Medi-Cal Managed Care Program
Quality Improvement Projects Status Report
July 1, 2008 – December 31, 2008

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

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Purpose of Report

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

This QIPs status report provides a summary of QIPs validated during the period of July 1, 2008, through December 31, 2008, and presents recommendations for future improvement.

Scope of External Quality Review Activities Conducted

DHCS contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to validate QIP proposals and remeasurement reports. The Centers for Medicare & Medicaid Services (CMS) produced protocols for plans to use when conducting QIPs[1-1] and for EQROs to use when validating QIPs.[1-2] 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, DHCS and interested parties can have confidence in reported improvements that result from the QIP.

HSAG began QIP validation as the new EQRO for the 2008–2009 contract year, beginning with QIPs received after July 1, 2008.

[1-1] 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

[1-2] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Managed Care Organization Protocol. *Validating Performance Improvement Projects (PIPs): 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

This report includes a summary of the 48 QIPs received during the first and second quarters of the 2008–2009 contract year—the period from July 1, 2008, through December 31, 2008. Due to a delay in finalizing HSAG's contract and additional time needed for DHCS to review and approve HSAG's validation approach, HSAG did not begin validation work on these 48 QIPs until November 2008.

HSAG evaluated the 48 QIPs submitted by plans using its QIP Validation Tool and scored the QIPs against the CMS validating protocol. Note that Medi-Cal managed care plans were unfamiliar with HSAG's validation process and its QIP Validation Tool prior to the submission of QIPs through December 31, 2008.

Of the 48 QIPs reviewed, none fully met HSAG's validation requirements for compliance with CMS' protocol for conducting QIPs. HSAG's review revealed that its application of the CMS validation requirements is more rigorous than previously experienced by the Medi-Cal managed care plans. Through the review process, HSAG found that plans documented and reported QIPs using a quality improvement activity (QIA) form developed by the National Committee for Quality Assurance (NCQA). While NCQA has eliminated use of this form except for Medicare studies, DHCS required that plans submit QIPs using the QIA form during the reporting period. HSAG found that the QIA form does not capture all the elements for conducting QIPs from the CMS protocol; therefore, plans submitting projects using the QIA form were likely to miss critical elements necessary to validate the QIP.

HSAG provided a completed QIP Validation Tool to the plans for each of the 48 QIPs, giving specific feedback on each evaluation element and establishing a resubmission date. Feedback from plans after they received their initial validation results from HSAG revealed that plans needed and wanted significant technical assistance to better understand the CMS protocols, HSAG's scoring methodology, and the instructions for using HSAG's forms. As a result of this feedback, DHCS and HSAG agreed not to require plans to resubmit these QIPs, but instead focus on providing more technical assistance and introducing the new QIP Summary Form that plans would use for their next QIP submissions. During this time, HSAG also identified opportunities to strengthen the Statewide Emergency Room (ER) Collaborative QIP study design and timeline, which should result in more plan QIP submissions that are reliable and valid.

Conclusions

Plans demonstrated some success with their QIPs, including the implementation of strong interventions such as targeted case management and pay-for-performance strategies, use of quality improvement tools throughout the QIP process, and consistent documentation of timelines. In addition, DHCS and its partnering plans selected a challenging statewide collaborative topic to reduce avoidable emergency room visits, demonstrating a strong commitment to address a topic area that is relevant to Medi-Cal members and plans statewide. HSAG noted an effective collaborative process among DHCS and all plans participating in this collaborative QIP as evidenced by cooperation, compromise, and a willingness to dedicate resources, all of which should help assure positive outcomes for this project.

The transition to a new EQRO for QIP validation has challenged health plans with a more rigorous validation process. Overall, plans have an opportunity to improve compliance with the CMS protocol for conducting QIPs in order to produce QIPs that have a greater likelihood of achieving improvement. Plans need a better understanding of the CMS protocols for conducting and validating QIPs as well as technical assistance with documenting their QIPs. In addition, most plans could benefit from using statistical testing methods to measure improvement.

The ultimate goal for the Medi-Cal Managed Care Program, its contracted plans, and the EQRO in periodic validation of QIPs is to improve the care and services provided to members. While compliance with the CMS protocol for conducting QIPs helps plans align their QIPs to achieve "real" improvement, the process of designing, conducting, and reporting QIPs in a methodologically sound manner is gradual. HSAG's experience with implementing its QIP validation process in other states has shown that it is advantageous to provide plans a transition period in which they can receive the technical assistance and additional time needed to become fully compliant with HSAG's validation requirements. HSAG expects that subsequent QIP submissions will result in improved validation findings as the plans become more familiar with CMS protocols and HSAG's validation requirements, gaining additional expertise and experience through the validation process.

