

State Innovations to Advance Quality

California Department of Health Services Quality Initiatives

The California Department of Health Services (CDHS) is one of the largest departments in state government, with over 5,800 employees and over 60 field offices located throughout the state. CDHS administers a broad range of public and clinical health programs to protect and improve the health of all Californians.

Through a variety of roles the state has the opportunity to improve the quality of health care. These include Trainer/Facilitator, Surveillance, Disseminator of Best Practices and Regulator. Of special interest for the California Health Policy Forum discussion are:

Assessing Quality Performance—core indicator development, provision of feedback to measure quality improvement, and data monitoring to provide technical assistance in recommending quality improvement objectives. (As demonstrated in the California Perinatal Quality Care Collaborative)

Purchaser—using the state's purchasing power to improve health outcomes, including scope of work requirements (QI Studies, HEDIS, etc.) and incentives in contracting to provide high quality health care. (As demonstrated in the managed care plans' Diabetes collaborative and our Performance-Based Auto Assignment Algorithm)

**California
California Perinatal Quality Care
Collaborative (CPQCC)**

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- I. **Program Type:** Public-Private Partnership
- II. **Established:** 1997
- III. **Service Population:**
California Obstetrical and Neonatal Providers
- IV. **Program Description:**
California Perinatal Quality Care Collaborative (CPQCC) was established to develop an effective perinatal and neonatal quality improvement structure in California, joining together various public and private partners that share the goal of improving health care outcomes for mothers and babies in California. The collaborative is a cooperative effort among CDHS Children's Medical Services (CMS) and Maternal Child Adolescent Health (MCAH)/Office of Family Planning (OFP), obstetric and neonatal providers, insurers and business groups. It has helped to develop a core indicator set to measure/assess quality improvement for obstetrical and neonatal providers.

Recently MCAH/OFP developed the Maternal Quality Collaborative (MQC), a joint effort with the CPQCC and UCLA's Maternal Quality Indicators group. The MQC leadership council includes staff from MCAH/OFP, CMS, Medi-Cal managed care and Medi-Cal Policy. The collaborative will direct statewide maternal quality improvement activities utilizing the methodology developed by the CPQCC.
- V. **Staffing:**
The project has received part time support from three MCAH/OFP and one CMS Branch staff.
- VI. **Results:**
Currently over 100 hospitals with CCS approved NICUs submit data on newborns requiring critical care. Hospitals receive an annual online report with comparative analysis on perinatal and neonatal data and can compare themselves to similarly structured NICUs. It also provides the ability for DHS staff to evaluate the outcomes at individual hospitals.

In addition, the Perinatal Quality Improvement Panel (PQIP), a subcommittee of CPQCC on which both CMS and MCAH/OFP participate, recommends quality improvement objectives for hospitals. It provides models for performance improvement and assists providers in a multi-step transformation of data into improved patient care through the use of toolkits, workshops and web casts. Toolkits released to date include

State Innovations to Advance Quality

Antenatal Corticosteroid Therapy, Postnatal Corticosteroid Therapy, Nutritional Support of the Very Low Birth Weight Infant, Severe Hyperbilirubinemia Prevention, Improving Initial Lung Function: Surfactant and Other Means and Nosocomial Infection Prevention.

VII. **Leading Organization/s:**

CPQCC and DHS.

VIII. **Key Partners:**

CDHS CMS Branch and MCAH/OFP Branch; California Association of Neonatologists; American College of Obstetricians and Gynecologists; Pacific Business Group on Health, Vermont Oxford Network, and Office of Statewide Health Planning and Development.

IX. **Lessons Learned:**

Value of partnerships; success of cooperatively developing methodologies of improving delivery of health care, with individual facilities measuring their own successes.

X. **Funding:**

David and Lucile Packard Foundation and MCAH/OFP Branch.

**California
Medi-Cal
Diabetes Collaborative
Medi-Cal Managed Care Division (MMCD)**

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- I. **Program Type:** Medicaid
- II. **Established:** January 2003, ended December 2005
- III. **Service Population:**
All California Medi-Cal Managed Care Beneficiaries 18 years and older with a diagnosis of diabetes.
- IV. **Program Description:**
Medi-Cal Managed Care Division (MMCD) staff and health plans worked collaboratively to improve the quality of diabetes care provided to members of participating health plans by:
 - Understanding and applying a chronic care delivery model developed by Dr. Ed Wagner of MacColl Institute of Healthcare Innovations; and
 - Raising the rate of screenings for three HEDIS outcome measures for diabetes management: elevated blood sugars (Hemoglobin A1c), detecting vision changes (retinal eye exams) and cardiovascular risk changes (LDL--low density lipoprotein cholesterol).
- V. **Staffing:**
DHS MMCD staff comprised of:
 - Medical Consultant (1)
 - Nurse Consultant (1)
 - Data Specialist (1)
 - Health Education Specialist (1)Plan staff:
 - Medical Director (1)
 - Quality Improvement Manager (1)
 - Data Analyst (1)
 - Health Education Manager (1)
- VI. **Results:**
The three HEDIS outcome measures selected for the CDHS Diabetes Collaborative for 18-75 year old members diagnosed with diabetes showed improvement from 2004 to 2005.
 - The rate of testing with hemoglobin A1c tests (HbA1c) that physicians use to evaluate control of blood sugar, increased by 7%;
 - The rate of dilated retinal eye exams to test for diabetic retinal disease increased by 3%; and
 - The rate of screenings to evaluate control of low-density lipoproteins increased by 9%.

