Medi-Cal Managed Care Program
Quality Improvement Projects Status Report
October 1, 2009 – December 31, 2009

Medi-Cal Managed Care Division
California Department of
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Purpose of Report

The California Department of Health Care Services (DHCS) is responsible for administering the Medi-Cal Managed Care Program and overseeing quality improvement activities. The DHCS requires its contracted, full-scope managed care plans, prepaid health plans, and specialty plans to conduct quality improvement projects (QIPs) to assess and improve the quality of a targeted area of clinical or nonclinical care or service provided to Medi-Cal managed care members.

This QIPs Status Report provides a summary of QIPs validated during the period of October 1, 2009, through December 31, 2009, and presents recommendations for improvement.

Scope of External Quality Review Activities Conducted

The DHCS contracts with Health Services Advisory Group, Inc. (HSAG) as the external quality review organization (EQRO) that validates QIP proposals and annual submissions. The Centers for Medicare & Medicaid Services (CMS) produced protocols for plans to use when conducting QIPs[1] and for EQROs to use when validating QIPs.[2] The EQRO reviews each QIP using the validating protocol to ensure plans design, conduct, and report QIPs in a methodologically sound manner, consistent with the protocol for conducting QIPs. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from the QIP.

[1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Managed Care Organization Protocol. *Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, *Final Protocol, Version 1.0, May 2002.* Available at: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/07_Tools_Tips_and_Protocols.asp

[2] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Managed Care Organization Protocol. *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 2002.* Available at: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/07_Tools_Tips_and_Protocols.asp

Summary of Overall Findings

HSAG evaluated QIPs submitted by plans using its QIP Validation Tool, which scores the QIPs against the CMS validation protocol. QIP validation assesses the plan's methodology for conducting the QIP and evaluates the overall validity and reliability of study results. The Introduction section of this report provides a detailed description of HSAG's validation process.

HSAG provided an overall validation status of *Met, Partially Met,* or *Not Met* for each QIP submission. In addition, this is the first review period in which HSAG included percentage scores of evaluation elements met and critical elements met for each validated QIP submission.

HSAG began applying its scoring methodology July 1, 2009, after the DHCS revised its QIP requirements to enforce HSAG's more rigorous enforcement of CMS' QIP requirements. For QIPs validated between July 1, 2008, through June 30, 2009, the DHCS allowed plans a transition period to comply with the new requirements. During the transition period, HSAG provided training to plans on its QIP validation process and forms.

HSAG validated 42 plan QIP submissions from October 1, 2009, through December 31, 2009. The 42 submissions represented 27 annual submissions, 12 resubmissions, and 3 proposals. Of the 42 QIPs validated, 27 received an overall *Met* validation status, 6 received an overall *Partially Met* validation status, and 9 received an overall *Not Met* validation status. The DHCS requires that plans' QIPs receive an overall *Met* validation status; therefore, plans must resubmit their QIPs until they achieve a *Met* validation status. As of December 31, 2009, 5 projects remained with a *Partially Met* or *Not Met* status, and the results of their resubmissions will be included in the next QIPs status report.

Plans achieved an average score of 82 percent for evaluation elements *Met* and an average score of 89 percent for critical elements *Met*. HSAG identifies critical elements as essential for producing a valid and reliable QIP. These validation scores will be helpful in comparing plan performance over time.

Conclusions

HSAG noted continued improvement in plan compliance with CMS' protocol for conducting QIPs. The number of plans achieving a *Met* validation status on the initial annual QIP submission increased over the prior review period, July 1, 2009, through September 30, 2009,

showing that plans are gaining proficiency with QIP documentation and HSAG's validation requirements.

In addition, the high scores for the percentage of evaluation elements *Met* and the percentage of critical elements *Met* further demonstrated that plans' designed and implemented their QIPs appropriately.

Care 1st, which participated in the small-group collaborative (SGC) QIP, *Appropriate Treatment for Children With Upper Respiratory Infection (URI),* demonstrated statistically significant improvement in the percentage of its identified high-volume primary care providers (PCPs) meeting minimum performance standards for not prescribing an antibiotic for a URI. As noted in the prior review period, all plans that have participated in this SGC have demonstrated good outcomes, which suggests this model and/or project as a best practice.

Despite the many challenges and barriers to decreasing avoidable emergency room (ER) visits, the statewide collaborative QIP results for seven plans demonstrated a reduction in avoidable ER rates, with five of the plans demonstrating statistically significant decreases.

In addition, three of the four internal QIPs that HSAG assessed for sustained improvement achieved sustained improvement for all or some of their study indicators. These projects improved childhood immunization rates, asthma management, and cervical cancer screening. The plan that did not have overall sustained improvement—because it was not able to achieve improvement for both study indicators—did demonstrate improvement over the baseline period for retinal eye exams among members with diabetes. This plan also had some significant increases in rates at the county level; however, HSAG did not validate this QIP at the county level due to some identified challenges with performing multi-county QIP validation. HSAG found that plans lacked sufficient documentation across CMS activities for county-level validation, and HSAG's QIP submission form did not support a single QIP submission with multi-county data.

QIPs validated during this review period showed that plans have an opportunity to improve documentation of data analysis and interpretation. Many plans struggle to conduct statistical testing between each remeasurement period. For the statewide collaborative QIP, not all plans used the reported *Ambulatory Care—Emergency Department Visits* rate to derive their avoidable rate, making comparisons among plan results difficult.

While plans continue to improve documentation and scores for sound study design and implementation, it becomes more difficult for plans to achieve higher scores with documentation alone for Activity IX and Activity X related to study outcomes—the goal of a QIP. With plans demonstrating greater proficiency with basic validation requirements related to study design and implementation, the DHCS, the plans, and HSAG have an opportunity to

focus on strategies to achieve more successful QIP outcomes, such as using evidence-based interventions, when available, as well as best and promising practices.

Recommendations

Based on the validation activities and findings, HSAG recommends the following:

- When participating as part of a statewide collaborative or small-group collaborative, plans should ensure that they are reporting QIP results in a consistent and standardized way for the comparability of results.
- The DHCS and plans may consider applying some of the strategies used by the URI small-group collaborative to other QIPs.
- The DHCS, plans, and EQRO should explore evidence-based strategies and interventions, as well as best and promising practices, when designing QIPs and considering interventions to help increase the likelihood of improving outcomes for Medi-Cal managed care members.
- The DHCS should continue with implementation of the requirement for plans to submit and the EQRO to validate QIPs at the county level.

Organization of Report

This report has six sections:

- **Executive Summary**—Outlines the scope of external quality review activities, provides the status of plan submissions and overall validation findings for the review period, and presents recommendations.
- **Introduction**—Provides an overview of QIP requirements and HSAG's QIP validation process.
- **Quarterly QIP Activity**—Provides a table of all QIPs that HSAG validated during the review period, including evaluation element scores and the overall validation status by type of QIP.
- **Summary of QIP Validation Findings**—Summarizes validation findings across plans related to QIP study design, study implementation, quality outcomes achieved, strengths and opportunities for improvement, and recommendations by type of QIP.
- **Appendix A**—Includes a listing of all active QIPs and their status.
- **Appendix B**—Provides detailed scoring tables for each evaluation element within the 10 QIP activities for the statewide collaborative (SWC) QIPs, small-group collaborative (SGC) QIPs, and internal QIPs (IQIPs).

QIP Requirements

QIPs are a federal requirement. The Code of Federal Regulations (CFR) at 42 CFR 438.240[3] requires that all states operating a Medicaid managed care program ensure that their contracted plans conduct QIPs.

QIPs are a contract requirement for Medi-Cal managed care plans. The DHCS requires each of its contracted Medi-Cal managed care plans to conduct two DHCS-approved QIPs in accordance with federal requirements. Plans must always maintain two active QIPs. For full-scope plans, the statewide Medi-Cal managed care collaborative project serves as one of the two required QIPs. The second QIP can be either an IQIP or an SGC QIP involving at least three Medi-Cal managed care plans.

[3] Federal Register/Vol. 67, No. 115, June 14, 2002, 2002/Rules and Regulations, p. 41109.

Description of the QIP Validation Process

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

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

Federal regulations also require that plans conduct and that an EQRO validate QIPs in a manner consistent with the CMS protocols for conducting and validating QIPs.[4]

The CMS protocol for validating QIPs focuses on two major areas:

- Assessing the plan's methodology for conducting the QIP.
- Evaluating the overall validity and reliability of study results.

QIP validation ensures that:

- Plans design, implement, and report QIPs in a methodologically sound manner.
- Real improvement in quality of care and services is achievable.
- Documentation complies with the CMS protocol for conducting QIPs.
- Stakeholders can have confidence in the reported improvements.

Evaluating the Overall Validity and Reliability of Study Results

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

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

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

QIP Validation Activities

HSAG reviewed 42 QIPs for the period from October 1, 2009, through December 31, 2009. Of these, 27 QIPs were annual submissions, 12 were resubmissions, and 3 were new project proposals. A resubmission means a plan updated a previously submitted QIP with additional documentation because it received an overall validation status of *Not Met* or *Partially Met* on its annual submission. The DHCS requires plans to resubmit its QIP until it achieves an overall *Met* status. Plans submit new project proposals when they have closed out a QIP to maintain two active projects, a DHCS requirement.

Table 3.1 summarizes QIPs validated during the review period with an overall validation status of *Met*, *Partially Met,* or *Not Met*. In addition, Table 3.1 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. Critical elements are those within the validation tool that HSAG has identified as essential for producing a valid and reliable QIP. All critical elements must be *Met* for a QIP to receive an overall validation status of *Met*.

All 21 full-scope Medi-Cal managed care plans submitted their annual ER collaborative QIPs—*Reducing Avoidable Emergency Room Visits*—for validation during this review period. This report provides validation results and findings while the DHCS expects to release a separate remeasurement report of the statewide collaborative QIP that will provide detailed analysis of the remeasurement results. The DHCS has targeted release of the remeasurement report in summer 2010.