Recommendations

HSAG recommends the following:

- Disseminate CMS conducting and validating protocols to the plans to increase success with documenting and submitting valid and reliable QIPs. *Note:* DHCS redistributed the CMS protocols to plans in March 2009.
- Transition plans from use of the QIA form to HSAG's QIP Summary Form to increase compliance with the CMS protocols. *Note:* DHCS formalized a process to fully implement this transition by July 1, 2009.
- Coordinate the timing of changes to the QIP reporting requirements with the release of HSAG's *Quality Improvement Assessment Guide for Medi-Cal Managed Care Plans*. The guide serves as a reference for plans by outlining the 10 activities contained in the CMS protocol for conducting QIPs and provides detailed instructions to plans on documenting and completing HSAG's QIP Summary Form. *Note:* DHCS released the *Quality Improvement Assessment Guide for Medi-Cal Managed Care Plans* in May 2009.
- Hold EQRO technical assistance conference calls for plans, focusing on the CMS protocols, HSAG's validation requirements and scoring methodology, and instructions for documenting QIPs using HSAG's QIP Summary Form. *Note:* HSAG provided two formal technical assistance calls in June 2009 and offered ongoing technical assistance to the plans.
- Consider revising the statewide collaborative QIP timeline to allow plans adequate time to implement statewide collaborative interventions and evaluate their effectiveness. *Note:* DHCS updated the collaborative timeline.

Organization of Report

This report has seven sections:

- **Executive Summary**—Outlines the scope of EQR activities conducted, summarizes overall validation findings for the quarter, and provides recommendations.
- **Introduction**—Provides an overview of QIP requirements and HSAG's QIP validation process.
- **Quarterly QIP Activity**—Provides a table of all QIPs reviewed by HSAG for the quarter, 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 QIP, small-group collaborative QIPs, and individual QIPs.
- **Appendix C**—Provides a comparison scoring table by QIP activity for the statewide collaborative QIP, small-group collaborative QIPs, and individual QIPs.

QIP Requirements

QIPs are a federal requirement. The Code of Federal Regulations (CFR) at 42 CFR 438.240[2-1] 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. DHCS requires each of its contracted Medi-Cal managed care plans to conduct two DHCS-approved QIPs in accordance with federal requirements.

For full-scope managed care plans, the statewide Medi-Cal managed care collaborative project serves as one of the two required QIPs. The second QIP can be either an internal QIP (IQIP) or a small-group collaborative (SGC) QIP involving at least three Medi-Cal managed care plans.

[2-1] 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 an EQRO validate QIPs in a manner that is consistent with the CMS protocols for conducting and validating QIPs.[2-2]

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 the 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:

- ***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

[2-2] 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 (PIPs): A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 2002.*

QIP Validation Activities

HSAG reviewed a total of 48 QIPs for the period of July 1, 2008, to December 31, 2008. Of the QIPs submitted during this period, 47 were annual submissions and one was a QIP proposal.

Table 3.1 summarizes QIPs validated during the reporting period. HSAG reports an overall validation status of *Not Applicable (NA)* for QIPs validated during this reporting period due to HSAG's more rigorous approach to validating QIPs as the new EQRO. None of the QIPs validated during the reporting period fully met HSAG's validation requirements for compliance with CMS' protocol for conducting QIPs.

DHCS established a transition period to allow plans time to adjust to HSAG's more rigorous validation approach, receive technical assistance, and become oriented with HSAG's validation process, forms, and requirements. DHCS is requiring plans to transition QIPs to HSAG's QIP Summary Form and address all validation findings beginning July 1, 2009, as part of their next annual submission.

In future QIPs Status Reports reflecting QIPs submitted after July 1, 2009, HSAG will begin reporting an overall validation status for each QIP as *Met, Partially Met,* or *Not Met.*

Table 3.1—Medi-Cal Managed Care Program Quarterly QIP Activity from 7/1/2008 to 12/31/2008

(See page 3-4 for grid category explanations.)

Plan Name	Name of Project/Study	Type of Review*	Overall Validation Status*
Statewide Collaborative QIPs			
Alameda Alliance for Health—Alameda	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Anthem Blue Cross—Alameda, Contra Costa, Fresno, Sacramento, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Cal Optima—Orange	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Care 1st—San Diego	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
CenCal Health—Santa Barbara	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Central CA Alliance for Health**—Monterey, Santa Cruz	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Community Health Group—San Diego	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Contra Costa Health Plan—Contra Costa	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Health Net—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, Tulare	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Health Plan of San Joaquin—San Joaquin	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Health Plan of San Mateo—San Mateo	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Inland Empire Health Plan—Riverside, San Bernardino	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Kaiser Permanente (North)—Sacramento	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Kaiser Permanente (South)—San Diego	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Kern Family Health Care—Kern	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
LA Care Health Plan—Los Angeles	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Molina Healthcare—Sacramento, San Bernardino, San Diego, Riverside	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Partnership Health Plan—Napa, Solano, Yolo	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
San Francisco Health Plan—San Francisco	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Santa Clara Family Health Plan—Santa Clara	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*
Western Health Advantage—Sacramento	Reducing Avoidable Emergency Room Visits	Annual Submission	*NA*

Table 3.1—Medi-Cal Managed Care Program Quarterly QIP Activity from 7/1/2008 to 12/31/2008

(See page 3-4 for grid category explanations.)

