Medi-Cal Managed Care Division

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

Statewide Collaborative QIP:
Reducing Avoidable Emergency Room Visits
Baseline Report

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DHCS
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Improving Health in the Communities We Serve

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Executive Summary

In July 2007, the Medi-Cal Managed Care Division of the California Department of Health Care Services (DHCS) initiated a statewide collaborative Quality Improvement Project (QIP) with all contracted managed care plans (plans) focused on reducing avoidable emergency room (ER) visits among Medi-Cal managed care beneficiaries. The collaborative defined an avoidable ER visit as a visit which could have been more appropriately managed and/or referred to a primary care provider in an office or clinic setting. As part of DHCS' s contract requirements in the area of quality assurance, all contracted plans, with the exception of specialty plans, are required to participate in DHCS's Statewide Collaborative QIP (collaborative).

This report describes the planning process for the collaborative, establishes the baseline for measures that will be tracked throughout the life of the collaborative, and presents interventions already implemented by participating plans and others still being developed. The collaborative planning process included the selection of a HEDIS measure used to measure improvement in overall ER utilization and also the development of a HEDIS–like measure to determine improvement in the frequency with which Medi-Cal members are using the ER for avoidable visits.

DHCS and participating plans developed and administered surveys to members and primary care providers (PCP) to help understand member reasons for seeking care in the ER and to determine the availability of providers for after hours care. In addition, DHCS also surveyed plans to understand their role and the challenges related to administration of emergency room services. Survey results identified the need for more intensive member education regarding emergency room use, collaboration with hospital emergency departments, and coordination with provider offices to facilitate greater access to after hours care.

Under the direction of DHCS, the collaborative is taking a multifaceted approach to educate both members and providers in order to reduce avoidable ER visits. Common interventions include a statewide comprehensive member health education campaign, a pilot with plan-selected hospitals to improve the timely exchange of information regarding members seen in the ER, and the development of a standardized provider phone message for members calling after hours to seek urgent or emergent care.

This baseline report describes the collaborative process and provides baseline measurements as of calendar year (CY) 2006. The collaboration is scheduled to end in October 2010.

Background

Through the Medi-Cal Managed Care Program, California provides comprehensive health care services to approximately 3.4 million beneficiaries enrolled in managed care plans operating in 23 counties. Care is provided through three plan models:

- Geographic Managed Care (GMC) – Enrollees choose from several commercially-operated plans within a certain geographic area (South -San Diego County; North - Sacramento County). Enrollment is mandatory for beneficiaries in some Aid Codes and voluntary for others.
- Two-Plan Model – Enrollees chose from two plans, a commercial plan (CP) or a local initiative (LI) plan. LI plans are community developed and operated as quasi-government agencies. Enrollment is mandatory for beneficiaries in some Aid Codes and voluntary for others.
- County-Organized Health Systems (COHS) – County operated managed care organizations with enrollment mandatory for all Medi-Cal beneficiaries in the county.

As part of federally required quality assurance activities mandated in plan contracts, DHCS requires contracted plans to participate in a statewide collaborative Quality Improvement Project (QIP) directed by DHCS. The current DHCS quality improvement and performance measurement requirements are detailed in All Plan Letter 08-009 available on the DHCS webpage at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2008/APL08-009.pdf

The following contracted plans are participating in DHCS's current statewide collaborative QIP on Reducing Avoidable ER Visits:

Plan Name	Model **	County of Operation
Alameda Alliance	2P:LI	Alameda
Anthem Blue Cross Partnership Plan (previously known as Blue Cross Partnership Plan)	GMC	Sacramento San Diego
Anthem Blue Cross Partnership Plan (previously known as Blue Cross Partnership Plan)	2P:CP	Alameda Contra Costa Fresno San Francisco San Joaquin Santa Clara
Anthem Blue Cross Partnership Plan (previously known as Blue Cross Partnership Plan)	2P:LI	Stanislaus Tulare
CalOptima	COHS	Orange
Care 1st Partner Plan	GMC	San Diego

Plan Name	Model **	County of Operation
CenCal Health Plan (previously known as Santa Barbara Health Authority)	COHS	Santa Barbara San Luis Obispo
Central Coast Alliance for Health	COHS	Monterey Santa Cruz
Community Health Group Partnership Plan	GMC	San Diego
Contra Costa Health Plan	2P:LI	Contra Costa
Health Net Community Solutions	GMC	Sacramento San Diego
Health Net Community Solutions	2P:CP	Fresno Los Angeles Kern Stanislaus Tulare
Health Plan of San Joaquin	2P:LI	San Joaquin
Health Plan of San Mateo	COHS	San Mateo
Inland Empire Health Plan	2P:LI	Riverside San Bernardino
Kaiser Permanente (North)	GMC	Sacramento
Kaiser Permanente (South)	GMC	San Diego
Kern Family Health Plan	2P:LI	Kern
LA Care Health Care	2P:LI	Los Angeles
Molina Healthcare of California Partner Plan	2P:CP	Riverside San Bernardino
Molina Healthcare of California Partner Plan	GMC	Sacramento San Diego
Partnership Health Plan of California	COHS	Napa Solano Yolo
San Francisco Health Plan	2P:LI	San Francisco
Santa Clara Family Health Plan	2P:LI	Santa Clara
Western Health Advantage	GMC	Sacramento

** Abbreviations: COHS= County Organized Health System, GMC=Geographic Managed Care, 2P=Two-Plan Model, LI=Local Initiative, CP=Commercial Plan

Purpose of Collaborative

Historically, managed care emphasizes access to primary care and encourages timely preventive care to avoid or minimize later development of chronic conditions. Despite this emphasis, many managed care plan members – whether covered by public or private sector plans, continue to use the emergency room for primary care and treatment of non-urgent conditions. For several years, plans have recognized this problem and have implemented plan-specific strategies to reduce unnecessary emergency room utilization. Several internal quality improvement projects conducted by Medi-Cal managed care plans have focused on reducing ER use and improving the utilization of ambulatory care services and treatment of chronic conditions such as asthma, diabetes, and congestive heart failure.

Numerous published reports have described the use of emergency rooms by Medi-Cal managed care plan members. [1, 2] (See Reference section at the end of the report.) These reports cite use of the emergency room in lieu of a primary care physician or for treatment of non-urgent conditions. An Institute of Medicine (IOM) report brief published in June 2006 described the challenges of providing emergency room services and included emergency department overcrowding and the inability of ERs to respond adequately to major disasters as central findings requiring attention.[3] The IOM report, which focused primarily on the crisis of ER overcrowding, stimulated DHCS to examine ER utilization across all Medi-Cal managed care plans. A review of this and other reports on this issue made it clear that reducing avoidable ER visits would require DHCS and its contracted plans to explore many different possible interventions and to pool resources and share information through the statewide collaborative process.[4]

Collaborative Components and Process

In January 2007, DHCS formed a preliminary workgroup with the plans to discuss which aspects of ER overuse should be addressed by the Statewide Collaborative QIP. The workgroup recognized from literature review that member, provider and health plan factors all impact ER overuse. DHCS developed an electronic survey to gain an understanding of the health plans challenges related their members' use of the ER. The workgroup developed provider and member surveys to zero in on specific provider and member issues related to inappropriate ER use. The workgroup also began development of objective, claims-based measures on ER visits as described later in this report. After evaluating preliminary data, the workgroup determined that the focus of the collaborative should be on "avoidable" ER visits defined as: "A visit that could have been more appropriately managed and/or referred to a primary care provider in an office or clinic setting."

In addition to claims-based ER data, supplemental data was analyzed in an effort to further understand use of the ER specifically by members enrolled in Medi-Cal managed care. This supplemental data included ER visit data, such as day of the week, member language, ethnicity and age, and anecdotal data from member, provider, and plan surveys. The supplemental data was used to help identify and develop targeted interventions that would have the greatest impact on avoidable ER visits by Medi-Cal managed care members. After this preliminary work, the Statewide ER Collaborative, with all plans participating, began in July 2007.

Health Plan Surveys

With assistance from Delmarva Foundation for Medical Care, Inc., DHCS's External Quality Review Organization (EQRO) at the time the collaborative began, DHCS developed and administered an electronic survey to plans during January 2007(Appendix A). The collaborative also developed a supplemental health plan survey administered in October 2007(Appendix C). These surveys helped determine the plans' experiences and challenges related to members who sought care in the emergency room and helped determine the focus of the collaborative and direction of interventions.

The health plan survey questions included, but were not limited to, the following areas:

- Access for members to after-hours care, *e.g.*, urgent care clinics and retail clinics.
- Relationship of member disenrollment to ER use.
- Relationship with contracted hospitals.
- Availability of provider incentives to expand their office hours.
- Focus of current plan-specific QIPs related to ER use.
- Emergency room related interventions previously implemented by health plans.

Survey findings (Appendix B & D) provided the following insights from the plans' perspective:

- Medi-Cal Managed Care members visit the ER frequently.
- Members often visit the ER due to the lack of alternatives to the ER and lack of education regarding other options.
- Many members who use the ER are repeat users.
- More than half of the 22 contracted plans had already implemented quality improvement projects related to ER visits
- The focus of ER quality improvement projects varied among plans, but included reducing emergency room use and hospital admissions related to disease specific conditions (asthma, congestive heart failure, and upper respiratory infections), member education, and specific interventions targeting primary care physicians, such as provider incentives to extend office hours.
- Common barriers to changing ER usage patterns included the difficulty of influencing member behavior and limited alternatives to ER care.

- Common interventions directed toward improving members' understanding of how to access urgent and emergent care included member informing materials, use of nurse advice/member services lines, lists of providers available after hours, and case management.
- Plans reported the need to collaborate with hospital emergency rooms regarding their members seen in the emergency room.
- Facilities available to provide after hours care are limited.

Demographic Data of Members Who Use the ER

Plans provided Avoidable ER Visit data and member demographic data on a worksheet provided by DHCS (Appendix E). After extensive analysis by DHCS staff, the aggregate findings were presented to the collaborative participants, including the following findings specific to the Medi-Cal managed care population as of calendar year (CY) 2006:

- Seven of the most common "avoidable" diagnoses treated in the ER comprised 80 percent of the total avoidable ER visits:
  - Acute Respiratory Infections
  - Otitis Media (inflammation of the middle ear)
  - Acute Pharyngitis (inflammation of the throat or pharynx)
  - Headache
  - Urinary Tract Infections
  - Lumbago (lower back pain)
  - Acute Bronchitis (inflammation of the bronchi)

- Children ages one to nine used the ER most frequently for avoidable visits, followed by adults ages 45 to 64, followed by children ages 10 to 19.
- Frequency of ER use for total *avoidable* plus *non-avoidable* ER visits: 45 percent used the ER two to four times in one calendar year followed by 38 percent with one visit per CY. Members using the ER five or more times during the CY ("frequent flyers") occurred 17 percent of the time.
- Members used the ER uniformly all days of the week.
- No significant differences were found related to ethnicity and language.

Member Surveys

The collaborative developed a set of core questions to be used in the member surveys (Appendix F). Member surveys solicited input in the following areas:

- Member understanding of what to do if medical care is needed after hours.
- Member use of an advice line (if offered by health plan or PCP).
- Member contact with PCP prior to going to the ER.
- Member use of ER within the last 12 months.

- Frequency of ER use by member.
- Member reason for most recent ER visit.
- Member access to same day and after hour appointments when calling the PCP for urgent problems.