From October 1, 2009, through December 31, 2009, HSAG provided technical assistance to plans requesting additional QIP training and guidance. Six plans received training in various areas of statistical significance testing, benchmark documentation, study indicator clarification, QIP proposals, data analysis, understanding prior QIP validation feedback, intervention standardization and modification, and general QIP documentation. In addition, HSAG provided ongoing technical assistance to Family Mosaic Project, a specialty plan, in developing two QIP proposals, the first of which is due to the DHCS in May 2010 to comply with contractual requirements.

In October 2009, the DHCS reviewed and supported HSAG's proposed approach for validating QIPs at the county level beginning with new plan QIP proposals. During the review period, the DHCS began incorporating these changes into an All Plan Letter that addresses quality and performance improvement program requirements for 2010. The DHCS

released its All Plan Letter 10-001 in March 2010, available on the DHCS Web site at http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

The impact of new QIP requirements will require greater documentation from plans at the county level for HSAG to validate projects. HSAG began revising its QIP Summary Form Completion Instructions and will provide training at the June 2010 DHCS quality improvement call with plans.

Table 3.1—Medi-Cal Managed Care Program Quarterly QIP Activity
October 1, 2009, through December 31, 2009

Plan Name	Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Overall Validation Status[4]
Statewide Collaborative QIPs					
Alameda Alliance for Health	*Reducing Avoidable Emergency Room Visits*	Annual Submission	84%	100%	*Met*
Anthem Blue Cross	*Reducing Avoidable Emergency Room Visits*	Annual Submission	73%	60%	*Partially Met*
Anthem Blue Cross	*Reducing Avoidable Emergency Room Visits*	Annual Resubmission 1	100%	100%	*Met*
CalOptima	*Reducing Avoidable Emergency Room Visits*	Annual Submission	76%	90%	*Partially Met*
CalOptima	*Reducing Avoidable Emergency Room Visits*	Annual Resubmission 1	92%	100%	*Met*
Care 1st	*Reducing Avoidable Emergency Room Visits*	Annual Submission	57%	30%	*Not Met*
Care 1st	*Reducing Avoidable Emergency Room Visits*	Annual Resubmission 1	89%	100%	*Met*
CenCal Health	*Reducing Avoidable Emergency Room Visits*	Annual Submission	92%	100%	*Met*
Central California Alliance for Health	*Reducing Avoidable Emergency Room Visits*	Annual Submission	62%	50%	*Partially Met*
Central California Alliance for Health	*Reducing Avoidable Emergency Room Visits*	Annual Resubmission 1	84%	60%	*Partially Met*
Community Health Group	*Reducing Avoidable Emergency Room Visits*	Annual Submission	65%	90%	*Partially Met*
Contra Costa Health Plan	*Reducing Avoidable Emergency Room Visits*	Annual Submission	68%	80%	*Not Met*
Contra Costa Health Plan	*Reducing Avoidable Emergency Room Visits*	Annual Resubmission 1	86%	100%	*Met*
Health Net	*Reducing Avoidable Emergency Room Visits*	Annual Submission	86%	100%	*Met*
Health Plan of San Joaquin	*Reducing Avoidable Emergency Room Visits*	Annual Submission	97%	100%	*Met*
Health Plan of San Mateo	*Reducing Avoidable Emergency Room Visits*	Annual Submission	84%	100%	*Met*
Inland Empire Health Plan	*Reducing Avoidable Emergency Room Visits*	Annual Submission	89%	100%	*Met*
Kaiser Permanente—North	*Reducing Avoidable Emergency Room Visits*	Annual Submission	95%	100%	*Met*
Kaiser Permanente—South	*Reducing Avoidable Emergency Room Visits*	Annual Submission	89%	100%	*Met*
Kern Family Health Care	*Reducing Avoidable Emergency Room Visits*	Annual Submission	57%	50%	*Not Met*
Kern Family Health Care	*Reducing Avoidable Emergency Room Visits*	Annual Resubmission 1	86%	100%	*Met*
LA Care Health Plan	*Reducing Avoidable Emergency Room Visits*	Annual Submission	84%	100%	*Met*

Table 3.1—Medi-Cal Managed Care Program Quarterly QIP Activity
October 1, 2009, through December 31, 2009

Plan Name	Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Overall Validation Status[4]
Molina Healthcare	*Reducing Avoidable Emergency Room Visits*	Annual Submission	86%	100%	*Met*
Partnership Health Plan	*Reducing Avoidable Emergency Room Visits*	Annual Submission	68%	60%	*Partially Met*
Partnership Health Plan	*Reducing Avoidable Emergency Room Visits*	Annual Resubmission 1	89%	100%	*Met*
Santa Clara Family Health Plan	*Reducing Avoidable Emergency Room Visits*	Annual Submission	89%	100%	*Met*
San Francisco Health Plan	*Reducing Avoidable Emergency Room Visits*	Annual Submission	26%	10%	*Not Met*
Western Health Advantage	*Reducing Avoidable Emergency Room Visits*	Annual Submission	92%	100%	*Met*
Small-Group Collaborative QIPs					
Care 1st	*Appropriate Treatment for Children With Upper Respiratory Infection*	Annual Submission	84%	90%	*Not Met*
Care 1st	*Appropriate Treatment for Children With Upper Respiratory Infection*	Annual Resubmission 1	97%	100%	*Met*
Internal QIPs					
Alameda Alliance for Health	*Decrease Return Emergency Room Visits for Asthmatic Exacerbations in Children*	Annual Submission	89%	100%	*Met*
Anthem Blue Cross	*Improving Diabetes Management*	Annual Submission	Not Applicable*	Not Applicable*	*Met*/Closed
CenCal Health—San Luis Obispo	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children & Adolescents*	Proposal	85%	100%	*Met*
CenCal Health—Santa Barbara	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children & Adolescents*	Proposal	75%	85%	*Not Met*
Central California Alliance for Health	*Improving Effective Case Management*	Annual Submission	41%	30%	*Not Met*
Health Plan of San Mateo	*Cervical Cancer Screening*	Annual Submission	90%	100%	*Met*
Kaiser Permanente—North	*Childhood Obesity*	Proposal	86%	100%	*Met*
Kern Family Health Care	*Use of Immunization Registry for Children*	Annual Resubmission 3	68%	80%	*Not Met*
Kern Family Health Care	*Use of Immunization Registry for Children*	Annual Resubmission 4	100%	100%	*Met*
Partnership Health Plan	*Asthma Spread*	Annual Resubmission 2	84%	100%	*Met*

Table 3.1—Medi-Cal Managed Care Program Quarterly QIP Activity
October 1, 2009, through December 31, 2009

Plan Name	Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements Met[2]	Percentage Score of Critical Elements Met[3]	Overall Validation Status[4]
SCAN Health Plan	*Chronic Obstructive Pulmonary Disease Management*	Annual Submission	68%	90%	*Not Met*
SCAN Health Plan	*Chronic Obstructive Pulmonary Disease Management*	Annual Resubmission 1	81%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a new proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

*Not Applicable—Percentage scores were not applied for a small number of QIPs still in the process of final QIP submission/closeout, for which new scoring methodology had not yet been implemented.

The CMS protocol for conducting a QIP specifies ten core activities. Rather than assessing them separately, HSAG categorizes them into three main stages to examine strengths and opportunities for improvement across key areas. For each of the three types of QIPs—SWCs, SGCs, and IQIPs—HSAG presents validation findings according to these three main stages:

Study Design—CMS Protocol Activities I–IV

- Selecting an appropriate study topic(s).
- Presenting a clearly defined, answerable study question(s).
- Documenting a clearly defined study indicator(s).
- Stating a correctly identified study population.

Study Implementation—CMS Protocol Activities V–VII

- Presenting a valid sampling technique (if sampling was used).
- Specifying accurate/complete data collection procedures.
- Designing/documenting appropriate improvement strategies.

Quality Outcomes Achieved—CMS Protocol Activities VIII–X

- Presenting sufficient data analysis and interpretation.
- Reporting evidence of real improvement achieved.
- Documenting data for sustained improvement achieved.

This section provides specific findings for each of the three QIP types and discusses strengths, opportunities for improvement, and recommendations. At the end of the section, HSAG also provides conclusions across all QIPs.

Findings Specific to the DHCS Statewide Collaborative

HSAG received 28 statewide collaborative QIP submissions for validation, which represented 21 plans. Of the 28 submissions, 21 were annual submissions and 8 were resubmissions.

Table 4.1 provides average rates for each activity within the CMS protocols. Appendix B includes a table of scores for each evaluation element within the activities.

Table 4.1––Statewide Collaborative QIP Activity Average Rates* (N = 28 Submissions)
October 1, 2009, through December 31, 2009

QIP Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Study Design	**I: Appropriate Study Topic**	86%	9%	5%
	II: Clearly Defined, Answerable Study Question(s)	93%	7%	0%
	III: Clearly Defined Study Indicator(s)	88%	11%	1%
	IV: Correctly Identified Study Population	77%	20%	3%
Study Implementation	**V: Valid Sampling Techniques (if sampling is used)**	Δ	Δ	Δ
	VI: Accurate/Complete Data Collection	87%	10%	3%
	VII: Appropriate Improvement Strategies	80%	11%	9%
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	81%	13%	6%
	IX: Real Improvement Achieved	45%	0%	55%
	X: Sustained Improvement Achieved	Δ	Δ	Δ

* The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity. See Table B.1 in Appendix B for the number and description of evaluation elements.

Δ No QIPs were assessed for this activity/evaluation element.

Study Design

Statewide collaborative QIP validation findings for Activities I through IV include the following:

Activity I. Appropriate Study Topic

Activity Summary: Overall, plans met the criteria for the evaluation elements in Activity I, Appropriate Study Topic, but showed a decrease in meeting the criteria for elements compared to the prior year's submissions

Despite most submissions meeting the evaluation elements, Activity I was the only activity for which plans showed a decrease in the average percentage of *Met* elements compared to statewide collaborative QIP submissions from 2008. The average rate for *Met* elements decreased from 95 percent in 2008 to 86 percent in 2009. This decrease may be due to plans not addressing *Points of Clarification* from the prior validation period feedback from 2008, during the review period of July 1, 2008, through December 31, 2008.