Plan Name	Name of Project/Study	Type of Review*	Overall Validation Status*
Small-Group Collaborative (SGC) QIPs			
CalOptima—Orange	Appropriate Treatment for Children with Upper Respiratory Infection	Annual Submission	*NA*
Care 1st—San Diego	Appropriate Treatment for Children with Upper Respiratory Infection	Annual Submission	*NA*
Health Net—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, Tulare	Appropriate Treatment for Children with Upper Respiratory Infection	Annual Submission	*NA*
LA Care Health Plan—Los Angeles	Appropriate Treatment for Children with Upper Respiratory Infection	Annual Submission	*NA*
Care 1st—San Diego	Improving Treatment of Chronic Obstructive Pulmonary Disease (COPD)	Annual Submission	*NA*
Community Health Group—San Diego	Improving Treatment of Chronic Obstructive Pulmonary Disease (COPD)	Annual Submission	*NA*
Internal QIPs			
AHF Healthcare Centers—Los Angeles	Reducing Adverse Reactions to Coumadin for Patients with HIV/AIDS	Annual Submission	*NA*
AHF Healthcare Centers—Los Angeles	Controlling High Blood Pressure	Annual Submission	*NA*
Alameda Alliance for Health—Alameda	Decrease Return Emergency Room Visits for Asthmatic Exacerbations in Children 2–18	Annual Submission	*NA*
Anthem Blue Cross—Alameda, Contra Costa, Fresno, Sacramento, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	Improving Diabetes Management	Annual Submission	*NA*
CenCal Health—Santa Barbara	Proper Antibiotic Use	Annual Submission	*NA*
Central CA Alliance for Health**—Monterey, Santa Cruz	Improving Effective Case Management	Annual Submission	*NA*
Contra Costa Health Plan—Contra Costa	Reducing Health Disparities	Annual Submission	*NA*
Health Plan of San Joaquin—San Joaquin	Chlamydia Screening	Annual Submission	*NA*
Inland Empire Health Plan—Riverside, San Bernardino	Child Upper Respiratory Infections	Annual Submission	*NA*
Kaiser Permanente (North)—Sacramento	Childhood Obesity	Proposal	*NA*

Table 3.1—Medi-Cal Managed Care Program Quarterly QIP Activity from 7/1/2008 to 12/31/2008

	Plan Name	Name of Project/Study	Type of Review*	Overall Validation Status*
	Kaiser Permanente (South)—San Diego	Improving Blood Sugar Levels in Diabetic Members	Annual Submission	*NA*
	Kaiser PHP—Marin, Sonoma	Cervical Cancer Screening	Annual Submission	*NA*
	Kaiser PHP—Marin, Sonoma	Smoking Prevention	Annual Submission	*NA*
	Kern Family Health Care—Kern	Use of Immunization Registry for Children	Annual Submission	*NA*
	Partnership Health Plan—Napa, Solano, Yolo	Asthma Spread	Annual Submission	*NA*
	San Francisco Health Plan—San Francisco	Diabetes Care Management	Annual Submission	*NA*
	SCAN Health Plan—Los Angeles, Orange, San Bernardino, Riverside	Chronic Obstructive Pulmonary Disease (COPD)	Annual Submission	*NA*
	Western Health Advantage—Sacramento	Improving Timeliness of Prenatal and Postpartum Care	Annual Submission	*NA*

*Grid category explanations:

Type of Review—Indicates whether the review is a new proposal, annual submission, or resubmission.

Overall Validation Status—Populated from the individual QIP Validation Tool and based on the percentage scores and whether or not critical elements were *Met*, *Partially Met*, or *Not Met*. For this initial submission, HSAG reported the overall validation status as *Not Applicable* due to reasons previously discussed in this report.

**Central Coast Alliance for Health changed its name to Central CA Alliance for Health effective July 1, 2009.

The CMS protocol for conducting a QIP specifies 10 core activities. HSAG categorizes the core activities into three main stages, rather than assessing them separately, to examine strengths and opportunities for improvement across key areas. For each of the three types of QIPs—statewide collaboratives (SWCs), small-group collaboratives (SGCs), and internal quality improvement projects (IQIPs)—HSAG presents the 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
- Documenting appropriate improvement strategies

Quality Outcomes Achieved—CMS Protocol Activities VIII–X

- Presentation of sufficient data analysis and interpretation
- Evidence of real improvement achieved
- Data supporting sustained improvement achieved

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

DHCS Statewide Collaborative Specific Findings

The selected topic of the DHCS statewide collaborative QIP is "Reducing Avoidable Emergency Room Visits." Plans submitted a total of 24 statewide collaborative QIPs during the period from July 1, 2008, to December 31, 2008. Table 4.1 provides HSAG's findings for each activity within the CMS protocol. Appendix B includes a table of scoring for each evaluation element within the activities.