The member survey was used to identify problems in the delivery of services in provider offices (Appendix F - G). A summary of responses follows:

- Most members were instructed by their PCP to go to the ER if the member thought it was an emergency.
- Most members received information regarding after-hours care through their PCP or the office staff either in person or via the telephone.
- Most members were aware of how to access the advice lines provided by some plans or the PCP, but very few members had used the advice line the last 12 months. Few members had used the advice line before visiting the ER.
- Very few members contacted their primary care physician before going to the ER.
- Most surveyed members who went to the ER felt they might have a life-threatening condition or stated that their symptoms began after office hours or on a weekend.

Provider Surveys

A sample of primary care providers were surveyed to determine provider availability for same-day access (scheduled and unscheduled appointments), for appointments after hours, and for weekend outpatient care (Appendix H). A summary of responses follows:

- Many providers offer same-day appointments for both scheduled and unscheduled appointments.
- Very few providers offer primary care services after 5 pm or on the weekends.

It should be noted that survey data is anecdotal. The plans were not required to use a standardized survey tool, and members and providers were not surveyed in all Medi-Cal managed care counties, although the survey sample was required to represent each plan's population. Some plans only provided the member surveys in English[8]. Plans were given the discretion to translate the survey to other languages based upon their specific populations. Surveys were conducted using telephone, mail, and focus groups. The plans faced many barriers to the timely implementation and analysis of surveys, including time to set up vendor contracts and limited health plan resources to conduct and analyze survey results. The majority of the member, provider, and health plan survey results were submitted to DHCS by December 2007.

Development of Performance Measures: Specifications and Methodologies

The collaborative selected two performance measures to establish baseline measurements, track progress toward the identified statewide goal, and standardize performance re-measurements:

Measure I: HEDIS *Ambulatory Care—Emergency Department Visits* (AMB: ED). This HEDIS measure summarizes use of ambulatory care in the Emergency Department during the reporting year, reported as total number of visits and visits per 1,000 member months. Each visit to an Emergency Department that does not result in an inpatient stay is counted, regardless of the intensity or duration of the visit. Visits are reported for the following age groups: <1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, 85+, and unknown. It should be noted that HEDIS is a nationally recognized, standardized set of performance indicators developed by the National Committee for Quality Assurance (NCQA). More than 90 percent of all national plans use HEDIS to measure their performance for established dimensions of both health care outcomes and their plan services.

Measure II: Avoidable ER Visits Measure (Avoidable ER). This HEDIS-like measure developed by DHCS and the participating plans summarizes the percentage of designated "avoidable" ER visits. To develop Measure II, the collaborative discussed methods to identify and measure avoidable visits during weekly meetings for eight months in 2007. The collaborative reviewed published literature and consulted with noted experts on ER use from the University of California at San Francisco, the University of California at Davis, and New York University for assistance in developing a practical list of diagnosis codes for selected avoidable visits.

DHCS and the plans reviewed the following data and resources to develop the final list of avoidable visits:

- The top 10 plan-specific ICD 9 codes identified as avoidable diagnosis codes used for ER visits in calendar year 2005.
- Health plan administrative data related to ER use in calendar year 2006.
- Plan-specific outpatient services and hospital admissions data.
- Diagnosis codes designating avoidable visits.
- Medi-Cal managed care ER claims data for CY 2006.
- New York University's Center for Health and Public Service Research Algorithm for diagnosis codes used to classify emergency department utilization.[5]
- Agency for Healthcare Research and Quality (AHRQ) Quality Indicators: *Guide to Quality Indicators, Hospital Admission for Ambulatory Care Sensitive Conditions*.[6]

After extensive review of the above data and resources and discussion of a large number of potential diagnoses, the collaborative selected and approved a list of diagnoses that were felt to be highly predictive for an avoidable ER visit (Appendix I). For example, many sources reported upper respiratory infections, otitis

media, and pharyngitis as specific diagnoses that did not require immediate attention or require the services specifically available in an emergency department.

The selected diagnosis codes identify those problems that could have appropriately been managed within 24 hours at a PCP's office, a clinic, or other ambulatory setting. The collaborative excluded infants (less than 12 months of age) from the data collection for avoidable visits because it was felt that the parents/caregivers may not be able to determine the seriousness of the infants' condition and correctly decide whether the condition could be managed in an outpatient setting outside of the emergency department.

Submission of Data and Data Challenges

To establish plan-specific baseline measures, DHCS asked that plans submit baseline rates for the HEDIS AMB: ED measure and the Avoidable ER visits measure by September 30, 2007, using CY 2006 data. The plans are required to submit annual remeasurements for both measures through October 2010 to determine the rate of improvement over time. For submission of data for the Avoidable ER Visits measure, DHCS asked plans to use the standardized Health Plan Reporting Template (Appendix E). This worksheet provided the format and record layout for data reporting to DHCS.

Because the HEDIS AMB: ED measure is a standardized, nationally used measure which plans have reported to DHCS for several years, plans experienced no difficulties submitting the baseline rate for this measure. However, the plans did experience a number of challenges when reporting the rate of Avoidable ER Visits. DHCS anticipated some problems since this was a DHCS-developed measure which had not been field tested as HEDIS measures are before the standardized technical specifications are finalized.[7] However, DHCS was willing to work through these data challenges in order to have avoidable visits data that truly reflected behavior of plan members seeking care that could have been provided by their PCP.

Plans submitted a total of 44 data files totaling 1,335,000 records for the *Avoidable ER Visits* baseline measurements. Some of the data discrepancies that DHCS discovered and had to resolve with plans included:

- Diagnosis codes were submitted with and without decimals.
- ER compliance codes for members less than 12 months of age were not flagged as non-avoidable visits.
- ER compliance codes for members 12 months and over were not flagged correctly.
- The Medi-Cal Avoidable ICD-9 Codes listed diagnosis codes in ranges rather than as individual specific codes.

Each "avoidable" diagnosis was identified by its designated ICD-9 code. The ICD-9 codes initially were listed in ranges for each diagnosis heading (for example, 372:372.39, Disorders of Conjunctiva (Appendix I).

However, using diagnosis code ranges created confusion for some plans about which codes within the range to include, and reporting was inconsistent. Therefore the list was revised to contain all individual codes within the specified ranges, for a total of 129 individual codes (Appendix I). The revised list was then noted to include some diagnoses that were not clearly "avoidable" visits, such as disseminated candidiasis (invasive fungal infection), and candida endocarditis (fungal infection of the inner layer of the heart). The inclusion of these diagnoses, which are rare, did not create any appreciable effect on the rate of "avoidable" ER visits and for future reporting will be eliminated from the list to avoid confusion.

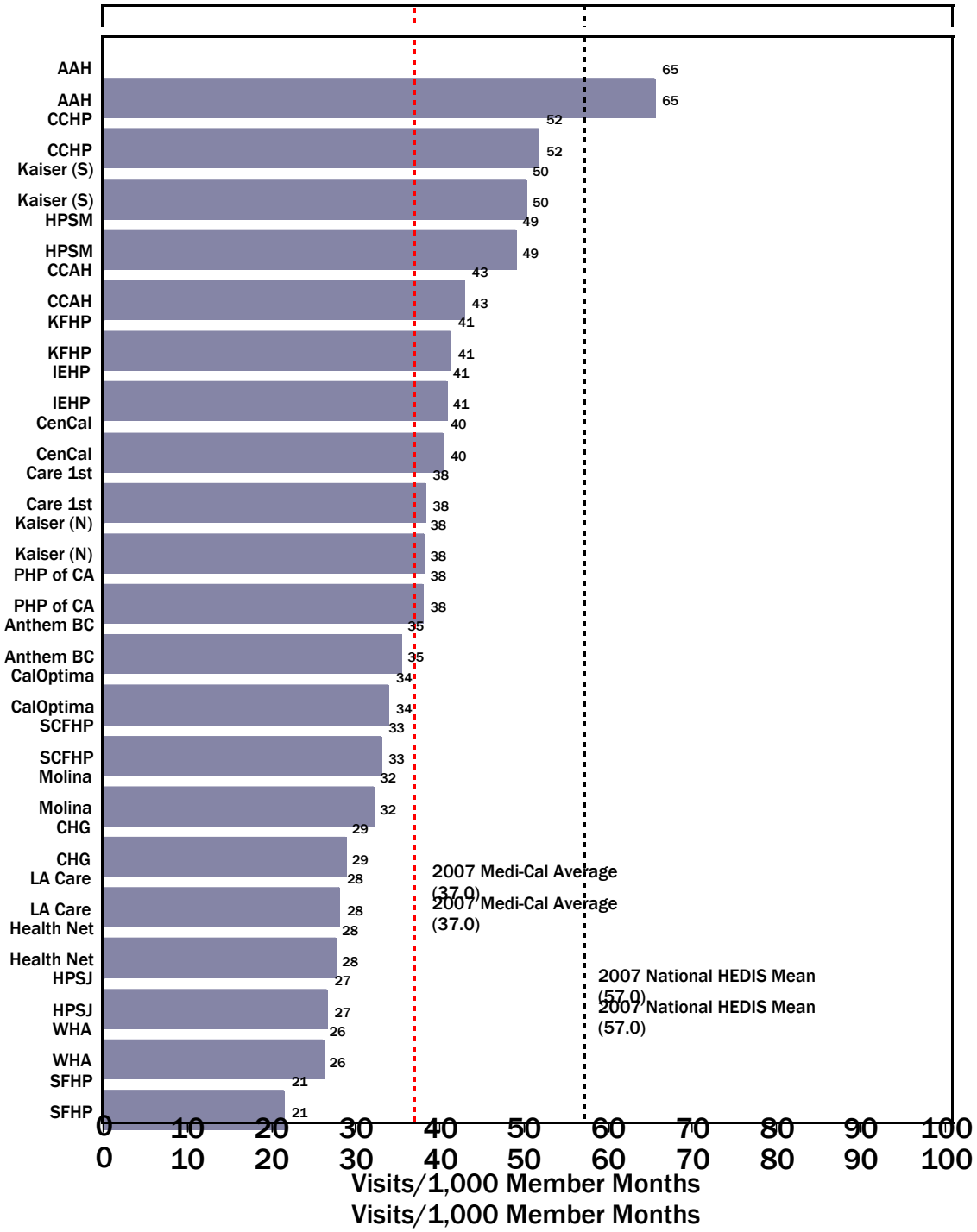
After the initial data submission and the discovery of the data discrepancies, DHCS asked the plans to review their data files for accuracy and completeness and to resubmit corrected data files. During April and May 2007, DHCS held teleconferences with individual plans to discuss and resolve the data discrepancies. Of the 44 data files originally submitted, 13 files, comprising 66 percent of records received required resubmission.

Measure II is fully defined in Appendix I

Baseline Measurements

Figure 1 shows the HEDIS measure *Ambulatory Care--Emergency Department Visits* rate for each plan in calendar year 2006. The bar chart allows comparison of each plan's performance on this measure compare to the 2007 Medi-Cal average and 2007 Medicaid HEDIS average.

Figure 1. Baseline HEDIS *Ambulatory Care–Emergency Department Visits* Rates (CY 2006)



The rates for the 2007 HEDIS *Ambulatory Care--Emergency Department Visit* measure were provided by the plans in their ER QIPs. For plans that serve multiple counties (Anthem, Health Net, and Molina), their combined rates are reported for purposes of the statewide plan comparison.

- HEDIS rates for ER visits ranged from 21 to 65 visits per 1,000 member months for CY 2006. The statewide simple average (2007 Medi-Cal average) is 37/1,000 member months; significantly below the 2007 HEDIS Medicaid average of 57/1,000 member months.
- One-half of all plans reported rates higher than the 2007 Medi-Cal average, but only one plan reported a rate higher than the 2007 HEDIS Medicaid average.