HSAG uses *Points of Clarification* to indicate that the evaluation element has the basic components; however, enhanced documentation would demonstrate a stronger understanding of the CMS protocol for conducting QIPs. Plans that did not provide the additional documentation to fully satisfy the evaluation element in this year's annual submission were scored accordingly.

Plan submissions that did not meet the criteria for all evaluation elements lacked documentation of all eligible populations, including evidence that members with special health care needs were not excluded. Furthermore, those submissions did not indicate that the project topic was selected by the DHCS.

Activity II. Clearly Defined, Answerable Study Question(s)

Activity Summary: Plans demonstrated strong improvement in defining answerable study questions compared to the validation results in 2008, when no plan achieved compliance with this activity.

Plan submissions achieved 93 percent on this QIP activity by providing an answerable study question in an appropriate study format.

The DHCS supplied plans with a statewide collaborative QIP study question to use in an approved CMS format. Only two plans did not include a study question in the appropriate format in the initial submission, and all plans met the criteria in subsequent resubmissions.

Activity III. Clearly Defined Study Indicator(s)

Activity Summary: Plans did well with basing their QIPs on current, evidenced-based practice guidelines, using available data to report study indicators, using nationally recognized HEDIS measures, and providing the basis for internally developed indicators.

For this activity, plans increased their average percentage of *Met* elements from 60 percent in 2008 to 88 percent in 2009.

Plans used the HEDIS *Ambulatory Care—Emergency Department Visits* measure as the first QIP indicator, which provided the basis for the collaborative-developed second QIP indicator, *Avoidable ER Visits*. Two key factors contributed to the improvement. First, most plan submissions included codes necessary to define the study indicators, which were lacking in the 2008 submissions. Second, by plans including an appropriate study question in Activity II, HSAG was able to determine that the study indicators aligned to answer the study question.

Activity IV. Correctly Identified Study Population

Activity Summary: Plan submissions showed increased compliance with this activity, with most plans meeting the criteria for the evaluation elements.

Plans' collaborative QIP submissions demonstrated an increase in *Met* evaluation elements from 32 percent in 2008 to 77 percent in 2009. Plans still have an opportunity to accurately and completely define the study population. Some plans did not document or did not document correctly the age ranges for the second QIP indicator, which excludes members younger than 1 year of age.

The greatest improvement achieved by plans between submission periods was capturing all members to whom the study question applied. With the increase in plans submitting an appropriate study question in Activity II, HSAG could assess whether the QIP captured members appropriately.

Study Implementation

Findings for statewide collaborative QIP Activities V through VII included the following:

Activity V. Valid Sampling Techniques

Activity Summary: HSAG did not assess QIPs for this activity because plans did not use sampling techniques. The activity, therefore, was not applicable.

Activity VI. Accurate/Complete Data Collection

Activity Summary: Plans demonstrated proficiency with the applicable evaluation elements within this activity. Plans appropriately identified the sources of data and provided an estimated degree of data completeness.

HSAG evaluates QIP submissions to determine if plans reported accurate and complete data when reporting their rates. The statewide collaborative used an administrative data process to gather claims and encounter data to report ER visits; therefore, many elements related to a manual data collection process did not apply. Plans met the criteria for 87 percent of the applicable evaluation elements for this activity. This compares to only 36 percent of applicable evaluation elements receiving a *Met* score in 2008.

This activity requires that plans document the source of data for reporting both collaborative QIP study indicators: avoidable ER visits and HEDIS *Ambulatory Care—Emergency Department Visits*. Plans must also document the data elements to be collected, such as Current Procedural Terminology (CPT) codes and place of service codes, to distinguish ER visits from outpatient or inpatient visits, as well as the timeline for collecting the data, activities conducted to produce the indicators, and the estimated degree of data completeness.

For this data submission, plans reported baseline and remeasurement data reflecting the 2007 and 2008 calendar years respectively. All plans underwent a National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ for both measurement years; therefore, plans increased their compliance with this activity by including final audit reports in which HSAG audited the HEDIS *Ambulatory Care—Emergency Department Visits* measure as part of DHCS' external accountability set. The final audit report provides enough documentation to satisfy many elements within this activity since the external quality review organization's audit team validates the process and data used to report rates. To fully meet the criteria for this element, plans needed to also include how they derived their avoidable ER visits rate from the audited rate, which most plans did.

Plans that did not meet the criteria for all of the activity's evaluation elements could increase compliance by documenting all data elements to be collected, providing a timeline for collecting data for each measurement period, and including either a data collection flowchart or algorithm that shows the steps in producing the study indicator rates. In addition, plans need to provide an estimate of data completeness at the time the data were used to demonstrate that at least 80 percent of claims and encounter data for ER visits for the reporting periods were used to produce the rate.

Activity VII. Appropriate Improvement Strategies

Activity Summary: Plans demonstrated moderate improvement on two of the evaluation elements while still showing opportunities to demonstrate improvement on the other two evaluation elements.

Plans improved their QIP submission scores this year by including documentation that linked their interventions to reduce avoidable ER visits to the statewide and plan-specific identified barriers. Many plans lacked this documentation in the 2008 QIP submissions. Also, plans may have been more successful this year since the collaborative revised its QIP timeline to better align the remeasurement periods after statewide interventions and plan-specific interventions were under way. All QIPs included intervention strategies that were likely to induce permanent change.

Once a QIP progresses to a remeasurement period, plans need to evaluate whether they had improvement over the previous measurement period. For this reporting period, QIP submissions needed to include documentation that the plan standardized and monitored the existing intervention(s) if they showed a decrease in avoidable ER visits, or plans needed to document revised interventions if they were not successful.

Eight QIP submissions showed a decrease in the avoidable ER visits rate, and half of the submissions documented standardization and monitoring of the existing interventions. Of the 20 QIP submissions that showed no change or an increase in the avoidable ER visits rate, 60 percent included documentation of revised interventions. This area remains an opportunity for improvement.

Quality Outcomes Achieved

Statewide collaborative QIP validation findings for Activities VIII through X included the following:

Activity VIII. Sufficient Data Analysis and Interpretation

Activity Summary: Plans demonstrated strong improvement of data analysis and interpretation; however, plans have opportunities to improve their interpretation of findings and statistical testing.

For this activity, plans increased their average rate of *Met* evaluation elements from 42 percent in 2008, during the review period of July 1, 2008, through December 31, 2008, to 81 percent in 2009, during the review period of October 1, 2009, through December 31, 2009. For the 2008 QIP submissions, plans did not include a data analysis plan, which resulted in no plan fully meeting the criteria for the evaluation element. During this review period, 86 percent of QIP submissions included a data analysis plan. In addition, all QIP submissions identified the initial measurement and remeasurement periods appropriately.

The data analysis plan should include information on calculating the study indicators, the statistical test used to measure improvement, and a comparison of results to goals and benchmarks.

Most plans included documentation that there were no factors that threatened the internal or external validity of results. For plans that identified factors, these included missing administrative data and/or inaccurate claims and encounter coding, media attention regarding the influenza A H1N1 virus, problems with HEDIS software vendors and mapping data correctly, and acquiring significant new plan membership. Plans that identified such factors needed to discuss the impact and resolution of those factors.

Plans still have an opportunity to include an interpretation of the QIP findings. All QIPs, whether demonstrating an increase or decrease in avoidable ER visits, should include an interpretation of the results.

QIP submissions that included statistical testing increased from 8 percent in 2008 to 68 percent in 2009; nonetheless, the improved result indicated an opportunity for improvement. For this QIP submission, plans needed to include statistical testing between the baseline and first remeasurement period, calendar year 2007, and calendar year 2008.

Activity IX. Real Improvement Achieved

Activity Summary: Eight QIPs showed a decrease in the avoidable ER visits rate with six of the eight QIPs showing statistically significant improvement.

All statewide collaborative QIP submissions progressed to the first remeasurement period in which plans must assess whether there is statistical evidence to support that the reduction in the ER visits rate is true improvement.

Plans can only achieve full compliance with this activity by demonstrating statistically significant improvement. In the case of avoidable ER visits, a statistically significant decrease in the rate demonstrates improvement. Overall, 21 percent of QIP submissions demonstrated improvement by documenting a statistically significant decrease in the avoidable ER visits rates between calendar year 2007 and calendar year 2008.

Activity X. Sustained Improvement Achieved

Activity Summary: The statewide collaborative QIP has not progressed to a second remeasurement period; therefore, HSAG cannot assess for sustained improvement.

Plans will submit data in October 2010 for calendar year 2009, at which time HSAG will assess for sustained improvement as part of its validation review.

Statewide Collaborative QIP Strengths and Opportunities for Improvement

Of the 21 plans that submitted statewide collaborative QIP submissions, 13 achieved an overall *Met* validation status for the initial submission while 8 required resubmission. At the end of the review period only 3 plans had a *Partially Met* or *Not Met* validation status. This represented an improvement over the prior-year QIP submissions in which no plan was fully compliant with CMS' protocol for conducting a QIP.

Comparing validation scores from this review period of October 1, 2009, through December 31, 2009, to validation scores from the previous year during the review period of July 1, 2008, through December 31, 2008, plans' QIP submissions demonstrated an increase in average rates of meeting evaluation elements for all activities except Activity I.

As part of the QIP validation review, HSAG implemented a process to validate plan-reported HEDIS rates against the audited rate reported to NCQA. HSAG found a large number of discrepancies between the audited HEDIS *Ambulatory Care—Emergency Department Visits* rate and the plan-reported QIP rate. HSAG contacted each plan to resolve the discrepancy. In many cases, plans made an error in the QIP and updated the appropriate rate. In other cases, plans pulled the ER collaborative QIP data after the HEDIS reporting period to derive more accurate rates due to a claims lag. In many of these cases, plans were unable to revert to the previous HEDIS rate to derive their avoidable ER visit rate.

The statewide collaborative continued to show activity and momentum through the review period between October 1, 2009, and December 31, 2009. The collaborative finalized a survey that plans will administer to providers on its member health education campaign, "*Not Sure It's an Emergency*?" that was implemented in June 2009. The collaborative developed the survey to collect outcome information about the statewide intervention, including provider participation and satisfaction. In addition, the survey evaluates whether the campaign increased communication between providers and members as a strategy to decrease avoidable ER visits. The collaborative will begin work on a member survey in January 2010.