Table 4.1––Statewide Collaborative QIP Activity Findings* (N=24)

QIP Stages	Activity	*Met* Elements	*Partially Met/ Not Met* Elements
Study Design	**I: Appropriate Study Topic**	95%	5%
	II: Clearly Defined, Answerable Study Question(s)	0%	100%
	III: Clearly Defined Study Indicator(s)	60%	40%
	IV: Correctly Identified Study Population	32%	68%
Study Implementation	**V: Valid Sampling Techniques****	**	**
	VI: Accurate/Complete Data Collection	36%	64%
	VII: Appropriate Improvement Strategies	60%	40%
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	42%	58%
	IX: Real Improvement Achieved	44%	56%
	X: Sustained Improvement Achieved	**	**

* HSAG's findings are displayed as the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

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

Study Design

Activities I through IV are the preparatory stages of a QIP. They set the foundation upon which a plan transforms its knowledge of the health, functional status, or satisfaction of its members into meaningful QIPs through the quality improvement process.

The discussion below summarizes HSAG's findings for Activities I through IV.

Activity I. Appropriate Study Topic

Activity Summary: Overall, plans sufficiently met the criteria for the evaluation elements in Activity I. HSAG noted that some plans lacked specific data analysis to support the selection of the study topic. The CMS protocol requires that a plan document how the study topic is relevant to its Medi-Cal population.

The results from all six evaluation elements in Activity I strongly suggest that DHCS and the plans have an overall understanding of the constructs of a QIP topic and the documentation needed to select a QIP topic. Overall, plans received a *Met* finding for 95 percent of the applicable elements for this activity.

The lowest-scoring element, Evaluation Element 2, requires plans to document that they selected the study topic after conducting data collection and analysis (or that the State selected the study topic). For the collaborative QIP, DHCS selected the study topic after extensive consultation with the plans. However, the CMS protocol requires plans to determine the extent to which they considered their specific Medi-Cal member demographic characteristics, the prevalence of the chosen topic, or the need for a specific service.

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

Activity Summary: All plans lacked documentation of the two critical elements. Plans need to improve on stating the study question in simple terms and ensuring that the study question is answerable. *Note:* DHCS subsequently provided a study question for the SWC, which plans will include in their next status reports.

All plans submitted their QIP documentation using NCQA's QIA form, as directed by DHCS. The QIA form does not capture a study question, which meant plans submitting a QIA form were unlikely to include documentation of this critical evaluation element.

In addition, DHCS and participating plans had not formalized a study question at the time the QIP submissions were due. Once plans submit the DHCS-disseminated study question as part of their next status report, HSAG expects plans will meet criteria for Activity II.

Activity III. Clearly Defined Study Indicator(s)

Activity Summary: In general, plans demonstrated success with four of the seven study indicator elements. Plans clearly documented literature that supported the study indicators, had data available, used HEDIS® specifications when appropriate, and documented support for the collaborative-developed indicator.

In future QIP submissions, plans will need to better document codes used to define the study indicators.

Plans should include collaborative documentation for all codes used for emergency room visits and specify the year of the HEDIS specifications used.

Given that plans did not include a study question, HSAG could not determine if the study indicators aligned to answer the study question (a component of the CMS protocol).

Activity IV. Correctly Identified Study Population

Activity Summary: Most plans appropriately defined the study population; however, plans did not clearly document requirements for length of enrollment and mechanisms for ensuring that the study population captured all members to whom the study question applied.

In future QIP submissions, plans need to provide documentation related to length of enrollment for both indicators. When length of enrollment does not apply to a QIP, plans should document that continuous enrollment requirements are not applicable.

Because plans did not include a study question, HSAG could not determine if plans correctly identified the study population. When plans include the SWC study question in future QIP submissions, reviewers can then determine if the plans fully met the requirement.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Study Implementation

Activities V through VII reflect the implementation stage of a QIP. Through these activities, plans can improve the health, functional status, or satisfaction of their members. HSAG summarizes Activities V through VII below.

Activity V. Valid Sampling Techniques

Activity Summary: Plans did not use sampling techniques; therefore, HSAG did not need to assess this activity.

Activity VI. Accurate/Complete Data Collection

Activity Summary: All plans identified a data source, and nearly all plans included a timeline for the baseline and remeasurement data. With future submissions, plans need to identify all data elements for collection, provide a description of the data collection process, and provide an estimate of data completeness.

Activity VI, Accurate/Complete Data Collection, showed that plans identified the use of claims and encounter data for the study indicators.

Not all plans included codes to identify avoidable emergency room visits.

Plans can consider including HEDIS final audit reports to provide a description of how they collected the baseline and remeasurement data.