Baseline Avoidable Emergency Room Rate

All plans submitted data files that were used to calculate the "Avoidable" Emergency Room rate for CY 2006. Early in the development of this measure, plans requested that the baseline rate not be reported due to their unfamiliarity with the DHCS-developed measure and concerns regarding the data submitted. As previously discussed, DHCS experienced challenges receiving the data, and several plans were asked to resubmit their baseline report. Due to these difficulties, DHCS agreed that the collaborative will report baseline data and the first remeasurement data for Measure II together in the interim report to be released in mid 2009.

Barrier Analysis and Development of Interventions

Plans identified overuse of the ER by managed care members as an ongoing quality of care issue in spite of prior and ongoing plan interventions aimed at reducing inappropriate ER use.

DHCS and the plans spent much of 2007 reaching consensus on the collaborative focus, designing and administering surveys, and developing performance measures. In addition, the collaborative analyzed survey results and preliminary data in order to determine barriers to appropriate ER use and to determine statewide interventions. Specific issues related to ER use varied among plans.

Plan-specific data and survey responses indicated the following primary barriers, common to all plans, to reducing avoidable ER visits for Medi-Cal managed care members:

- Difficulty providing effective member education and changing member behavior.
- Lack of alternatives to the ER for persons seeking after-hours health care.
- Absence of a provider phone message giving alternative urgent care instructions.
- No disincentive for members who use the ER for non-emergency conditions since Medi-Cal managed care plan members have no co-pay.
- Lack of timely information communicated from hospitals to plans or providers about members seen in the ER.

- Lack of incentive for providers to provide after hours care.
- Lack of incentive for hospitals to reduce ER usage.

During 2008, DHCS and the plans met both in person and via teleconference to develop statewide interventions which would address major barriers and could be implemented by all plans. DHCS and participating plans agreed that a multifaceted approach that included efforts to create change at the systems level would be most effective. The collaborative agreed that a comprehensive member health education campaign and a hospital collaboration intervention were most feasible and would complement existing plan-specific interventions.

Because members ages 1 to 19 years uniformly showed a high avoidable rate of ER visits for all plans and across all ethnic and language subgroups and because avoidable diagnosis codes related to colds, coughs, and earaches were highest in this age group, the member health education campaign was designed to focus on parents and children with these diagnoses. In addition, the plans will implement an intervention that facilitates timely sharing of information by hospitals with plans and/or providers about plan members who visited the emergency room. DHCS agreed to develop a sample phone message for optional use by provider offices as a way to better inform members about access to after hours care.

The statewide collaborative goal is to reduce specifically identified avoidable ER visits by 10 percent for each plan over a three-year period and for each plan to establish a partnership to begin timely sharing of member ER visit data with one hospital.

Plan-Specific Interventions

In addition to the statewide interventions, it was determined via health plan surveys early in the collaborative process that at least 50 percent of the plans had already initiated interventions to reduce emergency room use or were in the process of developing new or expanding interventions to reduce avoidable ER visits. These interventions include:

- Nurse advice lines for plan members.
- Member education regarding use of nurse advice lines and self management instruction for conditions that generally don't require treatment in an ER.
- Strategies to increase access to primary care provider care after hours, including provider incentives to extend office hours and contracts with urgent care centers.

Plan-specific interventions are described in tabular format in Appendix J.

Next Steps for the Statewide ER Collaborative

- **Finalize and implement statewide member education campaign.** The poster and companion brochure are in the final stages of development. DHCS and plan health educators and medical directors worked extensively during 2008 on a common message acceptable to all plans and appropriate for all provider settings. With the assistance of Health Net Community Solutions, the graphic design is being finalized. Subsequently, the materials will be tested in focus groups, modified if necessary, and implemented by all plans in April 2009. Plans will print the materials in English and in Spanish, with the option of other languages appropriate to their populations as needed.

- **Finalize plan-hospital collaboration pilot measures.** During 2008, the plans developed criteria for this intervention, including the requirement that plans may work with only a single hospital in their network, the data specifications necessary for effective information sharing, and the requirements that the hospital information could be shared with either providers or plans and that some action must be taken to use the data to reduce avoidable ER visits. The process measures to document the effectiveness of this collaboration have been developed, and with final consensus anticipated to be reached in January 2009. Also in January 2009, DHCS will finalize a letter of support to be used by plans to assist with developing a collaborative relationship with a hospital.

- **After-hours phone message.** DHCS will develop an after-hours phone message, compliant with state and federal standards, to be used by providers to give clear instructions to members who may be considering visiting the emergency room. This was requested by the plans and will be implemented by providers on a voluntary basis. Completion is anticipated in March 2009.

- **Emergency Room Co-pay Pilot.** At the request of several plans, DHCS explored the possibility of an ER co-pay pilot program and in 2007 initiated discussions with the Center for Medicare and Medicaid (CMS). During 2008, DHCS developed a request for proposal and two health plans submitted proposals to participate in an ER co-pay pilot.

- **Small Group Collaborative.** DHCS expects to assist with development of the ER co-pay pilot as a small group collaborative and submit a waiver application to CMS during CY 2009.

All plans submitted their initial plan-specific proposals for the collaborative on the NCQA QIA forms by December 2007, documenting baseline ER rates, analysis of the barriers the plan will face in achieving the desired improvement, and the ongoing and proposed plan-specific interventions. Because of delays in conducting the member and provider surveys and analyzing the results, plans were allowed to develop additional plan-specific interventions and include them in an updated proposal or the first status report.

The first status reports with baseline data for the Avoidable ER Visits measure and the first remeasurement for both performance measures were submitted to DHCS in November 2008. Because of the data challenges inherent in the development of DHCS-developed Avoidable ER Visits measure, the baseline data for this measure will be included in an interim report along with the first remeasurement, rather than in this baseline report.

EQRO Comments and Recommendations

Challenges are inherent to a statewide collaborative designed to accomplish quality improvement. The Medi-Cal managed care plans participating in this collaborative serve the healthcare needs of a large, diverse population using different delivery models in varied geographical areas. Achieving consensus with a collaborative group of this size compounded the challenges. To mitigate these difficulties, DHCS promoted a broader approach in the design of the collaborative initiatives and goals.

Even though the overall statewide rate of ER visits (37/1,000 member months) compares favorably with the national Medicaid rate (57/1,000 member months), a number of plans exceed this average. We noted that respiratory conditions comprise a significant percentage of those diagnoses identified as avoidable or ambulatory sensitive and that children aged 1 to 9 years used the ER for avoidable visits the most.

The collaborative survey results revealed that very few members contacted their primary care physician or a Nurse Advice Line before going to the ER. Most of those who did contact their PCP's office were instructed to go to the ER if the member thought it was an emergency. While many members reported that their symptoms had occurred "after hours", very few providers offer primary care services after 5 p.m. or on the weekends.

The statewide collaborative goal is to reduce specifically identified avoidable ER visits by 10 percent for each plan over a three-year period and for each plan to establish a partnership to begin timely sharing of member ER visit data with one hospital. The collaborative identified four targeted interventions to achieve this health care delivery outcome:

- Finalize and implement a statewide member education campaign.
- Finalize plan-hospital collaboration pilot measures.
- Implement a standardized after-hours phone message.
- Establish an Emergency Room Co-pay Pilot with designated plans.

In order to accurately evaluate the results of a collaborative initiative, especially one with the complexities and size of the Medi-Cal population, the accurate collection and validation of data is critical. The HEDIS *Ambulatory Care—Emergency Department Visits* measure uses a standardized data collection methodology on a

national basis. This data is also validated before submission for annual rates and for comparative purposes. This provides the validity necessary when presenting and comparing individual plan data in a public reporting format.

Since improvements in the delivery of health care services across large populations often require several years to see results and sustainability, the standardized baseline data must be able to be replicated over subsequent years to report accurate results. National Medicaid HEDIS rates are utilized for this purpose and are recognized for comparative trending over time.

There are challenges with the methodology utilized with reporting the rates for the DHCS-developed the Avoidable ER Visits measure The data rate for this DHCS-developed measure has not been field-tested and will not be considered comparable to HEDIS measures for purposes of validity. This will likely continue to present a challenge to DHCS both for the baseline and subsequent remeasurement reporting years. These data will also be subject to increased scrutiny when presented for public comparison.

In order to provide a more standardized data collection and reporting for the baseline Avoidable ER Visits rate, Delmarva recommended that DHCS consider the collecting and analysis of plan administrative data versus having the plans submit their own data results. This coordinated approach could ensure consistent application of the Data Set Requirements developed by DHCS. The production of both the baseline and subsequent remeasurements, while still not comparable to any national benchmarks, could enhance the credibility of the data and provide a mechanism for consistent replication.

A major challenge in measuring the impact of collaborative interventions on outcomes is being able to define the actual results related to specific activities. It is difficult to determine whether one initiative was actually responsible for the subsequent results in the remeasurement time periods when multiple strategies are implemented concurrently versus introducing one at a time. As all the interventions are evaluated along with the remeasurement results, it will be difficult to determine the degree of impact that each activity may have had on the subsequent outcomes.

Due to the amount of time to reach consensus in the development of collaborative interventions, implementation has been delayed. Implementation is not anticipated for many of the interventions until 2009. As a result, remeasurement periods for years 2007 and 2008 will not be impacted by these collaborative interventions, delaying improvement in the project and associated performance measures. In future collaborative QIPs, Delmarva recommends that DHCS and the plans expedite the intervention development process to help accelerate the development and implementation efforts. *Note:* Subsequent to the development of this report, DHCS did decide to extend the timeline of this statewide collaborative due to the

delay in implementing the interventions. The revised timeline will be discussed in the upcoming *Interim Report* on this statewide collaborative which is scheduled for release in fall 2009.

DHCS and the participating health plans should continue with their statewide collaborative improvement efforts to reduce the percentage of avoidable ER visits by Medi-Cal managed care members. These initiatives have been developed to address the need for improved access to primary care preventive services and may identify strategies that could lead to system-wide solutions. Delmarva also recommends considering the inclusion of additional stakeholders as the collaborative proceeds to increase the probability of sustained improvement.

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9 NCQA Quality Improvement Activity (QIA) Form and Instructions are available at: http://www.ncqa.org/Programs/Accreditation/QIAInstructions.doc

Appendix A: Health Plan Electronic Survey

I. USE OF EMERGENCY ROOM

1. Plan Name:

2. Is avoidable emergency room utilization a challenge in your health plan (HP)? (Avoidable ER use is defined as a non-emergent visit that could have been treated in other than the ER i.e. PCP office, urgent care center, nurse advice line).

