospitals for exchange of data. Over 94 percent of plans were at least somewhat successful in collaborating with hospitals, while less than 6 percent were not successful.

8. How successful was your health plan in collaborating with the hospital(s) for exchange of data?		
Answer Options	**Response Percent***	**Response Totals**
Very Successful	55.6%	10
Successful	22.2%	4
Somewhat Successful	16.7%	3
Not Successful	5.6%	1
	Answered question	18

*Percentages do not total 100 percent due to rounding.



Question 9.1

Hospital Collaboration: Here are the responses received for open-ended follow-up Question 9.1: "If successful, what factors/aspects of the intervention contributed significantly to successful collaboration with the hospital(s)."

Summarized comments:

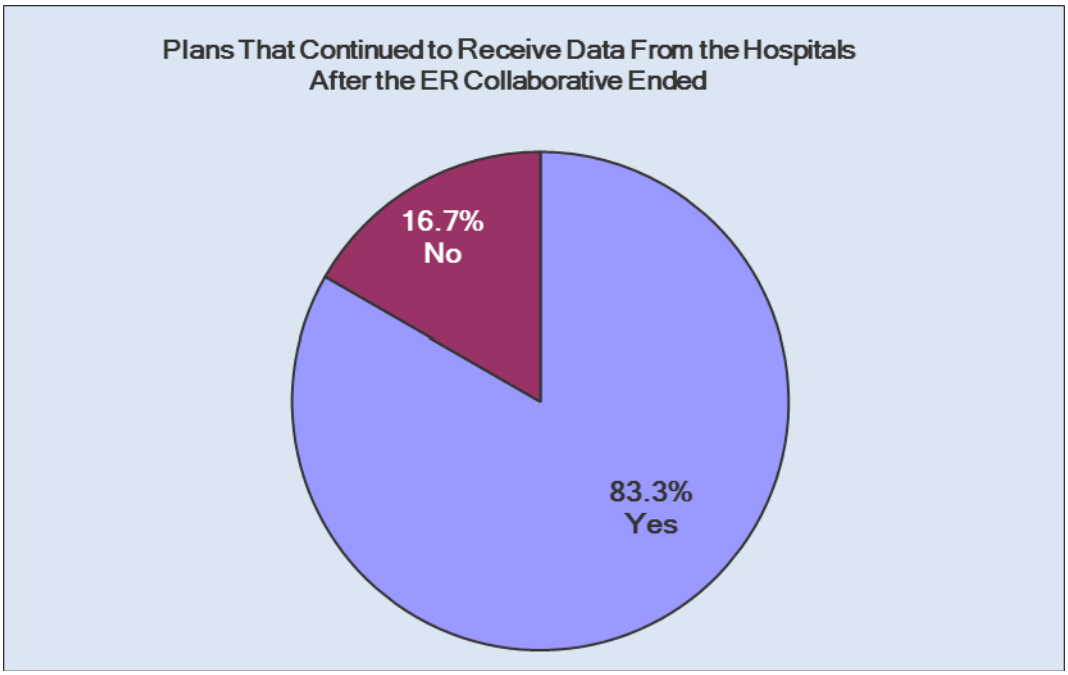
- Communication between medical director and hospital CEOs.
- Health plan sharing data reports and ER Collaborative interventions with hospital/ER staff.
- Health plans' long standing business relationship with the hospital.
- Commitment of both hospital and health plan to reduce avoidable ER visits.

Question 10

Hospital Collaboration: Plans were asked if they continued to receive data from the hospitals after the ER Collaborative had ended. Just over 83 percent of the plans continued to receive data from hospitals, while nearly 17 percent did not.

10. Does the health plan continue to receive data from the hospital(s) even though the ER Collaborative has ended?		
Answer Options	**Response Percent**	**Response Count**
Yes	83.3%	15
No	16.7%	3
	Answered question	18

Question 10 (Continued)



Question 10.1

Hospital Collaboration: Plans were asked to provide an explanation if they were not successful in continuing to receive data from hospitals. Although only three plans answered that they were not successful, four plans responded to this question: Fifty percent (two plans) indicated "limited health plan resources" as the reason, while the other 50 percent (the other two plans) included affirmative comments that were not reasons for not being successful.

10.1. If not, please explain:			
Answer Options	**Response Percent**	**Response Totals**	**Comments**
Hospital does not want to continue collaboration	0.0%	0	◆ Plan continues to conduct the intervention. ◆ Plan continues to have access to the data as needed.
Hospital does not want to discourage avoidable ER visits	0.0%	0	
Limited heath plan resources	50.0%	2	
No longer a priority for the health plan	0.0%	0	
Other (please specify)	50.0%	2	
Answered question		4	
Skipped question		0	

Question 11

Plans were asked to provide a brief description of successful plan-specific strategies that they will continue to implement after the end of the ER Collaborative. See a summary of their responses below:

The ER Collaborative intervention focused on a statewide education campaign to educate the member on the appropriate use of the emergency room and for the timely exchange of ER member information between a selected hospital and the health plan. In addition, health plans implemented plan-specific interventions. Several health plans report the following plan-specific member, provider, and hospital interventions that will continue following the completion of the ER Collaborative. These interventions include but are not limited to the following:

Provider-Specific Interventions:

- Contract with retail clinics' after-hours incentive programs.
- Provider access to member-specific ER utilization data electronically, by mail, and through meetings and health plan visits to provider offices; data are either provided monthly or quarterly.

Member-Specific Interventions:

- Health plan telephone contact generated from member referrals for education.
- Member education via:
  - Follow-up with member after ER visit through member mailing.
  - Telephone calls.
- Referrals to case management or disease management program.
- Newsletters.
- Member orientation calls.
- ER information via telephone member messaging "while on hold."
- Web portal.
- Nurse advice line.
- After-visit summaries following office visits.

Hospital Collaboration

- Fifteen health plans reported that they will continue to collaborate with hospitals to receive timely information regarding those members seen in the ER.

Question 12

Plans were asked what they believed were the benefits and value of implementing the ER Collaborative, regardless of whether they were able to reduce the avoidable ER rate.

12. Regardless of whether your health plan was able to reduce the avoidable ER rate, what were the benefits and value of implementing the ER Collaborative?			
Answer Options	**Response Percent**	**Response Totals**	**Comments**
Improved communication and coordination with hospitals	55.6%	10	◆ Real-time data from hospitals were very helpful. ◆ Providers who receive reports about their members' use of the ER continue to use the information to outreach and provide education to their members. ◆ Plan presented a successful hospital collaboration project at a national quality conference.
Improved communication with providers	61.1%	11	
Raised public awareness of avoidable ER use	16.7%	3	
Raised member awareness of options for ER use	77.8%	14	
Raised provider awareness of avoidable ER use	50.0%	9	
Other (please specify)	16.7%	3	
Answered question		18