Statewide Collaborative QIP Recommendations

Since the statewide collaborative QIP uses a HEDIS measure as its first indicator and the basis on which it derives its second indicator, the avoidable ER visits rate, plans should ensure that they are reporting and using their HEDIS rate to increase standardization and comparability of results.

Plans should strive to increase the rate of compliance with CMS' protocols for conducting QIPs in their first submission, thereby decreasing the rate of resubmissions.

Findings Specific to Small-Group Collaboratives

Care 1st was the only plan to submit a small-group collaborative (SGC) QIP for validation during the review period of October 1, 2009, through December 31, 2009. All other plans participating in the *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* QIP submitted their project in the prior review period, July 1, 2009, through September 30, 2009. Care 1st submitted its annual QIP submission along with a subsequent resubmission.

Table 4.2 provides average rates for each activity within the CMS protocols for both the annual QIP submission and the resubmission from Care 1st. Appendix B includes a table of scores for each evaluation element within the activities.

Table 4.2––Small-Group Collaborative QIP Activity Average Rates* (N = 2 Submissions)
October 1, 2009, through December 31, 2009

QIP Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Study Design	**I: Appropriate Study Topic**	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Study Implementation	**V: Valid Sampling Techniques**	Δ	Δ	Δ
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	69%	12%	19%
	IX: Real Improvement Achieved	75%	12.5%	12.5%
	X: Sustained Improvement Achieved	Δ	Δ	Δ

***** The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity. See Table B.1 in Appendix B for the number and description of evaluation elements.

Δ No QIPs used sampling techniques; therefore, evaluation elements were not assessed.

Study Design

Both QIP submissions met 100 percent of the criteria for the applicable evaluation elements for Activities I through IV, demonstrating a good understanding of the CMS protocols for a sound study design.

Study Implementation

Both QIP submissions met 100 percent of the criteria for the applicable evaluation elements for Activities VI and VII. Care 1st did not use sampling for this QIP; therefore, Activity V was not applicable. The QIP submissions demonstrated accurate and complete data collection and appropriate interventions strategies.

Quality Outcomes Achieved

Care 1st's initial QIP submission did not include all components of a data analysis plan, a critical element. Therefore, despite excellent validation scores for Activity I through VII, HSAG required the plan to resubmit the QIP to address the noncompliant critical element, which the plan did in its resubmission.

In addition, the QIP lacked documentation that discussed factors that threatened the internal or external validation of findings and a complete interpretation of the findings. In the initial submission, the QIP lacked the *p* values of the statistical test and the test used for HSAG to validate the results. Upon resubmission, Care 1st adequately addressed these areas.

The QIP demonstrated statistically significant improvement in the percentage of its identified high-volume primary care providers (PCPs) meeting minimum performance standards for not prescribing an antibiotic for a URI. The QIP also showed improvement with its second study indicator, a HEDIS measure, *Appropriate Treatment for Children With Upper Respiratory Infection*, although statistical testing could not be used since the remeasurement period included a different geographic population.

The QIP had not yet progressed to the point of assessment for sustained improvement for both indicators during the review period. The plan will submit the QIP again in 2010, at which time HSAG will assess for sustained improvement.

Small-Group Collaborative Strengths and Opportunities for Improvement

Care 1st's improvement for both indicators aimed at decreasing inappropriate antibiotic use for URI was consistent with results that other SGC plans reported in the prior review period, July 1, 2009–September 30, 2009.

The four other plans participating in the URI SGC all demonstrated statistically significant improvement in performance on the HEDIS URI measure, and two of the four plans demonstrated statistically significant improvement with high-volume PCPs. All four plans achieved sustained improvement.

With Care 1st's next submission, the plan will need to include an interpretation of findings for the second and final remeasurement period that meets CMS' protocol for conducting QIPs, similar to the analysis provided with this review period's resubmission.

Small-Group Collaborative Recommendations

Based on SGC success with decreasing inappropriate antibiotic use for URIs, HSAG previously recommended in the *QIPs Status Report: July 1, 2009–September 30, 2009*, that plans participating in the SGC URI QIP consider sharing their QIP results and intervention strategies with other plans and state Medicaid agencies. *Note:* the June 2010 Quality Improvement Workgroup conference call included a presentation on this QIP.

Health Net, a key SGC plan collaborator, submitted its QIP results to the Agency for Healthcare Research and Quality's (AHRQ's) Health Care Innovations Exchange for review. AHRQ approved the submission, "Medicaid Managed Care Plan Provides Performance Reports and Patient Education to Reduce Inappropriate Prescribing of Antibiotics to Children and Adolescents," for publication, expected to release in summer 2010.

The DHCS and plans may consider applying some of the strategies used by the URI small-group collaborative to other QIPs.

Findings Specific to Internal Quality Improvement Projects

Plans submitted 12 internal QIPs (IQIPs) for validation from October 1, 2009, through December 31, 2009. Five were annual submissions, three were proposals, and four were resubmissions. Table 4.3 provides average rates for each activity within the CMS protocols. Appendix B includes a table of scores for each evaluation element within the activities.

Table 4.3––Internal QIP Activity Average Rates* (N = 12 Submissions)
October 1, 2009, through December 31, 2009

QIP Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Study Design	**I: Appropriate Study Topic**	92%	3%	5%
	II: Clearly Defined, Answerable Study Question(s)	92%	8%	0%
	III: Clearly Defined Study Indicator(s)	96%	4%	0%
	IV: Correctly Identified Study Population	91%	6%	3%
Study Implementation	**V: Valid Sampling Techniques**	100%	0%	0%
	VI: Accurate/Complete Data Collection	86%	4%	10%
	VII: Appropriate Improvement Strategies	90%	0%	10%
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	68%	20%	12%
	IX: Real Improvement Achieved	42%	14%	44%
	X: Sustained Improvement Achieved	60%	20%	20%

***** The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity. See Table B.4 in Appendix B for the number and a description of evaluation elements.

Study Design

IQIP validation findings for Activities I through IV included the following:

> **Activity Summary:** Overall, plans met the criteria for the evaluation elements in Activities I through IV.

All IQIP submissions included a study topic, based on either a high-risk or high-volume condition, that addressed a broad spectrum of care. The submissions included data to support the relevance of the selected project to the plans' Medi-Cal managed care members.

While most plans included all eligible populations that met the study criteria, 4 of the 12 submissions lacked this documentation. Plans must include a discussion of the eligible study population even if they are using HEDIS methodology and specifications. In addition, two of

these four plans also lacked documentation that indicated whether members with special health care needs were included or excluded.

All but one plan provided an answerable study question.

One plan struggled to clearly define its study indicators because it did not include codes. HSAG recommended further technical assistance and discussion with this plan to strengthen the IQIP study design because of limitations within the existing structure of the indicators. The indicators included members in the denominator who could never end up in the numerator, which could impact the rate.

Study Implementation

Findings for IQIP Activities V through VII included the following:

> **Activity Summary:** Overall, plans met the criteria for the evaluation elements for Activities V through VII.

Half of the IQIP submissions that used sampling techniques met evaluation elements at a rate of 100 percent. Further, plans were successful with conducting causal/barrier analysis using quality improvement processes and linking interventions to the identified barriers.

The plans' greatest opportunity for improvement within the study implementation phase was in Activity VI, accurate and complete data collection. Plans that use a manual data collection process, such as chart abstraction, need to document detailed information about their process to fully meet the evaluation elements within this activity. IQIP documentation needs to include criteria related to a plan's selection of staff and/or personnel to conduct data collection to demonstrate the use of qualified staff. Plans should include a process for interrater reliability as a mechanism to ensure data accuracy among manual reviewers. IQIP submissions also lacked written instructions for completing the manual data collection tool and an overview of the study.

Quality Outcomes Achieved

Validation findings for Activities VIII through X included the following:

Activity VIII. Sufficient Data Analysis and Interpretation

Activity Summary: Activity VIII represented the greatest opportunity for plans to improve.

For this activity, plans had an average rate of 68 percent for *Met* elements for IQIPs validated during the review period, October 1, 2009 through December 31, 2009. This result was similar to rate of 73 percent for IQIPs reviewed during the prior review period, July 1, 2009, through September 30, 2009. In this activity, the plans' greatest opportunity for improvement was in conducting data analysis and interpretation.

Plans had reasonable success with generalizing study results to the study population if sampling was used, identifying the initial measurement and remeasurement periods, and interpreting the extent to which the study was successful.

Plans could improve IQIP scores in this area by including the statistical test used in the data analysis plan, including factors that threaten the internal or external validity of findings, documenting factors that affect the ability to compare the initial measurement and remeasurement results, and identifying statistical differences between the measurement periods. Most plans did not include an interpretation of the findings that compared results to the previous period and goal.

Activity IX. Real Improvement Achieved

Activity Summary: Only one of the seven projects assessed for real improvement demonstrated statistically significant improvement for all study indicators.

Nine IQIP submissions, representing seven plan projects, progressed to a remeasurement period or closeout. Of the seven projects, one plan had statistically significant improvement for all study indicators, another plan had statistically significant improvement for some study indicators, and five plans had no statistically significant improvement for any indicators.

Kern Family Health Plan demonstrated statistically significant improvement between its previous measurement period and its final remeasurement period for all four of its study indicators. The QIP targeted increasing childhood immunization rates as well as increasing its high-volume pediatric providers that use the regional immunization registry. Partnership

Health Plan achieved statistically significant improvement during its last remeasurement period over the previous period for three of its five study indicators. Partnership Health Plan improved the percentage of asthmatics dispensed one of two appropriate medications and reduced both ER visits and inpatient admissions among members with asthma.

Activity X. Sustained Improvement Achieved

Activity Summary: Two of four projects that progressed to the point of assessment for sustained improvement achieved sustained improvement.