- ○ Yes
- ○ No

3. What are the reason(s) for avoidable emergency room visits by members? Check all that apply:

- ☐ Not applicable, avoidable ER visits are not a challenge
- ☐ Access to specialty care
- ☐ Physician unavailable after hours
- ☐ Physician not aware of member's ER activity
- ☐ Sent to the emergency room by PCP for test and procedures that their physician could not perform in their office
- ☐ Member did not want to miss work
- ☐ Unable to obtain same day appointment
- ☐ Member unable to obtain outpatient diagnostic test in timely manner
- ☐ Rural Area and the only source of care for the beneficiary
- ☐ Member seeking drugs
- ☐ ER viewed as usual source of care by member
- ☐ ER's instruct member to return instead of instructing member to seek follow-up care with primary care physician (PCP)
- ☐ Transportation issues
- ☐ Lack of access to telephone
- ☐ Language Barriers
- ☐ Member unaware of plan advice line or other triage care
- ☐ Member was not sure what else to do
- ☐ Member did not want to call PCP or wait for an appointment
- ☐ Do not know
- ☐ Other, please specify:

4. How were these conclusions drawn? Check all that apply:

- ☐ Information obtained by federal or state health agencies
- ☐ Interviews with/or surveys of beneficiaries
- ☐ Interviews with/or surveys of PCP's or other providers
- ☐ Patient complaints
- ☐ Provider complaints
- ☐ Review of beneficiary ER reports
- ☐ Review of plan data; please specify type of data reviewed
- ☐ Other, please specify:

II. DATA

5. What methods does your HP use to evaluate timely access to routine office visits? Check all that apply:

- ☐ Secret shopper survey
- ☐ Member satisfaction survey
- ☐ Provider survey
- ☐ Onsite visit to PCP office
- ☐ Other, please specify:

6. Is your HP able to identify members who use the ER?

- ○ Yes
- ○ No

7. How are these members identified? Check all that apply:

- ☐ Not applicable, we cannot identify members who had an ER visit
- ☐ FAX connection received from ER for follow-up care
- ☐ Retrospective review of ER admission records
- ☐ ER claims
- ☐ Pharmacy claims
- ☐ Member call provider or plan for follow-up care
- ☐ Notification/communication from PCP to Plan
- ☐ Other, please specify:

8. Please provide an estimate of the total number of beneficiaries seen in the ER for a 30-day period:

9. Please estimate what percentage of beneficiaries who visit the ER are repeat visitors?

- ○ 10% or less
- ○ 20%
- ○ 30%
- ○ 40%
- ○ 50%
- ○ 60%
- ○ 70%
- ○ 80%
- ○ 90%
- ○ 100%
- ○ Cannot make a reasonable estimate

10. Of those beneficiaries who go to the ER, please estimate what time of DAY and WEEK they are seen; please denote the pattern that is most commonly found e.g. weekday mornings.

- ❑ Weekday
- ❑ Weekend
- ❑ Both weekdays and weekends
- ❑ Morning
- ❑ Evening
- ❑ Night
- ❑ Additional Comments:

11. In your opinion, which members most frequently visit the ER:

- ○ Children ages 0-9 years
- ○ Children ages 10-17 years
- ○ Adults 18 years and older
- ○ Other, please specify:

12. In your estimation, what percent of beneficiaries who go to the ER are admitted during that visit?

- ○ 10% or less
- ○ 20%
- ○ 30%
- ○ 40%
- ○ 50%
- ○ 60%
- ○ 70%
- ○ 80%
- ○ 90%
- ○ 100%
- ○ Cannot make a reasonable estimate

13. Are you able to identify members who use the ER by PCP?

- ○ Yes
- ○ No
- ○ If yes, how does your HP identify these members? If no, please explain reason.

14. Does your HP identify which PCPs have patients that visit the ER frequently?

- ○ Yes
- ○ No
- ○ Please explain:

15. What frequency does your HP use to identify ER overuse?

- ○ Once in 6 months
- ○ Once in 3 months
- ○ Once a month
- ○ Twice each month
- ○ Three times or greater a month
- ○ Other, please specify: _____

III. ER QI PROJECT

16. Has your HP (current or previously) conducted a QIP related to ER visits?

- ○ Yes
- ○ No

17. What was the main focus of the QIP? Check all that apply:

- ☐ Not applicable, my plan has not participated in a QIP related to ER
- ☐ Disease specific condition
- ☐ Population specific (e.g. children)
- ☐ Utilization of ambulatory conditions
- ☐ Patient Self-Management
- ☐ Hospital Admissions
- ☐ Data Sharing
- ☐ Reimbursement Issues/Claims
- ☐ Please indicate Disease specific condition:

18. Please check type of QIP: (check all that apply)

- ☐ Not applicable, my plan has not participated in a QIP related to ER
- ☐ Internal QIP
- ☐ Small Group Collaborative
- ☐ Regional Collaborative
- ☐ Local (county) Collaborative
- ☐ Hospital generated Collaborative
- ☐ University research project
- ☐ Other, please specify:

19. Please check phase of project: (check all that apply)

- ❑ Not applicable, my plan has not participated in a QIP related to ER
- ❑ Data gathering
- ❑ Development
- ❑ Implementation
- ❑ Evaluation
- ❑ QI work completed
- ❑ Other, please specify:

20. What intervention(s) does your HP intend to implement or have already implemented to address avoidable ER visits? Check all that apply:

- ❑ Use of urgent care centers for after hours and/or weekend care
- ❑ Use of federally qualified health centers for after hours and/or weekend care
- ❑ Pay for Performance - Beneficiary Incentives
- ❑ Pay for Performance - Provider Incentives
- ❑ Pay for Performance - Both Beneficiary and Provider Incentives
- ❑ Same day appointment with PCP's
- ❑ PCP Profiling for high volume frequent ER users
- ❑ Beneficiary Profiling for frequent ER visits
- ❑ Follow-up of members seen in the ER
- ❑ Care Coordination of frequent ER users
- ❑ Nurse Advice Line
- ❑ Beneficiary Health Education - How to use plan services
- ❑ Beneficiary Health Education - Use of emergency rooms
- ❑ Beneficiary Health Education - Contact PCP or HP after hours
- ❑ Beneficiary Health Education - Self-management of selected chronic conditions
- ❑ Collaboration with hospitals
- ❑ Correct member demographics
- ❑ Other, please specify:

21. What intervention(s) have been most effective for your HP to reduce avoidable ER visits? Check top five (5):

- ❑ Use of urgent care centers for after hours care and/or weekend care
- ❑ Use of federally qualified health centers for after hours care and/or weekend care
- ❑ Pay for Performance - Beneficiary Incentives
- ❑ Pay for Performance - Provider Incentives
- ❑ Pay for Performance - Both Beneficiary and Provider Incentives
- ❑ Same day appointments with PCP's
- ❑ PCP Profiling of high volume frequent ER users
- ❑ Beneficiary Profiling of frequent ER users
- ❑ Member Services follow-up of members seen in the ER
- ❑ Care Coordination of frequent ER users
- ❑ Beneficiary Health Education - How to use plan services
- ❑ Beneficiary Health Education - Use of emergency rooms
- ❑ Beneficiary Health Education - Contact PCP or HP after hours

- ❑ Beneficiary Health Education - Self-management of selected chronic conditions
- ❑ Nurse Advice Lines
- ❑ Collaboration with hospitals
- ❑ Contractual arrangement with ER
- ❑ Timely access to specialist
- ❑ Other, please specify:

_____

IV. ER STATEWIDE COLLABORATION PLANNING WORKGROUP

22. Review of the ER literature and interviews with State Medicaid Medical Directors strongly suggests the following in reducing ER Utilization: Same day appointments (Open Access); Access to primary care after hours; Pay for Performance incentives; Encouraging beneficiaries to contact physician after hours. What are the HP barriers to implementing one or more of the above interventions as part of a pilot? Check all that apply:

- ❑ Providers unwilling to participate in expanding after hours care
- ❑ Providers unwilling to redesign office to allow for same day appointments
- ❑ Limited dollars for P4P
- ❑ Limited plan resources
- ❑ Influencing beneficiary behavior
- ❑ Other, please specify:

23. Which of the following areas should be the focus of the ER State Wide Collaborative? Please select one or more from the following:

- ❑ Beneficiary Health Education - Use of ER
- ❑ Beneficiary Health Education - Use of plan services e.g. nurse advice line
- ❑ Beneficiary Health Education - Self Management of specific chronic conditions
- ❑ Disease Management
- ❑ Providers - Open Access
- ❑ Providers - Pay for Performance
- ❑ Providers - Advice Line or referral to HP advice line
- ❑ Infrastructure - Collaborative project with acute care hospitals
- ❑ Infrastructure - Contracting with urgent care centers, community health centers for after hours care and/or weekend care
- ❑ Do not know at this time
- ❑ Other, please specify:

24. A planning workgroup will be established to assist MMCD staff and Delmarva in the development of the ER Collaborative. Plan representatives (i.e. medical directors, QI staff, etc.) from all managed care models (i.e. COHS, Two Plan Model, GMC) are encouraged to participate. PLANNING WORKGROUP WILL BE RESPONSIBLE FOR: Identifying the focus of collaborative; Developing AIM statement; Developing measure and specifications; Designing a pilot, if necessary; Developing an evaluation tool. TIME COMMITMENT: Initially once a week for 6 weeks for 1.5 hours each time via teleconference; additional time may be required depending on tasks to be completed as a result of the teleconferences. The first teleconference is scheduled for Tuesday, January 30, 2007 from 8:30 am - 10:00 am. METHOD OF COMMUNICATION: Based on the needs of the group and tasks to be completed; includes use of teleconferences. Would you or someone from your HP be interested in participating in the planning workgroup?

- Name
- Company
- Address 1
- Address 2
- City/Town
- State/Province
- Zip/Postal Code
- Telephone Number
- Email Address

25. Please indicate preferred day of week and time for teleconferences:

- ❑ Monday
- ❑ Tuesday
- ❑ Wednesday
- ❑ Thursday
- ❑ Friday
- ❑ 8:30 am - 10:00 am
- ❑ 10:00 am - 11:30 am
- ❑ 11:30 am - 1:00 pm

26. Although your HP is unable to participate in the planning workgroup, would you like to share your successes and lessons learned with the planning workgroup?

- Name
- Company
- Address 1
- Address 2
- City/Town
- State/Province
- Zip/Postal Code
- Telephone Number
- Email Address

27. OTHER: There was discussion about CHDP services during the December 13, 2006 Medical Directors Meeting. To reduce the number of surveys your HP receives, questions related to CHDP services are included in this survey. Which of the following is TRUE for your health plan?

- ○ CHDP services are carved in
- ○ CHDP services are carved out

28. Does your provider network include one or more school-based or school-linked health centers?

- ○ Yes
- ○ No

Appendix B: Health Plan Electronic Survey Responses

With assistance from Delmarva Foundation for Medical Care, Inc, DHCS' External Quality Review Organization (EQRO), MMCD developed and administered an electronic survey to health plans during January 2007. The survey identified plans' experiences related to members use of the ER.

Twenty five individuals including 19 health plans responded to the survey. Their responses revealed the following:

1. 95% of health plans indicated that avoidable ER utilization is a challenge for their health plans.

2. Health plans reported members use the ER for avoidable visits because of the following:
    a. Physician unavailable after hours (76%),
    b. ER viewed as usual source of care by member (71%)
    c. Member did not want to call PCP or wait for an appointment (76%).

3. 57% of health plans reported members commonly go to the ER on both weekdays and weekends.

4. 53% of health plans currently or previously conducted quality improvement projects (QIPs) related to ER visits.

5. 41% of QIPs focused on utilization of ambulatory conditions.

6. Health plans reported implementation or planned to implement the following interventions:
    a. Use of urgent care centers for after hours care (72%)
    b. Pay for performance (39%)
    c. Same day appointments (56%)
    d. PCP profiling for high volume frequent ER users (76%)
    e. Beneficiary profiling for frequent ER visits (72%),
    f. Beneficiary education of how to use the ER (78%)

7. Health plans report the ability to influence beneficiary behavior (100%) and providers unwilling to participate in expanding after hours care (84%) as barriers to implementing interventions.