Plans also have an opportunity to provide an administrative data collection algorithm, flow charts, or a narrative description outlining the steps for collecting data from the data source, the data analysis process, and calculating study indicators.

Plans did not provide an estimate of data completeness. To receive a *Met* score for this element, plans need to provide evidence that data are 80 percent to 100 percent complete. Plans can submit claims lag reports, trending of provider submission rates, and policies and procedures regarding timeliness of claims and encounter data to support the estimate of data completeness.

Activity VII. Appropriate Improvement Strategies

Activity Summary: Results for the four elements in Activity VII varied among plans. Some plans demonstrated strength in presenting a causal/barrier analysis while others need to improve documentation of causal/barrier analysis activities.

Many plans appropriately included a causal/barrier analysis in the form of a fishbone diagram or other quality improvement tools. Some plans used the results of plan-specific surveys administered to both Medi-Cal plan members and contracted providers to identify barriers. Most plans successfully identified barriers. However, many plans did not link their interventions to an identified cause/barrier, or they did not appropriately time their causal/barrier analysis following baseline data collection and before implementing interventions.

While many plans documented interventions likely to induce permanent change, they did not completely describe the interventions. Plans may have been challenged with meeting this element since statewide collaborative interventions were not completely introduced or implemented prior to the first remeasurement period. Plans implementing plan-specific interventions were more successful with meeting these activity elements.

Quality Outcomes Achieved

Activities VIII through X assess if plans achieved quality outcomes. These activities require plans to assess, standardize, and monitor improvement of members' health, functional status, or satisfaction.

Activity VIII. Sufficient Data Analysis and Interpretation

Activity Summary: Overall, plans need to improve in eight of the nine elements within Activity VIII. While plans did well identifying initial measurement and remeasurement of the study indicators, they can improve by including a data analysis plan, providing external factors that threaten validity, interpreting findings, and using statistical testing.

For Activity VIII, the first evaluation elements are also the activity's two critical elements. The first element assesses if plans conducted data analysis according to their data analysis plan; the other is not applicable because plans did not use sampling techniques. Because plans did not include a data analysis plan, they were not compliant with this critical element. HSAG encourages plans to submit a data analysis plan that describes how they will calculate the

study indicators, compare the results to the goals and benchmarks, and document the statistical test the plans will use to determine statistical differences between the measurement periods.

Few plans included factors that threatened the internal or external validity of the findings. Examples of these factors are: changes in data collection staff or processes, use of a new vendor, implementation of new data systems, or the absorption of another plan's members. Plans should document if no such factors exist. While half of the plans provided some interpretation of the findings, the remaining plans have the opportunity to include this discussion.

Using statistical significance testing between the initial and remeasurement period(s) is an area where plans have an opportunity for substantial improvement. Most plans did not include statistical testing. Plans that did include statistical testing need to include additional information, including documentation of the statistical test used and enough documentation to replicate results.

Activity IX. Real Improvement Achieved

Activity Summary: While plans appropriately applied the same methodology for the baseline and remeasurement periods, they have the opportunity to demonstrate real improvement by using statistical testing.

HSAG assessed only one of the two QIP indicators for improvement when evaluating this activity. The collaborative-developed *Avoidable ER Visits* indicator measures those visits which could have been more appropriately managed and/or referred to a primary care provider in an office or clinic setting and is the QIP's focus.

The other collaborative indicator measures emergency room visits per member months, consistent with HEDIS methodology, and is necessary to calculate the *Avoidable ER Visits* rate. However, decreasing overall emergency room visits is not within the plans' control because so many factors impact this rate. Therefore, HSAG did not evaluate the HEDIS ER visits indicator for improvement during QIP validation.

Plans need to determine if they achieved "real" improvement in their *Avoidable ER Visits* rate by using statistical testing between the baseline and remeasurement years.

Activity X. Sustained Improvement Achieved

Activity Summary: HSAG did not evaluate this activity because the study had not progressed to a second remeasurement.

Statewide Collaborative QIP Strengths and Opportunities for Improvement

Medi-Cal managed care plans have both strengths and opportunities for improvement in their statewide collaborative QIPs. Of the 24 QIPs reviewed, none was in full compliance with the CMS requirements.

Strengths include many instances in which plans presented the interventions well. Targeted case management and pay for performance are strong interventions that are likely to demonstrate improvement. Many plans used quality improvement tools such as fishbone diagrams, flow charts, and intervention tables to document activities within their QIPs appropriately. The majority of plans documented consistent timelines throughout their QIPs.

Plans have an overall opportunity to improve their QIPs by providing more detailed documentation for required activities and attaching supporting documentation where indicated. Using statistical testing between baseline and remeasurement is also a significant area with an opportunity for improvement.