Unlike Activity IX, which measures for statistically significant improvement, Activity X assesses for sustained improvement over comparable time periods or determines that a decline in improvement is not statistically significant. Five IQIP submissions, representing four projects, had multiple remeasurement periods and progressed to the point of assessing for sustained improvement. For this activity, plans achieved an average rate of 60 percent for *Met* elements for IQIPs validated during this review period.

Two projects achieved sustained improvement for all study indicators. Health Plan of San Mateo increased cervical cancer screening rates and Kern Health Plan sustained improvement for increasing childhood immunization rates and provider use of the immunization registry. Partnership Health Plan received a *Partially Met* score and sustained improvement for increasing the percentage of controller medications dispensed for members with asthma, as well as increasing timely follow-up with a provider following an asthma-related visit to the ER.

Despite improvement over baseline results for diabetic retinal eye exams, Anthem Blue Cross, at the plan level, did not demonstrate sustained improvement for Hba1c testing. Although Anthem Blue Cross holds contracts in nine counties and provided county-level rates, HSAG assessed improvement at the plan level for all QIPs since the validation requirements and methodology for scoring QIPs at the county level were not in place at the time of this review. County-level validation will provide plans operating in multiple counties a better opportunity for recognition of real and sustained improvement.

All four QIPs progressing to Activity X were closed, and plans will submit new QIP proposals.

Internal QIP Strengths and Opportunities for Improvement

Plans demonstrated proficiency with IQIP study design and study implementation as evidenced by high average rates of *Met* evaluation elements for this review period, October 1, 2009, through December 31, 2009.

The plans' greatest opportunity for improvement relates to documentation of data analysis and interpretation of study results in Activity VIII.

Internal QIP Recommendations

As the IQIPs progress to assessment for quality outcomes achieved, it becomes more challenging for plans to improve average rates of *Met* evaluation elements for activities without achieving improvement, the goal of a project. Plans can perfectly design and implement a quality initiative and yet fail to achieve the desired result. As plans continue to demonstrate proficiency with CMS' requirements for documenting study design and implementation, the State, the plans, and the EQRO have the opportunity to focus on strategies to achieve more successful IQIP outcomes, such as using evidence-based interventions when available, as well as best and promising practices.

Conclusions—Overall QIP Validation Findings

The 42 QIPs validated by plans between October 1, 2009, and December 31, 2009, showed continued improvement of plan documentation to increase compliance with CMS' protocol for conducting QIPs.

Statewide collaborative annual ER QIP submissions showed dramatic improvement of validation scores during this review period, October 1, 2009, through December 31, 2009, compared to validation scores during the review period of July 1, 2008, through December 31, 2008. This demonstrated that plans increased proficiency with HSAG's requirements. Twenty percent of plans demonstrated a statistically significant decrease in avoidable ER visit rates.

Another plan participating in the SGC QIP for reducing inappropriate antibiotic use for URIs, demonstrated statistically significant improvement in the percentage of its identified high-volume PCPs meeting minimum performance standards for not prescribing an antibiotic for a URI. Plans implementing the SGC URI interventions continued to demonstrate improvement, which further supported this model and/or interventions as a best practice.

The greatest opportunity for improvement across all QIPs was improved data analysis and interpretation. Plans can improve in this area by including a discussion about the results compared to the QIP goal and benchmark, and by including statistical testing for each remeasurement period.

Appendix A presents the status of the following types of active QIPs:

- The DHCS Statewide Collaborative QIP
- Small-Group Collaborative QIPs
- Internal QIPs

Table A.1––The DHCS Statewide Collaborative QIPs
October 1, 2009, through December 31, 2009
(*See page A-8 for grid category explanations.)

Plan Name & County	Plan Model Type*	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
				Steps Validated*	Measurement Completion*
Name of Project/Study: Reducing Avoidable Emergency Room Visits					
Alameda Alliance for Health—Alameda	LI	Clinical	Reduce the number of members 1 year of age and older who use the emergency room for a visit that could have been more appropriately managed in an office or a clinic setting.	I – IX	Remeasurement 1
Anthem Blue Cross— Alameda, Contra Costa, Fresno, San Francisco, San Joaquin, Santa Clara, Sacramento Stanislaus, Tulare	 CP GMC LI			I – VIII	Baseline
CalOptima—Orange	COHS			I – IX	Remeasurement 1
Care 1st—San Diego	GMC			I – IX	Remeasurement 1
CenCal Health—Santa Barbara	COHS			I – IX	Remeasurement 1
Central California Alliance for Health**— Monterey, Santa Cruz	 COHS			I – IX	Remeasurement 1
Community Health Group—San Diego	GMC			I – IX	Remeasurement 1
Contra Costa Health Plan—Contra Costa	LI			I – IX	Remeasurement 1
Health Net— Fresno, Kern, Los Angeles, Stanislaus, Tulare Sacramento, San Diego	 CP GMC			I – IX	Remeasurement 1
Health Plan of San Joaquin—San Joaquin	LI			I – IX	Remeasurement 1
Health Plan of San Mateo—San Mateo	COHS			I – IX	Remeasurement 1
Inland Empire Health Plan—Riverside, San Bernardino	LI			I – IX	Remeasurement 1
**Central Coast Alliance for Health changed its name to Central California Alliance for Health effective July 1, 2009.					

Table A.1––The DHCS Statewide Collaborative QIPs
October 1, 2009, through December 31, 2009
(*See page A-8 for grid category explanations.)

	Plan Name & County	Plan Model Type*	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
Name of Project/Study: Reducing Avoidable Emergency Room Visits						
	Kaiser Permanente (North)—Sacramento	GMC	Clinical	Reduce the number of members 1 year of age and older who use the emergency room for a visit that could have been more appropriately managed in an office or a clinic setting.	I – IX	Remeasurement 1
	Kaiser Permanente (South)—San Diego	GMC			I – IX	Remeasurement 1
	Kern Family Health Care—Kern	LI			I – VIII	Baseline
	L A Care Health Plan—Los Angeles	LI			I – IX	Remeasurement 1
	Molina Healthcare— Riverside, San Bernardino Sacramento, San Diego	 CP GMC			I – IX	Remeasurement 1
	Partnership Health Plan—Napa, Solano, Yolo	COHS			I – IX	Remeasurement 1
	San Francisco Health Plan—San Francisco	LI			I – IX	Remeasurement 1
	Santa Clara Family Health Plan—Santa Clara	LI			I – IX	Remeasurement 1
	Western Health Advantage—Sacramento	GMC			I – IX	Remeasurement 1

Table A.2––Small-Group Collaborative QIPs
October 1, 2009, through December 31, 2009
(*See page A-8 for grid category explanations.)

Plan Name & County	Plan Model Type*	Name of Project/Study	Clinical/ Nonclinical*	QIP Population Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
CalOptima—Orange	COHS	Appropriate Treatment for Children With Upper Respiratory Infection	Clinical	Decrease inappropriate use of antibiotics in children 3 months–18 years of age.	I – X	Remeasurement 2
Care 1st—San Diego	GMC				I – VIII	Baseline
Health Net— Fresno, Kern, Los Angeles, Stanislaus, Tulare Sacramento, San Diego	CP GMC				I – X closed	Remeasurement 2
L A Care Health Plan— Los Angeles	LI				I – X closed	Remeasurement 2
Molina Healthcare— Riverside, San Bernardino Sacramento, San Diego	CP GMC				I – X closed	Remeasurement 3
Care 1st—San Diego	GMC	Improving Treatment of Chronic Obstructive Pulmonary Disease (COPD)	Clinical	Improve treatment for adults 40 years of age and older with COPD.	I – VIII	Baseline
Community Health Group— San Diego	GMC				I – IX	Remeasurement 1

Table A.3––Internal QIPs
October 1, 2009, through December 31, 2009
(*See page A-8 for grid category explanations.)

Plan Name & County	Plan Model Type*	Name of Project/Study	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
AHF Healthcare Centers—Los Angeles	SP	Reducing Adverse Reactions to Coumadin for Patients With HIV/AIDS	Clinical	Reduce the number of hospitalizations for members on Coumadin therapy as a result of adverse reactions.	I – IX	Remeasurement 1
AHF Healthcare Centers—Los Angeles	SP	Controlling High Blood Pressure	Clinical	Increase the percentage of cases of controlled blood pressure among adults diagnosed with hypertension.	I – VIII	Baseline
Alameda Alliance for Health—Alameda	LI	Decrease Return Emergency Room Visits for Asthmatic Exacerbations in Children	Clinical	Reduce the number of children 2–18 years of age who visit the ER with asthma and return to the ER with additional asthmatic events.	I – VIII	Baseline
Anthem Blue Cross— Alameda, Contra Costa, Fresno, San Francisco, San Joaquin, Santa Clara, Sacramento Stanislaus, Tulare	CP GMC LI	Improving Diabetes Management	Clinical	Increase HEDIS rates for HbA1c screening and diabetic retinal eye exams among adults 21–65 years of age.	I – X closed	Remeasurement 4
CenCal Health—Santa Barbara	COHS	Proper Antibiotic Use	Clinical	Decrease inappropriate antibiotic prescribing for children 2–18 years of age.	I – X closed	Remeasurement 2
Central California Alliance for Health**—Monterey, Santa Cruz	COHS	Improving Effective Case Management	Clinical	Increase the effectiveness of case management to reduce hospitalizations related to diabetes and congestive heart failure among adults 21 years of age and older.	I – VIII	Baseline
**Central Coast Alliance for Health changed its name to Central California Alliance for Health effective July 1, 2009.						

Table A.3––Internal QIPs
October 1, 2009, through December 31, 2009
(*See page A-8 for grid category explanations.)