Appendix C: Health Plan Supplemental Survey Questions

ACCESS TO AFTER HOURS CARE
1. How does the health plan assist members in seeking urgent and emergency care? Please describe.
2. What do providers perceive as the challenges to offering care after 5pm for urgent conditions?
3. Does the health plan provide incentives to PCP's for offering after hours care? If yes, please describe incentive and methodology for payment of incentive.
4. If applicable, calculate the rate of providers that contract with both health plans in the county?
MEMBER ENROLLMENTS AND DISENROLLMENTS
5. How long does it take the health plan to notify members of their assigned PCP?
6. What system is in place to assist newly enrolled members to navigate the managed care system (other than use of member informing materials sent to the members)?
HOSPITALS AND OTHER ENTITIES
7. What challenges do the health plans experience when working with hospitals who treat the managed care member in the ER?
8. Does the health plan have challenges contracting with urgent care centers, community care clinics and other entities to provide urgent care services after hours? If, yes, please describe the challenge(s).
9. Under what situations does the health plan *not* reimburse for ER services? Please describe.
10. Does the health plan require prior authorization for non emergent or urgent conditions seen in the ER? If yes, please describe the process.
11. How does the health plan and ER's communicate regarding members seen in the ER?
12. Does the health plan routinely provide ER reports to PCP's? What type and frequency of reports are given to the PCP's?
13. Please provide names, addresses and contact person for several hospitals in your county with the highest ER rates. For each hospital please specify: • Contract or non contract hospital • Location - urban, inner city , rural or other • Name of hospital contact person and telephone number • Potential communication barriers
14. Of the hospitals provided above, please identify which hospital(s) willing to work with MMCD to conduct member surveys in the ER?

Appendix C: Health Plan Supplemental Survey Questions (continued…)

ADMINSTRATIVE FAIR HEARINGS
15. What is the average number of ER grievances that result in fair hearings?
16. What are the reasons for ER grievances?
17. Characterize the outcomes of fair hearings related to ER grievances.
OTHER ER MEASURES AND INTERVENTIONS
18. What other ER measures and interventions has the health plan implemented?
ER CO-PAYS
19. Is there a hospital in your county that would be willing to participate in ER Co-Pay pilot? If yes, please provide name(s) of hospital.
20. Has your health plan considered implementation of co - pays? If yes, • What are the barriers to implementing co-pays within your health plan assuming statutory authority and compliance? • Would your health plan be interested in participating in a co-pay pilot in the distant future? • How would your health plan implement co-pays? • Does your health plan have suggestions as MMCD moves forward to explore and if possible, implement co-pays?

Appendix D: Health Plan Supplemental Survey Responses

The collaborative workgroup developed a survey in July 2007 to identify other variables related to member ER use. Health plan responses to the survey were used to assist the collaborative in identifying barriers and areas to intervene. Anecdotal responses from 21 health plans revealed the following:

1. The majority of health plans assist members to seek urgent care and emergent care through member informing materials (60%) and the Nurse Advice Line (50%).

2. Health plans report primary care providers may be hesitant to offer urgent care after hours due to operational costs (55%), staffing (45%), no incentive (40%) and quality of life (30%). Other reasons cited included: provider and member safety and member access to transportation.

3. Health plans report the need to closely work with hospitals related to members seen in the ER. Health plans would like to receive timely information of members seen in the ER.

4. Health plans report establishing contracts with urgent care clinics and other entities for the provision of after hours care is a challenge for the following reasons:
   a. There are limited facilities available to provide after hours care.
   b. Locations of after hour facilities require members to travel outside of their geographic area.
   c. Facilities are unwilling to accept Medi-Cal reimbursement rates.

Appendix E: Health Plan Reporting Template

1. Medi-Cal Managed Care Emergency Room (ER) Collaborative Reporting Specifications
2. ER Collaborative Data Checklist
3. Health Plan Reporting Template

Appendix E.1

Medi-Cal Managed Care Emergency Room (ER) Collaborative Reporting Specifications

To track progress toward the statewide goal and to assess the related phenomena, objective measures are necessary. Adoption of two performance measures: HEDIS ER Visits, and "Avoidable" ER Visits should make it possible to determine if implementation of interventions leads to change over time. The purposes of this document are to describe the two measures; to set forth the transmission format, frequency, and geographic breakdown; and to provide data specifications.

The Statewide goal of the ER collaborative is to achieve a reduction in the rate of "avoidable" ER visits of 1-5% annually based on plan goals and a 10% rate of improvement during the life of the collaborative. Annual rates of change compare current to previous values and the overall rate of improvement compare the initial baseline to the final. In theory, reducing "avoidable" ER visits should be accompanied by a reduction in all ER visits during the life of this collaborative. It is understood that individual health plan's goals for improvement may vary. To determine whether the change is a "real" improvement change or is a short-term artifact of an unrelated event or is caused by random chance, the Medi-Cal Managed Care Division (MMCD) and Plans will jointly determine how to calculate the extent to which changes in performance are statistically significant (real improvement has occurred).

Description of Measures (With Quotations from HEDIS 2007 Technical Specifications)

Measure I: HEDIS Emergency Room Visits[1]

"This category measures use of [ER] services, which are included because they occasionally substitute for ambulatory clinic encounters. While patient behavior is a factor in the decision to use a [ER] rather than a clinic or physician's office, the decision may be a result of insufficient access to primary care; therefore, trends in [ER] use are an important aspect of total utilization data. Count once each visit to an ER that does not result in an inpatient stay, regardless of the intensity of care required during the stay or the length of stay. Count only one [ER] visit per date of service." Do not include visits to urgent care centers.

Rate: per 1,000 Member Months.

[1] HEDIS 2007 refers to these as Emergency Department (ED) visits.

Measure II: "Avoidable" Emergency Room Visits

This category measures the percentage of ER visits for problems that could have more appropriately been seen and managed by a primary care provider in an office or clinic setting within twenty-four (24) hours, excluding infants (less than 12 months of age). The "avoidable" ER visits are those matching the selected primary diagnosis codes developed as a metric for the ER collaborative. This list is not inclusive for all possible avoidable visit codes. Rate: percent of all ER visits that match "avoidable" diagnosis codes.

Data Limitation Statement

The HEDIS count of ER visits is for members of all ages.
Rates of avoidable ER visits do not include visits when the member is an infant (less than 12 months of age).

Data Specifications

Measure I: HEDIS Emergency Room Visits[2]

Follow the HEDIS Use of Services: Ambulatory Care (AMB) technical specifications. Apply the HEDIS Technical specifications appropriate to the calendar year period starting with the HEDIS version 2007, limited to ER visits.

Follow the HEDIS instructions in the following areas:

- Member counts - Specific Guidelines for Use of Services Measures
- Do not count mental health and chemical dependency services that meet any of the HEDIS specified criteria
- Table AMB-B to identify ER (Emergency Department) Visits.

Make sure to adhere to annual HEDIS coding changes as they occur.

Measure II: "Avoidable" Emergency Room Visits

There are no technical specifications in the HEDIS manual for this measure. Specified diagnosis codes are to be used to define "avoidable" visits for members 12 months of age or greater that could have more appropriately been seen within 24 hours by a primary care provider.

- The total number of visits from HEDIS ER excluding infants (less than 12 months of age) becomes the denominator.

[2] HEDIS 2007 refers to these as Emergency Department (ED) visits.

- Visits with any of the collaborative-designated avoidable primary diagnosis codes will be the numerator.
- Exclude visits when the member is less than 12 months of age (numerator).
- Import relevant codes: Medi-Cal client index number (CIN), Medi-Cal Ethnicity, Medi-Cal Language, Primary Diagnosis, Date of service, and Medi-Cal Aid Code.
- Calculate: Age (on the date of service) and total length of plan enrollment as Member months.

Transmission Format, Frequency, and Geographic Breakdown

Measures I, and II are to be submitted on CD-R or via a secure web site as a flat file with the raw data containing records for every ER visit during the CY reporting period.

Plans also will submit tables containing rates for measures I and II by Age Ranges as specified by HEDIS AMB, Medi-Cal Ethnicity, Medi-Cal Language, Capitation Groups using Medi-Cal Aid Code. MMCD and plans will determine if annual submissions of demographic detail tables are needed in the future. Due September 28, 2007.

Measures I and II are to be reported annually to the State each August (following annual HEDIS reporting). After the August 2009 submission an evaluation will be completed to determine the possible extension to include an additional year.

ER Collaborative Report Periods	
Report Due 31st of the month	Twelve (12) Months of Service
September 28, 2007	January 1, 2006 - December 31, 2006
August 2008	January 1, 2007 - December 31, 2007
August 2009	January 1, 2008 - December 31, 2008

These two measures are to be reported for each Plan Code in each County of operation.

Flat File with Raw Data on Every ER Visit During 12-Month Reporting Period

- Complete:
  - "ER COLLABORATIVE DATA CHECK LIST"
  - "Health Plan Reporting Template"
  - "Health Plan Reporting Template – Demographic Detail"

- Create a CD-R or text file. Please note that in the All Plan Letter dated August 3, 2006 Number 06005 Protected Health Information (PHI) and Notification of Breaches. MMCD encourages the use of encryption when transmitting data. Another method to accomplish this is to send an encrypted CD-R by UPS, FedEx, USPS, etc., and to separately email instructions for decryption or send a file using a secure web site link. In addition the randomly assigned Client Index Number (CIN) is to be reported instead of SSN or Medi-Cal Eligibility Data System (MEDS) ID.

- Please e-mail Peggy.Vollstedt@dhcs.ca.gov to notify MMCD that the CD-R is en route and send the CD-R to:
  - Peggy Vollstedt
  - Medical Policy Section, Policy and Financial Management Branch
  - Medi-Cal Managed Care Division, MS 4418
  - Department of Health Care Services
  - Physical Address (for courier shipments): 1501 Capitol Avenue, 4th Floor, Sacramento, CA 95814
  - Mailing Address (for USPS): PO Box 997413, Sacramento, CA 95899-7413.

	Appendix E.2			
	ER COLLABORATIVE DATA CHECK LIST	**Yes**	**No**	**Reason why item not completed or comments**
	Emergency Room Use of Services and Primary Diagnosis for "Avoidable" Visits	**X**	**X**	
1	Use the Medicaid product line for the ER service records for each Plan Code in each County of operation.			
	Member Months and Ages			
2	Count the total number of member months for the measurement year for members with the benefit.			
3	Follow HEDIS instruction to calculate age. Describe method used in Reason column.			
	Emergency Room Visits			
4	Use the HEDIS instructions: ED Visits "count once each visit to an ED that does not result in an inpatient stay…. Count only one ED visit per date of service".			
5	Follow HEDIS instruction: "Count visits to urgent care under Outpatient Visits".			
6	Do not count mental health and chemical dependency services that meet any of the HEDIS specified criteria.			
7	Follow the HEDIS codes on table AMB-B to identify Emergency Department Visits.			
8	**STOP**- DO NOT REPORT ambulatory surgery/procedures and observation room stays.			
9	Include all member records regardless of age for ER visits.			
	Avoidable Emergency Room Visits (AER)			
10	Use the HEDIS records as the AER denominator. ***THE NUMERATOR AND DENOMINATOR EXCLUDE RECORDS WHEN AGE LESS THAN 12 MONTHS.*** Use Attachment A list of diagnosis codes to identify numerator records.			

11	Member records when age is less than 12 months for "Avoidable ER hit2" will be zero.			
	Steps to build the ER records for transmission			
12	Include your Medi-Cal managed care Plan Name and County of operation.			
13	Include your Medi-Cal managed care three digit Plan Code number.			
14	Include member's nine digit Client Index Number (CIN) as it appears on the Medi-Cal Data System (MEDS)/FAME file. Example: 91300001D.			
15	Include age as a two digit numeric value.			
16	Include single digit Ethnicity code as it appears on the Medi-Cal Data System (MEDS)/FAME file. Use "white" and/or "black" Do not substitute "Caucasian" and/or "African American."			
17	Include single digit alpha or numeric code for Language as it appears on the MEDS/FAME file.			
18	Include Primary diagnosis using specific ICD-9 code.			
19	Include date of service as CCYY-MM-DD.			
20	Include the Medi-Cal Aid Code as it appears on the MEDS/FAME file.			
21	Add single digit numeric value for each ER visit record matching diagnosis listed on Attachment A.			
22	Count member months and enter as a two digit numeric using preceding zeros where needed. May save as a text column if needed.			
23	Transmit after copied on CDR, or saved as a text file.			
	Emergency record data completion factor			
24	What is your emergency record completion factor expressed as a percent? How many records were available when the HEDIS AMB was run for the previous calendar year period?			