State Innovations to Advance Quality

VII. **Leading Organization/s:**

Participating health plans:

Alameda Alliance*, Central Coast Alliance for Health, Contra Costa Health Plan, Molina Health Care of California, Partnership Health Plan, Western Health Advantage, Sharp Health Plan• and Universal Care•.

*terminated participation after the 1st year due to conflicting priorities and funding

•health plan contract terminated

VIII. **Key Partners:**

CDHS Diabetes Prevention and Control Program

California Healthcare Foundation

California Pharmacy Foundation

Lumetra

MacColl Institute for Healthcare Innovations

IX. **Lessons Learned:**

Achievements:

The health plans:

- Learned and implemented a model to deliver chronic care;
- Identified and shared best practices among participating health plans; and
- Gained valuable insights and practical strategies for improving diabetes care from experts in the field of diabetes and quality improvement.

Challenges:

- Data interfaces between health plans and other agencies pose major barriers.
- Health plans encounter different intervention needs as determined by the diversity of providers, e.g. sole providers versus large county clinics.
- Significant changes in outcomes from a collaborative focused on chronic disease care and systems changes may take several years.
- Limited funds for multi-pronged interventions and no funds for provider incentives was a barrier to greater impact from this project.

X. **Funding:**

The California Health Care Foundation, the California Pharmacy Foundation and Web Ex Communication Systems made it feasible for health plans to receive training from experts in the field of diabetes and quality improvement. Pharmaceutical companies also supported in part three of the collaborative meetings. CDHS support of this project was solely in the form of staff resources. State and health plan staff were redirected to implement this project.

California
Medi-Cal Auto Assignment Project
Medi-Cal Managed Care Division

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- I. **Program Type:** Medicaid
- II. **Established:** An ongoing process that started in 2004 and began implementation December 1, 2005.
- III. **Service Population:**
Directly benefits Medi-Cal beneficiaries in Geographic Managed Care and Two Plan counties who do not select a health plan within the required amount of time and are to be assigned to a health plan. Indirectly benefits all Medi-Cal Managed Care beneficiaries, due to managed care health plan contractor incentive to improve quality health care delivery.
- IV. **Program Description:**
The Medi-Cal Managed Care Auto Assignment Project commenced in early 2004 as a joint effort of the California Department of Health Services (CDHS) and the California HealthCare Foundation (CHCF) to help CDHS develop a performance-based auto-assignment algorithm for Two-Plan and Geographic Managed Care counties. The Auto Assignment Project has resulted in the implementation of an innovative approach to assigning Medi-Cal eligible beneficiaries to a health plan when they fail to select a health plan or choose to have a health plan assigned to them. Default assignments under this new approach is based on health plan performance and will reward health plans with demonstrated superior performance in selected standardized performance measures, as described below.

A Stakeholder Advisory Group (consisting of representatives from health plans, CDHS, and advocacy groups) met in March, May, and September 2004, January 2005, and May 2005. The Advisory Group and CDHS reached agreement on the new algorithm's parameters that would include five measures from the Health Plan Employer Data and Information Set (HEDIS) scores and two measures based on safety net provider utilization. Also, CDHS limited a change in default rates to a maximum of 10 percent in the first year so that health plans would not be severely impacted by a loss of defaulted beneficiaries in the first year of implementation.

The new default rates became effective on December 1, 2005. CDHS will evaluate the first few months of data on the default algorithm to determine if the algorithm needs to be adjusted or the cap increased in year 2.

- V. **Staffing:**

State Innovations to Advance Quality

California Department of Health Services (Medi-Cal Managed Care Division, Payment Systems Division, Disproportionate Share Hospital Unit of the Rate Development Branch), Health Care Options (MAXIMUS).

VI. Results:

Rather than evenly distributing people who must be assigned to a health plan, this algorithm assigns a percentage of this group of people based on various performance measures. With this algorithm, the CDHS also stopped offsetting default assignments made for continuity of care. Finally, CDHS ended its prior policy to assign 100 percent of the default population to a health plan if it fell below a minimum level.

Overall, in the Two Plan Model counties, the Local Initiative plans performed better than the commercial plans (seven of ten counties). There was significant variation in the Sacramento County Geographic Managed Care plans performance, whereas the plans performed at about the same level in San Diego County. The project sought to motivate plans to improve the quality measures used in the algorithm in order to alter their allotment of default assignments.

VII. Leading Organization/s:

Stakeholder Advisory Group organizations include Santa Clara Family Health Plan, California Primary Care Association, San Francisco Health Plan, Community Health Councils, Inland Empire Health Plan, Contra Costa Health Plan, L. A. Care Health Plan, Maternal and Child Health Access, HealthNet of California, California Association of Public Hospitals and Health Systems, Western Center on Law and Poverty, Community Health Group, Blue Cross of California and Molina Healthcare.

VIII. Key Partners:

The California Health Care Foundation, Bailit Health Purchasing, LLC

IX. Lessons Learned:

CDHS made a commitment to expand its efforts to integrate value-based purchasing principles into its Medi-Cal HMO purchasing activity. This project has revealed that available measures exist to implement such an algorithm in a manner that does not unduly tax the agency's limited administrative resources.

The project also revealed that stakeholders are generally supportive of such an approach, provided that the measures are objective, the algorithm is fair, and the implementation impact on health plans is not traumatic. The contributions of stakeholders in the design process proved invaluable.

X. Funding:

The California Health Care Foundation provided most of the funding; in-kind contributions of CDHS staff and resources were absorbed by the program.