Plan Name & County	Plan Model Type*	Name of Project/Study	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
Community Health Group—San Diego	GMC	Increasing Follow-up to Positive Postpartum Screens	Clinical	Increase the percentage of women receiving a postpartum visit within six months of delivery.	I – IX	Remeasurement 1
Contra Costa Health Plan—Contra Costa	LI	Reducing Health Disparities in Childhood Immunizations	Clinical	Improve childhood immunization rates and well-care visits in the first 15 months of life for African-American and Hispanic children.	I – X closed	Remeasurement 4
Contra Costa Health Plan—Contra Costa	LI	Reducing Health Disparities in Pediatric Obesity	Clinical	Reduce health disparities in childhood obesity among children 3–11 years of age.	I - V	Proposal
Family Mosaic Project—San Francisco	SP	*Project pending – 5/31/2010*				
Family Mosaic Project—San Francisco	SP	*Project pending – 12/31/2010*				
Health Plan of San Joaquin—San Joaquin	LI	Chlamydia Screening	Clinical	Increase the rate of chlamydia screening in sexually active women 16–25 years of age.	I – IX	Remeasurement 1
Health Plan of San Mateo—San Mateo	COHS	Cervical Cancer Screening	Clinical	Increase the percentage of women who receive a Pap test.	I – IX closed	Remeasurement 1
Inland Empire Health Plan—Riverside, San Bernardino	LI	Child Upper Respiratory Infections	Clinical	Decrease antibiotic overuse in children 3 months–18 years of age.	I – X closed	Remeasurement 2
Kaiser Permanente (North)—Sacramento	GMC	*Project pending*				
Kaiser Permanente (South)—San Diego	GMC	Improving Blood Sugar Levels in Diabetic Members	Clinical	Increase the percentage of diabetic members having at least one HbA1c test within the last 12 months.	I – X closed	Remeasurement 4

Table A.3––Internal QIPs
October 1, 2009, through December 31, 2009
(*See page A-8 for grid category explanations.)

Plan Name & County	Plan Model Type*	Name of Project/Study	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
Kaiser PHP—Marin, Sonoma	PHP	Cervical Cancer Screening	Clinical	Increase cervical cancer screening among women 18–64 years of age.	I – X	Remeasurement 3
Kaiser PHP—Marin, Sonoma	PHP	Smoking Prevention	Clinical	Increase the percentage of members 18 years of age and older receiving advice to quit smoking.	I – X	Remeasurement 4
Kern Family Health Care—Kern	LI	Use of Immunization Registry for Children	Clinical	Increase the number of children seen by providers who access and use the regional immunization registry for children 2 years of age and younger.	I – X	Remeasurement 4
Partnership Health Plan—Napa, Solano, Yolo	COHS	Asthma Management	Clinical	Improve management of asthma for members 5–56 years of age.	I – X	Remeasurement 4
San Francisco Health Plan—San Francisco	LI	Diabetes Care Management	Clinical	Improve comprehensive diabetes care: blood glucose control, retinal eye exams, and reduced cholesterol and blood pressure levels.	I – X closed	Remeasurement 3
Santa Clara Family Health—Santa Clara	LI	Adolescent Obesity Prevention	Clinical	Increase screening for adolescent obesity and timeliness of appropriate health education intervention.	I – VIII	Baseline
SCAN Health Plan—Los Angeles, Riverside, San Bernardino	SP	Chronic Obstructive Pulmonary Disease (COPD)	Clinical	Improve treatment for adults 40 years of age and older with COPD.	I – VIII	Baseline
SCAN Health Plan—Los Angeles, Riverside, San Bernardino	SP	Prevention of Stroke and Transient Ischemic Attack (TIA)	Clinical	Reduce the risk and recurrence of stroke or TIA.	I - VIII	Baseline

Table A.3––Internal QIPs
October 1, 2009, through December 31, 2009

Plan Name & County	Plan Model Type*	Name of Project/Study	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
Western Health Advantage—Sacramento	GMC	Improving Timeliness of Prenatal and Postpartum Care	Clinical	Increase the percentage of pregnant women who receive timely prenatal and postpartum care.	I – X closed	Remeasurement 3

*Grid category explanations:

Plan Model Type—designated plan model type:

- County-Operated Health System (COHS) plan
- Geographic-Managed Care (GMC) plan
- Two-Plan Model
  - Local initiative plan (LI)
  - Commercial plan (CP)
- Specialty plan (SP)

Clinical/Nonclinical—designates if the QIP addresses a clinical or nonclinical area of study.

QIP Description—provides a brief description of the QIP and the study population.

Level of QIP Progress—provides the status of each QIP as shown through *Steps Validated* and *Measurement Completion:*

- *Steps Validated*—provides the number of CMS activities/steps completed through Step X.
- *Measurement Completion*—indicates the QIP status as proposal, baseline assessment, Remeasurement 1, Remeasurement 2, etc.

Table B.1—Statewide Collaborative QIP Activities I to IV Ratings (N = 28 Submissions)
October 1, 2009, through December 31, 2009

	Evaluation Elements	*Met*	*Partially Met*	*Not Met*
Activity I: Appropriate Study Topic				
	1. Reflects high-volume or high-risk conditions (or was selected by the State).	93% (26/28)	7% (2/28)	0% (0/28)
	2. Is selected following collection and analysis of data (or was selected by the State).	100% (28/28)	0% (0/28)	0% (0/28)
	3. Addresses a broad spectrum of care and services (or was selected by the State).	89% (25/28)	4% (1/28)	7% (2/28)
	4. Includes all eligible populations that meet the study criteria.	68% (19/28)	21% (6/28)	11% (3/28)
	5. Does not exclude members with special health care needs.	68% (19/28)	21% (6/28)	11% (3/28)
C*	6. Has the potential to affect member health, functional status, or satisfaction.	96% (27/28)	0% (0/28)	4% (1/28)
	Activity Average Rates**	**86% (144/168)**	**9% (15/168)**	**5% (9/168)**
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	93% (26/28)	7% (2/28)	0% (0/28)
C*	2. Is answerable.	93% (26/28)	7% (2/28)	0% (0/28)
	Activity Average Rates**	**93% (52/56)**	**7% (4/56)**	**0% (0/56)**
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	75% (21/28)	25% (7/28)	0% (0/28)
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	100% (28/28)	0% (0/28)	0% (0/28)
C*	3. Allow for the study questions to be answered.	75% (21/28)	25% (7/28)	0% (0/28)
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	75% (21/28)	25% (7/28)	0% (0/28)
C*	5. Have available data that can be collected on each indicator.	96% (27/28)	4% (1/28)	0% (0/28)
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	100% (28/28)	0% (0/28)	0% (0/28)
	7. Includes the basis on which each indicator was adopted, if internally developed.	96% (27/28)	0% (0/28)	4% (1/28)
	Activity Average Rates**	**88% (173/196)**	**11% (22/196)**	**1% (1/196)**
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	79% (22/28)	18% (5/28)	3% (1/28)
	2. Includes requirements for the length of a member's enrollment in the plan.	Not applicable	Not applicable	Not applicable
C*	3. Captures all members to whom the study question applies.	75% (21/28)	21% (6/28)	4% (1/28)
	Activity Average Rates**	**77% (43/56)**	**20% (11/56)**	**3% (2/56)**

Note: Activity evaluation element columns represent the average percentage for *Met*, *Partially Met*, and *Not Met* elements. All *Not Applicable* and *Not Assessed* elements are excluded.

*"C" in this column denotes a critical element in HSAG's validation protocol. Plans must receive a *Met* score for these elements for a QIP to receive a *Met* validation status.

**The activity average rate represents the average percentage of elements with a *Met*, *Partially Met, or Not Met* finding across all the evaluation elements for a particular activity. All *Not Applicable* or *Not Assessed* findings are excluded.

Δ No QIPs were assessed for this activity/evaluation element.

Table B.2—Statewide Collaborative QIP Activities V to VII Ratings (N = 28 Submissions)
October 1, 2009, through December 31, 2009

	Evaluation Elements	Met	Partially Met	Not Met
Activity V: Valid Sampling Techniques				
	1. Consider and specify the true or estimated frequency of occurrence.	Δ	Δ	Δ
	2. Identify the sample size.	Δ	Δ	Δ
	3. Specify the confidence level.	Δ	Δ	Δ
	4. Specify the acceptable margin of error.	Δ	Δ	Δ
C*	5. Ensure a representative sample of the eligible population.	Δ	Δ	Δ
	6. Are in accordance with generally accepted principles of research design and statistical analysis.	Δ	Δ	Δ
	Activity Average Rates**	**Δ**	**Δ**	**Δ**
Activity VI: Accurate/Complete Data Collection				
	1. The identification of data elements to be collected.	79% (22/28)	14% (4/28)	7% (2/28)
	2. The identification of specified sources of data.	100% (28/28)	0% (0/28)	0% (0/28)
	3. A defined and systematic process for collecting baseline and remeasurement data.	Δ	Δ	Δ
	4. A timeline for the collection of baseline and remeasurement data.	75% (21/28)	25% (7/28)	0% (0/28)
	5. Qualified staff and personnel to abstract manual data.	Δ	Δ	Δ
C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	Δ	Δ	Δ
	7. A manual data collection tool that supports interrater reliability.	Δ	Δ	Δ
	8. Clear and concise written instructions for completing the manual data collection tool.	Δ	Δ	Δ
	9. An overview of the study in written instructions.	Δ	Δ	Δ
	10. Administrative data collection algorithms/flowcharts that show activities in the production of indicators.	89% (25/28)	4% (1/28)	7% (2/28)
	11. An estimated degree of automated data completeness.	93% (26/28)	7% (2/28)	0% (0/28)
	Activity Average Rates**	**87% (122/140)**	**10% (14/140)**	**3% (4/140)**
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	82% (23/28)	14% (4/28)	4% (1/28)
	2. System changes that are likely to induce permanent change.	100% (28/28)	0% (0/28)	0% (0/28)
	3. Revised if original interventions are not successful.	60% (12/20)	15% (3/20)	25% (5/20)
	4. Standardized and monitored if interventions were successful.	50% (4/8)	25% (2/8)	25% (2/8)
	Activity Average Rates**	**80% (67/84)**	**11% (9/84)**	**9% (8/84)**

Note: Activity evaluation element columns represent the average percentage for *Met*, *Partially Met*, and *Not Met* elements. All *Not Applicable* and *Not Assessed* elements are excluded.

*"C" in this column denotes a critical element in HSAG's validation protocol. Plans must receive a *Met* score for these elements for a QIP to receive a *Met* validation status.