	Mailing to MMCD			
	AFTER CHECKING YES/NO/FILLING OUT REASON COLUMN, send e-mail notice of completion to: Peggy.Vollstedt@dhcs.ca.gov and mail to:			
	Peggy Vollstedt			
	Medical Policy Section Policy and Financial Branch			
	Medi-Cal Managed Care Division MS 4418			
	Department of Health Care Services			
	Mailing address (for UPS): PO Box 997413 Sacramento, CA 95899-7413			
	*Physical address (for courier): 1501 Capitol Avenue, 4th Floor Sacramento, CA 95814			
	Accepted Oct 22, 2007			

Appendix E.3
Health Plan Reporting Template
Due September 28, 2007 - August 31, 2008 - August 31, 2009

Medi-Cal Managed Care Division (MMCD) Health Plan Emergency Room Collaborative Data Format

Data Format and Files for the HEDIS Use of Services:Ambulatory Care LIMITED TO: ED as described on Table AMB-B and Avoidable ER visits.
The following data format and record layouts are to be used for reporting the service records.
Instructions are part of the data check list that must accompany this file.
One file is to be submitted with a single submeasure (ER_VISITS). (Please refer to annually revised HEDIS and MMCD Specifications).
This file must include a list of all members who will be included in the ER numerator and become the Avoidable ER denominator
Please Note this data is written to one file ER_VISITS on tab two of this file. Reference files are on added tabs.
If you are not using Excel, please send each contracted county as individual tables in Access. Text files with delimiters are accepted.
However, do not change the sequence or the Headings of the data columns in the this file.

Description	*Field Name*	*Field Type*	*Field Size*	*Values*
Emergency Department Visits (ED)				
Plan Name and county of operation	PL_NAME	Alpha	Abbreviated, w/o any space between letters	MyHlthPlNameSanDiego
Plan Code	PL_CODE	Numeric	3	048 (example)
CIN Number	CIN	Numeric/alpha	9	91300001D (example)
Age in years as specified in HEDIS	AGE	numeric	2	00= 0 thru 11 months; 01=12 thru 23 months, etc.
Ethnicity as it appears on the FAME file	ETHNICITY	numeric/alpha	1	1 = White (example)
Language spoken in the home	LANGUAGE	numeric/alpha	1	1=Spanish (example)
Primary diagnosis as it appears on the claim include decimal if appropriate	DIAGNOSIS	numeric/alpha	3-5 characters, or 5 characters + decimal point + 1 digit	112=Candidiasis; 112.0=Candidiasis of mouth; 112.82=Candidal otitis externa,
Date of service	DATE	numeric	10	CCYY-MM-DD (2007-02-27 example)
Aid Code at the time of visit	AIDCODE	numeric\alpha	2	30 TANF-FG (example)
Avoidable ER Compliance Code	AER	Numeric	1	1=yes or 0=no
Total member months	MEM_MOS	Numeric	2	03=3 months

Description	**Definitions for Data File**
Plan Name:	Your Medi-Cal Managed Care Plan Name and County
Plan Code:	Each of your Medi-Cal Managed Care three digit Plan Code(s)
CIN Number:	Member's nine digit Client Index Number as it appears on the FAME file
Age	Age in years as specified in HEDIS
Ethnicity	Ethnicity as it appers on the FAME file
Language	Language spoken in the home as shown on the FAME file
Diagnosis	Primary diagnosis as specific ICD-9 code
Date	Date of service member seen as: CCYY-MM-DD
Aid Code	Member Medi-Cal aid code as it appears on the claim or verified by link to plan eligibility FAME file
Compliance Code:	HIT indicates member should be included in the Avoidable ER numerator excludes members less than 12 months of age.
Total member months	Count of the number of months of enrollment in plan for each member during the year

File Naming Convention
Use the following file naming convention when submitting data files of the members who will be included in the
ER and avoidable ER numerator. The file extension will allow MMCD to determine what software we will need to access the file.
Please send us back completed ED Template
Abbreviated Plan name followed by a underscore indicating which year's data and file extension
Example of file name: ER_VISITS_MyHlthPlanName_06.mdb
File Media
Please submit your files on CD-R or by a secure web site. Excel, Access, or text delimited files are accepted.

THANK YOU

Send e-mail notice of completion to: Peggy.Vollstedt@dhcs.ca.gov and mail to address:
Peggy Vollstedt
Medical Policy Section, Policy and Financial Management Branch
Medi-Cal Managed Care Division, MS 4418
Department of Health Care Services
* Physical address (for courier shipments): 1501 Capitol Avenue, 4th Floor, Sacramento, CA 95814
* Mailing Address (for USPS): PO Box 997413, Sacramento, CA 95899-7413.

200xData										
Plan Name	Plan Code	CIN Number	Age	Ethnicity	Language	Primary Diagnosis	Date of Service	Aid Code	AER	Member Months
alpha_no_space	numeric3	num8+1alph	numeric2	numeric/alpha1	numeric/alpha1	alpha/numericX+decimal	numeric10	numeric1/alpha1	numeric1	numeric2
									1or 0	
PL_NAME	PL_CODE	CIN	AGE	ETHNICITY	LANGUAGE	DIAGNOSIS	DATE	AID_CODE	AER	MEM-MOS

Appendix E.3		
	Dx Code Range	Medi-Cal Avoidable ICD-9 Diagnosis Codes for ER Collaborative
	Code	Label
1	110.5	Dermatophytosis of the body (Herpes circinatus, Tinea imbricata)
2	112:112.3	Candidiasis
	112.5:112.9	Disseminated
4	133: 133.9	Acariasis
8	372: 372.39	Disorders of Conjunctiva
10	382:382.9	Suppurative
12	460	Acute nasopharyngitis (common cold)
13	462	Acute Pharyngitis
14	465: 465.9	Acute upper respiratory infections of multiple or unspecified sites
18	466:466.0	Acute bronchitis
19	472: 472.2	Chronic pharyngitis & nasopharyngitis
23	473:473.9	Chronic sinusitis
30	474: 474.9	Chronic disease of tonsils & adenoids
34	595: 595.9	Cystitis
42	599.0	Urinary tract infection, site not specified
43	616:616.1	Inflammatory disease of cervix, vagina, & vulva
46	628.8	Infertility, female-Of other specified origin
47	698.8	Other specified pruritic conditions (hiemalis, senillis, Winter itch)
48	698.9	Unspecified pruritic disorder (itch NOS, Puritis NOS)
49	705.1	Prickly heat
50	724.2	Lumbago
51	724.5	Backache, unspecified
52	724.7	Disorders of coccyx
53	724.8	Other symptoms referrable to back
54	784.0	Headache (excluded: 350.2; 346.0-346.9; & 307.1) atypical face pain, migraine, & tension headache
55	V67:V67.9	Follow up examination
56	V68:V68.9	Encounters for administrative purposes
57	V70:V70.9	General medical examination
58	V72:V72.9	Special investigations & examinations

REMOVE 4 DIGIT LIMIT ALLOW COLLECTION OF ENTIRE RANGE-The intent to collect all diagnosis codes (ICD-9) reported and then delete all but the first four (4) digits is misleading and if followed would unnecessarily eliminate many avoidable visits. Therefore the following changes are to be followed effective immediately: 1. Ignore the ICD-9 four(4) digit code restriction. 2. Import the ICD-9 codes to the ER Collaborative flat file of raw data as received by the plan. For example: 112=Candidiasis; 112.0=Candidiasis of mouth; or 112.82=Candidal otitis externa.

MEDS NETWORK USER MANUAL

DED NO. 0115, 0117

MEDS NETWORK NAME: ETHNIC

NARRATIVE NAME: Primary Ethnic Code, Secondary Ethnic Code

AKA NAMES:

SOURCE: COUNTY, SDX

LENGTH: 1

DEFINITION: This data element identifies the ethnic group the applicant represents in the opinion of the interviewer if not declared by the applicant.

VALUES:

1	White	H	Cambodian
2	Hispanic	J	Japanese
3	Black	K	Korean
4	Asian or Pacific Islander	M	Samoan
5	Alaskan Native or American Indian	N	Asian Indian
6	Not a valid value	P	Hawaiian
7	Filipino	R	Guamanian
8	No Valid Data Reported. Generated by MEDS.	T	Laotian
9	No response, client declined to state	V	Vietnamese
A	Amerasian	Z	Other
C	Chinese		

SPECIAL CONSIDERATIONS: The code of 8 is generated by MEDS when an invalid code is submitted. When a record is established on MEDS for an SSI/SSP recipient, the ETHNIC data on the SDX record is translated as follows:

SDX		MEDS	
W	White	1	White
B	Black	3	Black
O	Other	8	No Valid Code reported
U	Unknown	8	No Valid Code reported

Revision Date: 04/05/2007
Appendices / Appendix B Data element Dictionary / Data Elements / DE A To L / Data Elements Beginning With “E:
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MEDS NETWORK USER MANUAL DED NO. 0120

MEDS NETWORK NAME: LANG: SPOKEN

NARRATIVE NAME: SPOKEN LANGUAGE CODE

AKA NAMES: Primary Language, Language

SOURCE: County, DHS, Federal, MEDS, Other

LENGTH: 1

DEFINITION: This data element identifies either the client's primary spoken language or the primary spoken language of the case.

VALUES:

0	American Sign Language (ASL)
1	Spanish
2	Cantonese
3	Japanese
4	Korean
5	Tagalog
6	Other Non-English
7	English
8	No valid data reported. MEDS generated
9	Not a valid value. Reserved for IHSS.
A	Other Sign Language
B	Mandarin
C	Other Chinese Language
D	Cambodian
E	Armenian
F	Ilocano
G	Mien
H	Hmong
I	Lao
J	Turkish
K	Hebrew
L	French
M	Polish
N	Russian
O	Default to 0 (Zero)
P	Portuguese
Q	Italian
R	Arabic
S	Samoan
T	Thai
U	Farsi
V	Vietnamese