Statewide Collaborative QIP Recommendations

Based on its validation findings, HSAG recommends that:

- Plans transition from using the QIA form to using HSAG's QIP Summary Form, which supports plans in documenting all QIP requirements, including the study question. *Note:* DHCS has required that all plans begin using this form by July 1, 2009.
- DHCS or the collaborative work group develop a study question for the SWC and make it available to all participating collaborative plans. The collaborative work group can submit the study question to the EQRO for review prior to the next annual QIP submission. *Note:* DHCS distributed the formal, EQRO-reviewed study question to all plans for use in the next status report, due in October 2009.
- DHCS require that plans report the HEDIS *ER Visits* rate as a calculation indicator only since the collaborative and the plans cannot control many of the factors that impact the *ER Visits* rate. HSAG further recommends measuring the success of the collaborative based on the collaborative-developed *Avoidable ER Visits* rate. *Note:* DHCS has implemented these recommendations.

- DHCS consider revising and extending the SWC QIP reporting time frames since the statewide collaborative interventions were not fully developed and ready for plan implementation until late 2008 and early 2009. A revised time frame would provide DHCS and the plans an opportunity to measure the success of the collaborative interventions. *Note*: DHCS revised and extended the SWC QIP reporting time frames.

Small-Group Collaborative Specific Findings

During the reporting period, the plans submitted a total of six SGC QIPs. Four of the SGC QIPs targeted appropriate treatment for children with upper respiratory infection (URI), and two sought to improve treatment of chronic obstructive pulmonary disease (COPD). Table 4.2 provides HSAG's findings for each activity within the CMS protocol for conducting QIPs. Appendix B includes scoring for each activity element. Low percentages displayed for *Met* elements are the result of the transition to more rigorous validation requirements. DHCS expects steady improvement as plans benefit from the new QIP Summary Form and HSAG's technical assistance.

Table 4.2––Small-Group Collaborative QIP Activity Findings* (N=6)

QIP Stages	Activity	*Met* Elements	*Partially Met/ Not Met* Elements
Study Design	**I: Appropriate Study Topic**	95%	5%
	II: Clearly Defined, Answerable Study Question(s)	17%	83%
	III: Clearly Defined Study Indicator(s)	58%	42%
	IV: Correctly Identified Study Population	17%	83%
Study Implementation	**V: Valid Sampling Techniques****	**	**
	VI: Accurate/Complete Data Collection	25%	75%
	VII: Appropriate Improvement Strategies	62%	38%
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	42%	58%
	IX: Real Improvement Achieved	92%	8%
	X: Sustained Improvement Achieved	**	**

* HSAG's findings are displayed as the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

** HSAG assessed no QIPs for this activity/evaluation element.

Study Design

HSAG summarizes the validation findings for Activities I through IV for SGC QIPs below.

Activity I. Appropriate Study Topic

Activity Summary: Overall, plans sufficiently met the criteria for the evaluation elements in Activity I, Appropriate Study Topic.

Activity I results show that the plans provided documentation to support the selection of the collaborative QIP topics. The selected study topics focus on care of acute and chronic conditions.

The plans that did not fully meet all evaluation elements had inconsistencies between the cited HEDIS specifications and documentation of the eligible population used, and/or they lacked documentation as to whether the study population included or excluded members with special health care needs. While many of the HEDIS specifications imply that the study population will not exclude members with special health care needs, plans should explicitly document the inclusion/exclusion of these members within their QIPs.

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

Activity Summary: Only one plan provided a study question; the remaining six plans did not. Overall, HSAG encourages plans to improve in this area by stating the study question in simple terms and ensuring that the study question is answerable.

The results for Activity II show that most plans did not include a study question. For all QIPs submitted for the period, plans documented QIPs using NCQA's QIA form. Because the form does not capture a study question, plans were unlikely to document this information. HSAG expects that plans will include an answerable study question in future QIP submissions as a result of DHCS's requirement that plans use HSAG's QIP Summary Form by July 2009.

Activity III. Clearly Defined Study Indicator(s)

Activity Summary: In general, plans demonstrated success with three of the seven indicator elements. All plans had data available and used HEDIS specifications when appropriate. Most plans documented practice guidelines that supported the selection of study indicators. Plans should more clearly define the study indicators by documenting the codes used and providing details on internally developed measures. Since plans did not include a study question, HSAG could not determine if the study indicators aligned to answer the study question.

Activity III results revealed opportunities to improve several elements to enhance plans' success with the overall activity. For both SGC projects, plans should document codes used from the HEDIS specifications. Plans should include pharmacy codes for QIPs that address inappropriate treatment of URIs. Some plans used inconsistent measurement periods for the baseline and remeasurement periods for QIPs that addressed COPD.

Some URI QIPs reported an internally developed indicator but did not include the basis upon which the plans adopted the indicator. In addition, one URI study indicator did not appear to align with the intent of the QIP. HSAG recommended that the plan remove this indicator from the QIP and use the indicator for internal monitoring.