**The activity average rate represents the average percentage of elements with a *Met*, *Partially Met, or Not Met* finding across all the evaluation elements for a particular activity. All *Not Applicable* or *Not Assessed* findings are excluded.

Δ No QIPs were assessed for this activity/evaluation element.

Table B.3—Statewide Collaborative QIP Activities VIII to X Ratings (N = 28 Submissions)
October 1, 2009, through December 31, 2009

	Evaluation Elements	Met	Partially Met	Not Met
Activity VIII: Sufficient Data Analysis and Interpretation				
C*	1. Is conducted according to the data analysis plan in the study design.	86% (24/28)	11% (3/28)	3% (1/28)
C*	2. Allows for the generalization of the results to the study population if a sample was selected.	Δ	Δ	Δ
	3. Identifies factors that threaten the internal or external validity of the findings.	89% (25/28)	4% (1/28)	7% (2/28)
	4. Includes an interpretation of the findings.	57% (16/28)	39% (11/28)	4% (1/28)
	5. Is presented in a way that provides accurate, clear, and easily understood information.	79% (22/28)	21% (6/28)	0% (0/28)
	6. Identifies initial measurement and remeasurement of study indicators.	100% (28/28)	0% (0/28)	0% (0/28)
	7. Identifies statistical differences between initial measurement and remeasurement.	68% (19/28)	25% (7/28)	7% (2/28)
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	75% (21/28)	4% (1/28)	21% (6/28)
	9. Includes interpretation of the extent to which the study was successful.	93% (26/28)	0% (0/28)	7% (2/28)
	Activity Average Rates**	**81% (181/224)**	**13% (29/224)**	**6% (14/224)**
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	100% (28/28)	0% (0/28)	0% (0/28)
	2. There is documented improvement in processes or outcomes of care.	29% (8/28)	0% (0/28)	71% (20/28)
	3. The improvement appears to be the result of planned intervention(s).	29% (8/28)	0% (0/28)	71% (20/28)
	4. There is statistical evidence that observed improvement is true improvement.	21% (6/28)	0% (0/28)	79% (22/28)
	Activity Average Rates**	**45% (50/112)**	**0% (0/112)**	**55% (62/112)**
Activity X: Sustained Improvement Achieved				
	1. Repeated measurements over comparable time periods demonstrate sustained improvement, or that a decline in improvement is not statistically significant.	Δ	Δ	Δ
	Activity Average Rates**	**Δ**	**Δ**	**Δ**

Note: Activity evaluation element columns represent the average percentage for *Met*, *Partially Met*, and *Not Met* elements. All *Not Applicable* and *Not Assessed* elements are excluded.

*"C" in this column denotes a critical element in HSAG's validation protocol. Plans must receive a *Met* score for these elements for a QIP to receive a *Met* validation status.

**The activity average rate represents the average percentage of elements with a *Met*, *Partially Met, or Not Met* finding across all the evaluation elements for a particular activity. All *Not Applicable* or *Not Assessed* findings are excluded.

Δ No QIPs were assessed for this activity/evaluation element.

Table B.4—Small-Group Collaborative QIP Activities I to IV Ratings (N = 2 Submissions)
October 1, 2009, through December 31, 2009

	Evaluation Elements	Met	Partially Met	Not Met
Activity I: Appropriate Study Topic				
	1. Reflects high-volume or high-risk conditions (or was selected by the State).	100% (2/2)	0% (0/2)	0% (0/2)
	2. Is selected following collection and analysis of data (or was selected by the State).	100% (2/2)	0% (0/2)	0% (0/2)
	3. Addresses a broad spectrum of care and services (or was selected by the State).	100% (2/2)	0% (0/2)	0% (0/2)
	4. Includes all eligible populations that meet the study criteria.	100% (2/2)	0% (0/2)	0% (0/2)
	5. Does not exclude members with special health care needs.	100% (2/2)	0% (0/2)	0% (0/2)
C*	6. Has the potential to affect member health, functional status, or satisfaction.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**100% (12/12)**	**0% (0/12)**	**0% (0/12)**
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	100% (2/2)	0% (0/2)	0% (0/2)
C*	2. Is answerable.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	100% (2/2)	0% (0/2)	0% (0/2)
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	100% (2/2)	0% (0/2)	0% (0/2)
C*	3. Allow for the study questions to be answered.	100% (2/2)	0% (0/2)	0% (0/2)
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	100% (2/2)	0% (0/2)	0% (0/2)
C*	5. Have available data that can be collected on each indicator.	100% (2/2)	0% (0/2)	0% (0/2)
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	100% (2/2)	0% (0/2)	0% (0/2)
	7. Includes the basis on which each indicator was adopted, if internally developed.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**100% (14/14)**	**0% (0/14)**	**0% (0/14)**
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	100% (2/2)	0% (0/2)	0% (0/2)
	2. Includes requirements for the length of a member's enrollment in the plan.	100% (2/2)	0% (0/2)	0% (0/2)
C*	3. Captures all members to whom the study question applies.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**100% (6/6)**	**0% (0/6)**	**0% (0/6)**

Note: Activity evaluation element columns represent the average percentage for *Met*, *Partially Met*, and *Not Met* elements. All *Not Applicable* and *Not Assessed* elements are excluded.

*"C" in this column denotes a critical element in HSAG's validation protocol. Plans must receive a *Met* score for these elements for a QIP to receive a *Met* validation status.

**The activity average rate represents the average percentage of elements with a *Met*, *Partially Met, or Not Met* finding across all the evaluation elements for a particular activity. All *Not Applicable* or *Not Assessed* findings are excluded.

Δ No QIPs were assessed for this activity/evaluation element.

Table B.5—Small-Group Collaborative QIP Activities V to VII Ratings (N = 2 Submissions)
October 1, 2009, through December 31, 2009

	Evaluation Elements	Met	Partially Met	Not Met
Activity V: Valid Sampling Techniques				
	1. Consider and specify the true or estimated frequency of occurrence.	Δ	Δ	Δ
	2. Identify the sample size.	Δ	Δ	Δ
	3. Specify the confidence level.	Δ	Δ	Δ
	4. Specify the acceptable margin of error.	Δ	Δ	Δ
C*	5. Ensure a representative sample of the eligible population.	Δ	Δ	Δ
	6. Are in accordance with generally accepted principles of research design and statistical analysis.	Δ	Δ	Δ
	Activity Average Rates**	**Δ**	**Δ**	**Δ**
Activity VI: Accurate/Complete Data Collection				
	1. The identification of data elements to be collected.	100% (2/2)	0% (0/2)	0% (0/2)
	2. The identification of specified sources of data.	100% (2/2)	0% (0/2)	0% (0/2)
	3. A defined and systematic process for collecting baseline and remeasurement data.	Δ	Δ	Δ
	4. A timeline for the collection of baseline and remeasurement data.	100% (2/2)	0% (0/2)	0% (0/2)
	5. Qualified staff and personnel to abstract manual data.	Δ	Δ	Δ
C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	Δ	Δ	Δ
	7. A manual data collection tool that supports interrater reliability.	Δ	Δ	Δ
	8. Clear and concise written instructions for completing the manual data collection tool.	Δ	Δ	Δ
	9. An overview of the study in written instructions.	Δ	Δ	Δ
	10. Administrative data collection algorithms/flowcharts that show activities in the production of indicators.	100% (2/2)	0% (0/2)	0% (0/2)
	11. An estimated degree of automated data completeness.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**100% (10/10)**	**0% (0/10)**	**0% (0/10)**
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	100% (2/2)	0% (0/2)	0% (0/2)
	2. System changes that are likely to induce permanent change.	100% (2/2)	0% (0/2)	0% (0/2)
	3. Revised if original interventions are not successful.	Δ	Δ	Δ
	4. Standardized and monitored if interventions were successful.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**100% (6/6)**	**0% (0/6)**	**0% (0/6)**

Note: Activity evaluation element columns represent the average percentage for *Met*, *Partially Met*, and *Not Met* elements. All *Not Applicable* and *Not Assessed* elements are excluded.

*"C" in this column denotes a critical element in HSAG's validation protocol. Plans must receive a *Met* score for these elements for a QIP to receive a *Met* validation status.

**The activity average rate represents the average percentage of elements with a *Met*, *Partially Met, or Not Met* finding across all the evaluation elements for a particular activity. All *Not Applicable* or *Not Assessed* findings are excluded.

Δ No QIPs were assessed for this activity/evaluation element.

Table B.6—Small-Group Collaborative Activities VIII to X Ratings (N = 2 Submissions)
October 1, 2009, through December 31, 2009

	Evaluation Elements	Met	Partially Met	Not Met
Activity VIII: Sufficient Data Analysis and Interpretation				
C*	1. Is conducted according to the data analysis plan in the study design.	50% (1/2)	0% (0/2)	50% (1/2)
C*	2. Allows for the generalization of the results to the study population if a sample was selected.	Δ	Δ	Δ
	3. Identifies factors that threaten the internal or external validity of the findings.	50% (1/2)	0% (0/2)	50% (1/2)
	4. Includes an interpretation of the findings.	50% (1/2)	50% (1/2)	0% (0/2)
	5. Is presented in a way that provides accurate, clear, and easily understood information.	100% (2/2)	0% (0/2)	0% (0/2)
	6. Identifies initial measurement and remeasurement of study indicators.	100% (2/2)	0% (0/2)	0% (0/2)
	7. Identifies statistical differences between initial measurement and remeasurement.	50% (1/2)	50% (1/2)	0% (0/2)
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	50% (1/2)	0% (0/2)	50% (1/2)
	9. Includes interpretation of the extent to which the study was successful.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**69% (11/16)**	**12% (2/16)**	**19% (3/16)**
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	100% (2/2)	0% (0/2)	0% (0/2)
	2. There is documented improvement in processes or outcomes of care.	100% (2/2)	0% (0/2)	0% (0/2)
	3. The improvement appears to be the result of planned intervention(s).	100% (2/2)	0% (0/2)	0% (0/2)
	4. There is statistical evidence that observed improvement is true improvement.	0% (0/2)	50% (1/2)	50% (1/2)
	Activity Average Rates**	**75% (6/8)**	**12.5% (1/8)**	**12.5% (1/8)**
Activity X: Sustained Improvement Achieved				
	1. Repeated measurements over comparable time periods demonstrate sustained improvement, or that a decline in improvement is not statistically significant.	Δ	Δ	Δ
	Activity Average Rates**	**Δ**	**Δ**	**Δ**

Note: Activity evaluation element columns represent the average percentage for *Met*, *Partially Met*, and *Not Met* elements. All *Not Applicable* and *Not Assessed* elements are excluded.