Code	Text	Capitation Group
00	Invalid	Invalid
01	Refugee Cash Assistance (RCA)	Refugee
02	Refugee Medical Assistance/Entrant Medical Assistance	Refugee
03	Adoption Assistance Program-Federal	Child
04	AAP/AAC-NON FEDERAL	Child
08	Entrant Cash Assistance	Refugee
0A	RCA-Exempt from Grant Cuts	Refugee
0M	Temporary Eligibility Breast & Cervical Cancer Tx Program	BCCTP
0N	BCCTP Accelerated Eligibility	BCCTP
0P	BCCTP	BCCTP
0R	Restricted Services-BCCTP	BCCTP
0T	BCCTP-State Only	BCCTP
0U	Restricted Services-LTC-BCCTP	BCCTP
10	Aged-SSI/SSP -Cash	Aged
13	Aged-Long Term Care (LTC)	LTC
14	Aged-Medically Needy	Aged
16	Aged-Pickle Eligibility	Aged
17	Aged-Medically Needy-Share Of Cost (SOC)	Aged
18	Aged-In Home Support Services (IHSS)	Aged
1E	Eligibility for the Aged	Aged
1H	Aged-Federal Poverty Level (FPL) Program	Aged
20	Blind-SSI/SSP -Cash	Blind/Disabled
23	Blind-Long Term Care	LTC
24	Blind-Medically Needy	Blind/Disabled
26	Blind-Pickle Eligibility	Blind/Disabled
27	Blind-Medically Needy-SOC	Blind/Disabled
2E	Eligibility for the Blind	Blind/Disabled
30	Temporary Assistance to Needy Families (TANF)-FG	Family
32	TANF-CalWORKS-Family Group (FG)-State Only (cash)	Family
33	TANF-CalWORKS-UP-State Only (cash)	Family
34	TANF-Medically Needy	Family
35	TANF-Unemployed Parent	Family
36	Disabled-COBRA-Widow/ers	Blind/Disabled
37	TANF/Medically Needy -SOC	Family
38	Edwards vs. Kizer	Family
39	Initial TMC (6 months)	Family
3A	TANF-Calif Altern Assist Program-FG	Family
3C	TANF-Calif Altern Assist Prog-Unempl Parent	Family
3E	CALWORKS LEGAL IMMIGRANTS-FG-MIXED CASES	Family
3G	TANF-CALWORKS-FG-EXEMPT-STATE ONLY (32)	Family
3H	TANF-CALWORKS-UP-EXEMPT-STATE ONLY (33)	Family
3L	CALWORKS LEGAL IMMIGRANT-FG-STATE ONLY	Family
3M	CALWORKS LEGAL IMMIGRANT-UP-STATE ONLY	Family
3N	1931(b)	Family
3P	TANF-UP-Exempt (35)	Family
3R	TANF-FG Exempt (30)	Family

Code	Text	Capitation Group
3U	CALWORKS LEGAL IMMIGRANT -UP-MIXED CASES	Family
3W	TANF-Timed Out, Mixed Case	Family
40	TANF-Foster Care(FC)/NonFederal	Family
42	TANF-Foster Care(FC)/Federal	Family
45	Foster Care (FC)	Child
47	200% - Infant Citizen	% of Poverty
4A	Out-of-state Adoption Assistance Program	Child
4C	TANF-VFC/Fed Voluntary Foster Care	Child
4F	KinGap Cash Assistance	Family
4G	KinGap Cash Assistance	Family
4K	Emergency Assistance Foster Care-Probation	Child
4M	Foster Care-Continuing Medi-Cal	Family
53	Medically Indigent-LTC	LTC
54	Four Month Continuing	Family
59	Continuing TMC (6 months)	Family
5K	EA Foster Care-CWS-State Only	Child
5X	2nd Year TMC (1 year) age 19 & older	Family
60	Disabled-SSI/SSP -Cash	Disabled
63	Disabled-Long Term Care	Disabled
64	Disabled-Medically Needy	Disabled
66	Disabled-Pickle Eligibility	Disabled
67	Disabled-Medically Needy-SOC	Disabled
6A	Disabled Adl Chld Blind	Disabled
6C	Disabled Adult Child (DAC)-Disabled	Disabled
6E	Eligibility for the Disabled	Disabled
6H	Disabled-FPL Program	Disabled
6J	SB87 Pending Disability	Disabled
6N	No Longer Disabled Bene in Appeal (not 6R)	Disabled
6P	PRWORA No Longer Disabled Children	Disabled
6R	Potential grandfathered SSI disabled children	Disabled
6V	Model/DDS Regional Waivers (No SOC)	Disabled
6W	Model/DDS Regional Waiver SOC	Disabled
6X	In Home Operations (IHO) Waiver	Disabled
6Y	IHO Waiver - SOC	Disabled
72	133%-Citizen/Lawful Perm Res/PRUCOL/Cond Stat	% of Poverty
7A	100% Citizen Child	% of Poverty
7J	Continuous Eligibility Child	Child
7X	One Month HF Bridge	Family
81	Medically Indigent (MI) Adults Aid Paid Pending	Adult
82	Medically Indigent(MI) Person under 21	Child
83	Medically Indigent(MI) Person under 21 SOC	Child
86	Medically Indigent(MI) Pregnant No SOC	Adult
87	Medically Indigent(MI) Pregnant SOC	Adult
8P	133% Excess Property Child	% of Poverty
8R	100% Excess Property Child	% of Poverty
	Medicare/Medicaid	All categories with Medicare

Aid Code assignment into "capitation groups" varies by managed care contract. These groupings most clearly accommodate all plan model types.

These designations are limited to the Emergency Room Collaborative performance measure reporting.
Members eligible for Medi-Cal and Medicare (dual eligibles) are to be counted only once.
Dual eligibles are to be counted in the category "All categories with Medicare".

Appendix F: Member Survey Questions

1) Who is your primary care doctor/clinic?

☐ Name _____

Not Sure

☐ Don't have one

2) Has your doctor's office ever told you what you should do if you need medical care when the doctor's office is closed?

☐ Yes
☐ No
☐ Not Sure

If you answered yes to Question 2, please answer the next two questions:

What were you told?

☐ Call the office after hours to receive advice
☐ Call the next business day
☐ Go to the emergency room
☐ Page the doctor
☐ Call your health plan's 24 hour advice line
☐ Other:

Specify:

_____

_____

How were you told?

☐ By the doctor/office staff

If you answered yes above, how were you told?

☐ In person
☐ On the phone

☐ Through written material
☐ Through information found on doctor's website
☐ By a recording when I called the doctor's office.
☐ Other:

Specify:

_____

3) Do you know how to contact your health plan's 24-hour Health Advice Telephone Line?

- ☐ Yes
- ☐ No
- ☐ Not Sure
- ☐ My health plan does not have a 24-hour health advice telephone line
- ☐ I'm not sure if my health plan has a 24-hour health advice telephone line

If you answered yes to Question 3:

Have you called your health plan's 24-hour advice line in the past 12 months?

- ☐ Yes
- ☐ No

4) In the past 12 months, how often, if at all, have you used a hospital emergency room for yourself or for your child?

- ☐ Never
- ☐ How many times?

Did you try to contact and schedule a visit with your regular primary care doctor before going to the ER?

- ☐ Yes
- ☐ No
- ☐ Not applicable

5) Did you try to contact your plan's Health Advice Telephone Line before going to the ER?

- ☐ Yes
- ☐ No
- ☐ Didn't know there was one
- ☐ Not applicable (I did not use the ER at all)

(Note: if made contact, this info also available from Advice line data)

6) If you, or your child, went to ER, thinking of the most recent visit, which of the following was the main reason for going?

- ☐ I couldn't get an appointment with my personal doctor as soon as I needed it
- ☐ My symptoms happened after my doctor's office hours or on a weekend
- ☐ The emergency room is the usual place I go for medical care
- ☐ I was advised to go by my doctor or a nurse advice line
- ☐ I was advised to go by my family or friends
- ☐ I didn't want to miss a day of work
- ☐ I thought I would have easier access to specialists or to diagnostic testing
- ☐ I needed to refill my medications
- ☐ I had a potentially life-threatening condition, was in severe pain or was taken by an ambulance
- ☐ Other reason not listed above

Specify:

Appendix G: Member Survey Responses

Member Survey Questions	Member Response Rate	Total Number of Member Responses	Number of Health Plans With Member Responses
Member knew name of Primary Care Physician	87%	7,078	20
Member received instructions – what to do if the office was closed	59%	4,095	20
Member told to go to the ER when the office was closed	58%	2,117	14
Member aware of advice line	59%	5,447	14
Member contacted advice line last 12 months	39%	4,601	14
Member contacted advice line before going to the ER	25%	4,063	14
Member tried to schedule appointment with PCP before going to the ER	41%	3,464	16
Reason member sought care in the ER	38% 19% 10% 8%	2,564 -life threatening symptoms -symptoms began after hours -advised by doctor or nurse advice line -unable to obtain appointment soon enough	14

Appendix H: Provider Survey Questions

Provider Questions (part a and b are optional)

1. Does your office accommodate: Check all that apply

☐ Same day appointments

☐ Walk-in (unscheduled) patients

☐ After 5 pm appointments

If YES, until what time ☐ PM ☐ AM

☐ Week-end appointments

a. If YES, what days?

☐ Saturday ☐ Sunday

b. If YES, how many hours are you open on weekends?

_____ hours

Appendix I: Avoidable Visits Specifications and Codes

1. Avoidable Visits Data Specifications
2. Medi-Cal Avoidable ICD-9 Diagnosis Codes for ER Collaborative (abbreviated list)
3. Avoidable Visits ICD-9 Diagnosis Codes (expanded list)

Appendix I.1
Avoidable Visits Data Specifications

"Avoidable" ER visits are defined as visits with a primary diagnosis that match the diagnosis codes selected by the ER collaborative. This list does not include all possible avoidable visit codes. Many additional diagnosis codes could also represent avoidable visits, but were not selected by the collaborative. The rate of avoidable ER visits used in Measure II represents the percentage of all ER visits that match the selected "avoidable" diagnosis codes.

Plans were required to use the following data specifications when collecting baseline data for the "avoidable rate" visit measures:

- 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 is represented by ER visits containing any of the collaborative-designated avoidable primary diagnosis codes.
- Visits for members less than 12 months of age were excluded from the numerator.
- Plans identified the: Medi-Cal client index number (CIN), Medi-Cal Ethnicity, Medi-Cal Language, Primary Diagnosis, Date of Service, and Medi-Cal Aid Code.
- Plans to calculate and include in their data collection Age (on the date of service) and total length of plan enrollment as Member months.

The Baseline Measurement Period:

- 12 month calendar year (January 1 through December 31, 2006)

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

- **Denominator:** Total HEDIS ER members 1 year of age or greater
- **Rate:** Percent of all ER visits that are defined as avoidable

Appendix I.2

	Dx Code Range	Medi-Cal Avoidable ICD-9 Diagnosis Codes for ER Collaborative
	Code	Label
1	110.5	Dermatophytosis of the body (Herpes circinatus, Tinea imbricata)
2	112:112.3	Candidiasis
	112.5:112.9	Disseminated
4	133: 133.9	Acariasis
8	372: 372.39	Disorders of Conjunctiva
10	382:382.9	Suppurative
12	460	Acute nasopharyngitis (common cold)
13	462	Acute Pharyngitis
14	465: 465.9	Acute upper respiratory infections of multiple or unspecified sites
18	466:466.0	Acute bronchitis
19	472: 472.2	Chronic pharyngitis & nasopharyngitis
23	473:473.9	Chronic sinusitis
30	474: 474.9	Chronic disease of tonsils & adenoids
34	595: 595.9	Cystitis
42	599.0	Urinary tract infection, site not specified
43	616:616.1	Inflammatory disease of cervix, vagina, & vulva
46	628.8	Infertility, female-Of other specified origin
47	698.8	Other specified pruritic conditions (hiemalis, senillis, Winter itch)
48	698.9	Unspecified pruritic disorder (itch NOS, Puritis NOS)
49	705.1	Prickly heat
50	724.2	Lumbago
51	724.5	Backache, unspecified
52	724.7	Disorders of coccyx
53	724.8	Other symptoms referrable to back
54	784.0	Headache (excluded: 350.2; 346.0-346.9; & 307.1) atypical face pain, migraine, & tension headache
55	V67:V67.9	Follow up examination
56	V68:V68.9	Encounters for administrative purposes
57	V70:V70.9	General medical examination
58	V72:V72.9	Special investigations & examinations

Revised August 22, 2007

- REMOVE 4 DIGIT LIMIT ALLOW COLLECTION OF ENTIRE RANGE- The intent to collect all diagnosis codes (ICD-9) reported and then delete all but the first four (4) digits is misleading and if followed would unnecessarily eliminate many avoidable visits. Therefore the following changes are to be followed effective immediately: 1. Ignore the ICD-9 four (4) digit code restriction. 2. Import the ICD-9 codes to the ER Collaborative flat file of raw data as received by the plan. For example: 112=Candidiasis; 112.0=Candidiasis of mouth; 112.82=Candidal otitis externa).