Once plans develop and submit a study question, HSAG will be able to assess whether the study indicators measure outcomes in health or functional status.

Activity IV. Correctly Identified Study Population

Activity Summary: Plans lacked documentation to support an appropriately defined study population. Plans can improve compliance by documenting enrollment criteria.

Within the HEDIS specifications, plans should provide documentation that gives information on the eligible population, including length of enrollment and any allowable gaps in enrollment. Without a study question, HSAG could not evaluate whether the study population included members to whom the study question applied.

Study Implementation

The discussion below summarizes HSAG's validation findings for Activities V through VIII for SGC QIPs:

Activity V. Valid Sampling Techniques

Activity Summary: HSAG did not assess QIPs for this activity because plans did not use sampling techniques.

Activity VI. Accurate/Complete Data Collection

Activity Summary: All plans identified the source of data, and most plans provided a timeline for baseline and remeasurement data collection. However, all plans should identify all data elements for data collection and provide a description of the data collection process.

Plans could increase compliance with Activity VI evaluation elements by documenting the data collection process more thoroughly. For QIPs that use audited HEDIS indicators, plans should submit a copy of the final audit report to demonstrate that a HEDIS measure has gone through validation for data accuracy and completeness. Plans should include an administrative data collection algorithm that documents steps in the data collection process and that includes information on data analysis and indicator calculation. Plans that undergo a performance measure audit (such as an NCQA HEDIS Compliance Audit™) can include the same information used to populate the NCQA *RoadMap* section on data collection for the HEDIS audit.

Only one plan documented the use of a manual data collection process, but did not provide the data collection tool and instructions. Plans that conduct data abstraction also should include information about the qualifications of the data abstraction staff.

NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

Activity VII. Appropriate Improvement Strategies

Activity Summary: Plans demonstrated system interventions that are likely to induce permanent change. Plans that submitted a causal/barrier analysis appropriately linked the intervention to a barrier. Plans need to improve on standardizing interventions and monitoring their success.

Not all submitted QIPs had progressed to the point of revising the original interventions, if needed. However, plans will need to assess the success of interventions with each remeasurement period.

Quality Outcomes Achieved

The discussion below summarizes the SGC QIP validation findings for Activities VIII through X.

Activity VIII. Sufficient Data Analysis and Interpretation

Activity Summary: Plans successfully presented data in an accurate, clear, and easily understood manner. Overall, plans could improve by including a data analysis plan, providing factors that threaten validity, and interpreting findings.

For Activity VIII, only one plan included a data analysis plan—a critical element that QIPs must meet to achieve an overall *Met* status. Only three of the six SGC QIPs have progressed beyond baseline reporting; therefore, HSAG did not assess many elements within this activity. Plans should be prepared to fully document each of the nine evaluation elements in the next annual submission to increase overall compliance with this activity.

Feedback provided under Activity VIII of the ER collaborative regarding data analysis and interpretation is relevant to the SGC QIPs.

Activity IX. Real Improvement Achieved

Activity Summary: QIPs assessed for this activity successfully used the same methodology, demonstrated improvement as a result of planned interventions, and provided statistical evidence to support true improvement.

HSAG found that plans did well with Activity IX and so did not identify opportunities for improvement.

Activity X. Sustained Improvement Achieved

Activity Summary: HSAG did not assess SGC QIPs for this activity because QIPs have not yet progressed to a second remeasurement period.

SGC QIP Strengths and Opportunities for Improvement

SGC QIPs demonstrated many strengths as well as opportunities for improvement. None of the SGC QIPs reviewed fully met CMS requirements.

HSAG noted strengths such as collaboration among several different Medi-Cal managed care model types, including County-Organized Health System (COHS) plans, Geographic Managed Care (GMC) plans, and commercial and local initiative plans within the Two-Plan Model. In addition, the selected project topics focused on quality of care for acute and chronic conditions and could result in improved functional status and health outcomes for many Medi-Cal managed care enrollees.

Most areas identified as opportunities for improvement lacked documentation to fully support the evaluation elements and address all 10 CMS protocol activities.

SGC QIP Recommendations

HSAG recommends that:

- DHCS transition plans from using NCQA's QIA form to a form that supports collection of all required CMS protocol activities. *Note:* DHCS has required that plans use HSAG's QIP Summary Form beginning July 2009.
- Plans share validation feedback and ideas for addressing opportunities for improvement within their collaborative groups as a way to strengthen each SGC QIP.
- Since SGCs have not yet progressed to Step X of the CMS protocols, plans can work within their respective collaborative groups to discuss the documentation needed to satisfy the evaluation element criteria for Step X before the next annual submission.