*"C" in this column denotes a critical element in HSAG's validation protocol. Plans must receive a *Met* score for these elements for a QIP to receive a *Met* validation status.

**The activity average rate represents the average percentage of elements with a *Met*, *Partially Met, or Not Met* finding across all the evaluation elements for a particular activity. All *Not Applicable* or *Not Assessed* findings are excluded.

Δ No QIPs were assessed for this activity/evaluation element.

Table B.7—Internal QIP Activities I to IV Ratings (N = 12 Submissions)
October 1, 2009, through December 31, 2009

	Evaluation Elements	Met	Partially Met	Not Met
Activity I: Appropriate Study Topic				
	1. Reflects high-volume or high-risk conditions (or was selected by the State).	100% (12/12)	0% (0/12)	0% (0/12)
	2. Is selected following collection and analysis of data (or was selected by the State).	100% (12/12)	0% (0/12)	0% (0/12)
	3. Addresses a broad spectrum of care and services (or was selected by the State).	100% (12/12)	0% (0/12)	0% (0/12)
	4. Includes all eligible populations that meet the study criteria.	67% (8/12)	16.5% (2/12)	16.5% (2/12)
	5. Does not exclude members with special health care needs.	83% (10/12)	0% (0/12)	17% (2/12)
C*	6. Has the potential to affect member health, functional status, or satisfaction.	100% (12/12)	0% (0/12)	0% (0/12)
	Activity Average Rates**	**92% (66/72)**	**3% (2/72)**	**5% (4/72)**
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	92% (11/12)	8% (1/12)	0% (0/12)
C*	2. Is answerable.	92% (11/12)	8% (1/12)	0% (0/12)
	Activity Average Rates**	**92% (22/24)**	**8% (2/24)**	**0% (0/24)**
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	92% (11/12)	8% (1/12)	0% (0/12)
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	100% (12/12)	0% (0/12)	0% (0/12)
C*	3. Allow for the study questions to be answered.	92% (11/12)	8% (1/12)	0% (0/12)
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	92% (11/12)	8% (1/12)	0% (0/12)
C*	5. Have available data that can be collected on each indicator.	100% (12/12)	0% (0/12)	0% (0/12)
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	100% (11/11)	0% (0/11)	0% (0/11)
	7. Includes the basis on which each indicator was adopted, if internally developed.	100% (3/3)	0% (0/3)	0% (0/3)
	Activity Average Rates**	**96% (71/74)**	**4% (3/74)**	**0% (0/74)**
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	92% (11/12)	8% (1/12)	0% (0/12)
	2. Includes requirements for the length of a member's enrollment in the plan.	92% (11/12)	0% (0/12)	8% (1/12)
C*	3. Captures all members to whom the study question applies.	92% (11/12)	8% (1/12)	0% (0/12)
	Activity Average Rates**	**91% (33/36)**	**6% (2/33)**	**3% (1/33)**

Note: Activity evaluation element columns represent the average percentage for *Met*, *Partially Met*, and *Not Met* elements. All *Not Applicable* and *Not Assessed* elements are excluded.

*"C" in this column denotes a critical element in HSAG's validation protocol. Plans must receive a *Met* score for these elements for a QIP to receive a *Met* validation status.

**The activity average rate represents the average percentage of elements with a *Met*, *Partially Met, or Not Met* finding across all the evaluation elements for a particular activity. All *Not Applicable* or *Not Assessed* findings are excluded.

Δ No QIPs were assessed for this activity/evaluation element.

Table B.8—Internal QIP Activities V to VII Ratings (N = 12 Submissions)
October 1, 2009, through December 31, 2009

	Evaluation Elements	Met	Partially Met	Not Met
Activity V: Valid Sampling Techniques				
	1. Consider and specify the true or estimated frequency of occurrence.	100% (6/6)	0% (0/6)	0% (0/6)
	2. Identify the sample size.	100% (6/6)	0% (0/6)	0% (0/6)
	3. Specify the confidence level.	100% (6/6)	0% (0/6)	0% (0/6)
	4. Specify the acceptable margin of error.	100% (6/6)	0% (0/6)	0% (0/6)
C*	5. Ensure a representative sample of the eligible population.	100% (6/6)	0% (0/6)	0% (0/6)
	6. Are in accordance with generally accepted principles of research design and statistical analysis.	100% (6/6)	0% (0/6)	0% (0/6)
	Activity Average Rates**	**100% (36/36)**	**0% (0/36)**	**0% (0/36)**
Activity VI: Accurate/Complete Data Collection				
	1. The identification of data elements to be collected.	92% (11/12)	8% (1/12)	0% (0/12)
	2. The identification of specified sources of data.	100% (12/12)	0% (0/12)	0% (0/12)
	3. A defined and systematic process for collecting baseline and remeasurement data.	100% (6/6)	0% (0/6)	0% (0/6)
	4. A timeline for the collection of baseline and remeasurement data.	92% (11/12)	8% (1/12)	0% (0/12)
	5. Qualified staff and personnel to abstract manual data.	67% (4/6)	0% (0/6)	33% (2/6)
C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	100% (6/6)	0% (0/6)	0% (0/6)
	7. A manual data collection tool that supports interrater reliability.	67% (4/6)	0% (0/6)	33% (2/6)
	8. Clear and concise written instructions for completing the manual data collection tool.	67% (4/6)	0% (0/6)	33% (2/6)
	9. An overview of the study in written instructions.	67% (4/6)	0% (0/6)	33% (2/6)
	10. Administrative data collection algorithms/flowcharts that show activities in the production of indicators.	83% (10/12)	8.5% (1/12)	8.5% (1/12)
	11. An estimated degree of automated data completeness.	83% (5/6)	17% (1/6)	0% (0/6)
	Activity Average Rates**	**86% (77/90)**	**4% (4/90)**	**10% (9/90)**
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	90% (9/10)	0% (0/10)	10% (1/10)
	2. System changes that are likely to induce permanent change.	90% (9/10)	0% (0/10)	10% (1/10)
	3. Revised if original interventions are not successful.	86% (6/7)	0% (0/7)	14% (1/7)
	4. Standardized and monitored if interventions were successful.	100% (3/3)	0% (0/3)	0% (0/3)
	Activity Average Rates**	**90% (27/30)**	**0% (0/30)**	**10% (3/30)**

Note: Activity evaluation element columns represent the average percentage for *Met*, *Partially Met*, and *Not Met* elements. All *Not Applicable* and *Not Assessed* elements are excluded.

*"C" in this column denotes a critical element in HSAG's validation protocol. Plans must receive a *Met* score for these elements for a QIP to receive a *Met* validation status.

**The activity average rate represents the average percentage of elements with a *Met*, *Partially Met, or Not Met* finding across all the evaluation elements for a particular activity. All *Not Applicable* or *Not Assessed* findings are excluded.

Δ No QIPs were assessed for this activity/evaluation element.

Table B.9—Internal QIP Activities VIII to X Ratings (N = 12 Submissions)
October 1, 2009, through December 31, 2009

	Evaluation Elements	Met	Partially Met	Not Met
Activity VIII: Sufficient Data Analysis and Interpretation				
C*	1. Is conducted according to the data analysis plan in the study design.	60% (6/10)	30% (3/10)	10% (1/10)
C*	2. Allows for the generalization of the results to the study population if a sample was selected.	100% (5/5)	0% (0/5)	0% (0/5)
	3. Identifies factors that threaten the internal or external validity of the findings.	60% (6/10)	20% (2/10)	20% (2/10)
	4. Includes an interpretation of the findings.	40% (4/10)	50% (5/10)	10% (1/10)
	5. Is presented in a way that provides accurate, clear, and easily understood information.	80% (8/10)	20% (2/10)	0% (0/10)
	6. Identifies initial measurement and remeasurement of study indicators.	89% (8/9)	11% (1/9)	0% (0/9)
	7. Identifies statistical differences between initial measurement and remeasurement.	67% (6/9)	11% (1/9)	22% (2/9)
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	56% (5/9)	0% (0/9)	44% (4/9)
	9. Includes interpretation of the extent to which the study was successful.	78% (7/9)	22% (2/9)	0% (0/9)
	Activity Average Rates**	**68% (55/81)**	**20% (16/81)**	**12% (10/81)**
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	100% (9/9)	0% (0/9)	0% (0/9)
	2. There is documented improvement in processes or outcomes of care.	22% (2/9)	22% (2/9)	56% (5/9)
	3. The improvement appears to be the result of planned intervention(s).	22% (2/9)	22% (2/9)	56% (5/9)
	4. There is statistical evidence that observed improvement is true improvement.	22% (2/9)	11% (1/9)	67% (6/9)
	Activity Average Rates**	**42% (15/36)**	**14% (5/36)**	**44% (16/36)**
Activity X: Sustained Improvement Achieved				
	1. Repeated measurements over comparable time periods demonstrate sustained improvement, or that a decline in improvement is not statistically significant.	60% (3/5)	20% (1/5)	20% (1/5)
	Activity Average Rates**	**60% (3/5)**	**20% (1/5)**	**20% (1/5)**

Note: Activity evaluation element columns represent the average percentage for *Met*, *Partially Met*, and *Not Met* elements. All *Not Applicable* and *Not Assessed* elements are excluded.

*"C" in this column denotes a critical element in HSAG's validation protocol. Plans must receive a *Met* score for these elements for a QIP to receive a *Met* validation status.

**The activity average rate represents the average percentage of elements with a *Met*, *Partially Met, or Not Met* finding across all the evaluation elements for a particular activity. All *Not Applicable* or *Not Assessed* findings are excluded.

Δ No QIPs were assessed for this activity/evaluation element.