Appendix I.3

Dx Code Range	Medi-Cal Avoidable ICD – 9 Diagnosis Codes for ER Collaborative
110.5	Dermatophytosis of the body (Herpes circinatus, Tinea imbricata
112	Candidiasis
112.0	Of mouth
112.1	Of vulva and vagina
112.2	Of other urogenital sites
112.3	Of skin and nails
112.5	Disseminated
112.8	Of other specified sites
112.81	Candidal endocarditis
112.82	Candidal otitis externa
112.83	Candidal meningitis
112.84	Candidal esophagitis
112.85	Candidal enteritis
112.89	Other
112.9	Of unspecified site
133	Acariasis
133.0	Scabies
133.8	Other Acariasis
133.9	Acariasis, unspecified
372	Disorders of Conjunctiva
372.00	Acute conjunctivitis unspecified
372.01	Serous conjunctivitis, except viral
372.02	Acute follicular conjunctivitis
373.03	Other mucopurulent conjunctivitis
372.04	Pseudomembranous conjunctivitis
372.05	Acute atopic conjunctivitis
372.1	Chronic conjunctivitis
372.10	Chronic conjunctivitis, unspecified
372.11	Simple chronic conjunctivitis
372.12	Chronic follicular conjunctivitis
372.13	Vernal conjunctivitis
372.14	Other chronic allergic conjunctivitis
372.15	Parasitic conjunctivitis
372.2	Blepharoconjunctivitis

Appendix I.3

372.20	Blepharoconjunctivitis, unspecified
372.21	Angular blepharoconjunctivitis
372.22	Contact blepharoconjunctivitis
372.3	Other and unspecified conjunctivitis
372.30	Conjunctivitis, unspecified
372.31	Rosacea conjunctivitis
373.33	Conjunctivitis in mucocutaneous disease
372.39	Other
382	Suppurative and unspecified otitis media
382.00	Acute suppurative otitis media without spontaneous rupture of ear drum
382.01	Acute suppurative otitis media with spontaneous rupture of ear drum
383.02	Acute suppurative otitis media in disease classified elsewhere
382.1	Chronic tubotympanic suppurative otitis media
382.2	Chronic atticoantral suppurative otitis media
382.3	Unspecified chronic suppurative otitis media
382.4	Unspecified suppurative otitis media
382.9	Unspecified otitis media
460	Acute nasopharyngitis
462	Acute pharyngitis
465	Acute upper respiratory infections with multiple or unspecified sites
465.0	Acute laryngopharyngitis
465.8	Other multiple sites
465.9	Unspecified site
466	Acute bronchitis and bronchiolitis
466.0	Acute bronchitis
472	Chronic pharyngitis and nasopharyngitis
472.0	Chronic rhinitis
472.1	Chronic pharyngitis
472.2	Chronic nasopharyngitis
473	Chronic sinusitis
473.0	Maxillary
473.1	Frontal
473.2	Ethmoidal
473.3	Sphenoidal
473.8	Other chronic sinusitis

Appendix I.3

473.9	Unspecified sinusitis (chronic)
474	Chronic disease of tonsils and adenoids
474.0	Chronic tonsillitis and adenoiditis
474.00	Chronic tonsillitis
474.01	Chronic adenoiditis
474.02	Chronic tonsillitis and adenoiditis
474.1	Hypertrophy of tonsils and adenoids
474.10	Tonsils with adenoids
474.11	Tonsils alone
474.12	Adenoids alone
474.2	Adenoid vegetations
474.8	Other chronic disease of tonsils and adenoids
474.9	Unspecified chronic disease of tonsils and adenoids
595	Cystitis
595.0	Acute cystitis
595.1	Chronic interstitial cystitis
595.2	Other chronic cystitis
595.3	Trigonitis
595.4	Cystitis in diseases classified elsewhere
595.8	Other specified types of cystitis
595.81	Cystitis cystica
595.82	Irradiation cystitis
595.89	Other
595.9	Cystitis unspecified
599.0	Urinary tract infection, site not specified
616	Inflammatory disease of cervix, vagina, vulva
616.0	Cervicitis and endocervicitis
616.1	Vaginitis and vulvovaginitis
628.8	Infertility, female of other specified origin
698.8	Other specified pruritic conditions (hiemalis, senillis, winter itch)
698.9	Unspecified pruritic disorder (itch NOS, puritis NOS)
705.1	Prickly heat
724.2	Lumbago
724.5	Backache, unspecified
724.7	Disorders of coccyx

Appendix I.3

724.8	Other symptoms referable to back
784.0	Headache (excluded 350.2; 346.0-346.9; & 307.1) atypical face pain, migraine, and tension headache
V67	Follow up examination
V67.0	Following surgery
V67.00	Following surgery, unspecified
V67.01	Follow up vaginal pap smear
V67.09	Following other surgery
V67.1	Following radiotherapy
V67.2	Following chemotherapy
V67.3	Following psychotherapy and other treatment for mental disorder
V67.4	Following treatment of healed fracture
V67.5	Following other treatment
V67.51	Following completed treatment with high risk medication, NEC
V67.59	Other
V67.6	Following combined treatment
V67.9	Unspecified follow up examination
V68	Encounters for administrative purposes
V68.0	Issue of medical certificates
V68.01	Disability examination
V68.09	Other issue of medical certificates
V68.1	Issue of repeat prescriptions
V68.2	Request for expert evidence
V68.8	Other specified administrative purposes
V68.81	Referral of patient without examination or treatment
V68.9	Unspecified administrative purposes
V70	General medical examination
V70.0	Routine general medical examination at health care facility
V70.1	General psychiatric examination, requested by authority
V70.2	General psychiatric examination, other and unspecified
V70.3	Other medical examination for administrative purposes
V70.4	Examination for medicolegal reasons
V70.5	Health examination of defined subpopulations
V70.6	Health examination in population surveys
V70.7	Examination of participant in clinical trial

Appendix I.3

V70.8	Other specified general medical examinations
V70.9	Unspecified general medical examination
V72	Special investigations and examinations
V72.0	Examination of eyes and vision
V72.1	Examination of ears and hearing
V72.11	Encounter for hearing examination following failed hearing screening
V72.12	Encounter for hearing conservation and treatment
V72.19	Other examinations of ears and hearing
V72.2	Dental examination
V72.3	Gynecological examination
V72.31	Routine gynecological examination
V72.32	Encounter for papanicolaou cervical smear to confirm findings of recent normal pap smear following initial abnormal pap smear
V72.4	Pregnancy examination or test
V72.40	Pregnancy examination or test, pregnancy unconfirmed
V72.41	Pregnancy examination or test, negative result
V72.42	Pregnancy examination or test, positive result
V72.5	Radiological examination, not elsewhere classified
V72.6	Laboratory examination
V72.7	Diagnostic skin and sensitization tests
V72.8	Other specified examinations
V72.81	Pre-operative cardiovascular examination
V72.82	Pre-operative respiratory examination
V72.83	Other specified pre-operative examination
V72.84	Pre-operative examination unspecified
V72.85	Other specific examination
V72.86	Encounter blood typing
V72.9	Unspecified examination

Appendix J: Plan-Specific Interventions

Types of Interventions	Health Plans	Comments
Case Management	Anthem Blue Cross Partnership Plan	High risk members (pain management, complex care coordination)
	CenCal Health	Frequent Users
	Central Coast Alliance for Health	Frequent Users - Asthma & Diabetes
	Health Net Community Solutions*	Frequent users
	Health Plan of San Joaquin	Targeted diagnoses
	Kaiser Permanente	Frequent users with complex medical conditions
	Santa Clara Family Health Plan	Frequent users
Health Education	Alameda Alliance for Health	
	Anthem Blue Cross Partnership Plan	Healthwise Handbook; Free digital thermometer for children 12 and younger seen in the ER with a diagnosis of Fever
	CenCal Health	Info to members seen after the 1st after-hour avoidable visit
	Central Coast Alliance for Health	Self help guide sent to members with follow up after 1 month to answer questions
	Community Health Group Partnership Plan	
	Health Plan of San Joaquin	Info when to use the ER and use of nurse advice line
	Health Net Community Solutions	Reminder postcards includes 24 hr nurse advice line and self care tips
	Inland Empire Health Plan	Instructions re: use of ER , PCP contact and nurse advice line;

Appendix J

Types of Interventions	Health Plans	Comments
		targeted mailings
	Kern Family Health Plan*	Newsletters
	Molina Healthcare of California Partner Plan	Newsletters
	L.A. CARE Health Care*	Healthy Child Handbook
	Western Health Advantage*	
Advice Lines	Anthem Blue Cross Partnership Plan	
	Care 1st Health Plan *	
	Community Health Group Partnership Plan	
	Contra Costa Health Plan	
	Health Plan of San Joaquin*	
	Health Plan of San Mateo	
	Health Net Community Solutions	
	Inland Empire Health Plan	
	Kaiser Permanente (North and South)	
	Kern Family Health Plan	
	LA Care Health Care	
	Health Plan of San Mateo	
	Molina Healthcare of California Partner Plan	
	Santa Clara Family Health Plan	
Outreach Calls to Members seen in ER	Alameda Alliance for Health *	
	Anthem Blue Cross Partnership Plan	PCP appointment scheduling, transportation options, care management prescreening, community, resources referrals
	Community Health Group Partnership Plan	3 phone calls to member by member services

Appendix J

Types of Interventions	Health Plans	Comments
Reports to Primary Care Physicians	Anthem Blue Cross Partnership Plan	Monthly report of members with 3+ visits; Monthly medical record insert of ER visits
	Central Coast Alliance for Health	Semiannual report of frequent users including date of service and diagnosis
	Community Health Group Partnership Plan	Frequent ER user info via faxes, graphs, and reports, site visits to PCP offices
	Health Net Community Solutions	Member with 3+ ER visits
	Health Plan of San Joaquin	Monthly list of users
	Inland Empire Health Plan	List of urgent care clinics
	Molina Healthcare of California Partner Plan	Work collaboratively with PCP re: treatment plans for frequent users
	Santa Clara Family Health Plan	ER report of members with 3+ ER visits
Physician Incentives	CalOptima	Contracts with urgent care centers or extended office hours
	CenCal Health	After hours care, refer patients to open practices for after hours care instead of referral to ER; FFS and bonus payments
	Central Coast Alliance for Health	Quality based incentive for lower rates of non emergent ER use
	Health Plan of San Mateo	Adjust capitation for after hours care
	Inland Empire Health Plan	Function as urgent care center for directly contracted providers

Types of Interventions	Health Plans	Comments
	LA Health Care	Adjusted capitation for e.g. provider promotion of nurse advice line and contracts with urgent care centers
	Partnership Health Plan of California	Fee for service for provision of after hours care
	Santa Clara Family Health Plan	ER usage per membership
Other	CenCal Health	Direct communication with hospitals of members seen in the ER
	Community Health Group Partnership Plan	Direct communication with hospitals of members seen in the ER; contracting with urgent care centers
	Kern Family Health Care*	Newsletters to provider; contracting with urgent care centers
	LA CARE*	Provider trainings and technical assistance
	Inland Empire Health Plan	contracting with urgent care centers

Plan specific interventions were compiled from health plan survey responses and Quality Improvement Activity (QIA) Forms. The information listed may not be all inclusive. Additional plan specific interventions may be provided in the subsequent reports. *Denotes proposed plan specific interventions at the start of the ER Collaborative.