Internal Quality Improvement Project Specific Findings

Table 4.3––Internal QIP Activity Findings* (N=18 IQIPs)

QIP Stages	Activity	*Met* Elements	*Partially Met/ Not Met* Elements
Study Design	**I: Appropriate Study Topic**	91%	9%
	II: Clearly Defined, Answerable Study Question(s)	3%	97%
	III: Clearly Defined Study Indicator(s)	60%	40%
	IV: Correctly Identified Study Population	15%	85%
Study Implementation	**V: Valid Sampling Techniques**	37%	63%
	VI: Accurate/Complete Data Collection	35%	65%
	VII: Appropriate Improvement Strategies	64%	36%
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	39%	61%
	IX: Real Improvement Achieved	27%	73%
	X: Sustained Improvement Achieved	36%	64%

* HSAG's findings are displayed as the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

Study Design

The following discussion summarizes HSAG's validation findings for IQIPs for Activities I through IV.

Activity I. Appropriate Study Topic

Activity Summary: Overall, the plans sufficiently met the criteria for the evaluation elements in Activity I, Appropriate Study Topic.

The 18 study topics selected for IQIPs reflect a broad range of clinical topics addressing primary prevention, secondary prevention, risk reduction, management of acute and chronic disease, reducing adverse events, reducing health disparities, improving coordination of care, and promoting practice guidelines to improve quality of care. All selected topics have the potential to affect member health, functional status, or satisfaction.

For the few plans that either did not meet or partially met an element, their greatest opportunity for improvement was in documenting if members with special health care needs were included or excluded, providing additional documentation on the eligible population, and/or including the rationale for the study topic using plan-specific data.

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

> **Activity Summary:** Only one plan provided a study question, and no plan provided a study question that was answerable.

The results for Activity II were consistent with the results for all QIPs submitted for this period (a study question was not included).

Activity III. Clearly Defined Study Indicator(s)

> **Activity Summary:** Plans successfully *Met* many of the indicator elements within Activity III. Plans have an opportunity to improve by clearly documenting all codes and including HEDIS specifications when appropriate. Plans missed a critical element because they did not submit a study question. The omission of study questions also impacted HSAG's ability to determine if the study indicators measured member health outcomes.

Plans can improve compliance by documenting the HEDIS specifications used and specifying the year. While some plans documented use of HEDIS specifications, reviewers noted small deviations from the cited HEDIS specifications. Plans that choose to modify HEDIS specifications should clearly outline these modifications and provide a rationale for the changes.

Some plan-developed study indicators appeared to measure the effectiveness of an intervention versus measuring outcomes in health or functional status. HSAG recommends that plans use these indicators for internal program monitoring and omit them as QIP indicators. Once plans document a study question, they should review their study indicators to determine what each indicator is measuring and then simplify the QIP to include only those indicators that answer the study question.

Activity IV. Correctly Identified Study Population

> **Activity Summary:** Plans overall lacked documentation to support an appropriately defined study population. Plans have an opportunity to document enrollment information to include length of enrollment and eligibility gaps.

Many of the submitted IQIPs had multiple remeasurement years. Plans should update HEDIS specifications for each year the study progresses.

Study Implementation

HSAG includes findings for IQIP Activities V through VII below.

Activity V. Valid Sampling Techniques

Activity Summary: Most plans using sampling techniques successfully specified the true or estimated frequency of the occurrence and identified the sample size. Plans could improve by documenting the confidence level and margin of error and providing more detail on the process of sampling to determine if the sample represents the eligible population.

This activity applies only to the four QIPs that used sampling techniques. Plans generally lacked documentation on the sampling process that would demonstrate that the sample represented the eligible population. Plans using HEDIS methodology can provide final audit reports to support that the plan used valid sampling techniques. If plans use a certified HEDIS software vendor, they can include a copy of their vendor's certified software seal, which demonstrates a successful audit review of the vendor's methodology for sampling techniques. Plans also should provide the actual population size for the measurement period instead of an estimate.

Activity VI. Accurate/Complete Data Collection

Activity Summary: All plans identified the source of data and provided a timeline for baseline and remeasurement data collection. However, all plans have an opportunity to identify the data elements for collection, provide a description of the data collection process, and estimate the degree of data completeness.

Similar to HSAG's findings for collaborative QIP and small-group collaborative QIP submissions, plans have an opportunity to provide an administrative data collection algorithm, flow charts, or a narrative description outlining the steps for collecting data from the data source, the data analysis process, and for calculating study indicators.

Activity VII. Appropriate Improvement Strategies

> **Activity Summary:** Most plans successfully demonstrated system interventions likely to induce permanent change. Plans have an opportunity to more thoroughly document the link between their interventions and the identified causes/barriers, revise or add interventions if the remeasurement periods did not change, and include a discussion on standardizing and monitoring successful interventions.

Not all plans were able to link their interventions to causes/barriers. In some cases, plans that appropriately linked interventions to causes/barriers lacked documentation of the quality improvement process they used to identify the barriers. Some plans did not implement interventions prior to the first remeasurement period. Plans should initiate interventions after the baseline period and before the first remeasurement period, and they should include a discussion about delays in interventions or why they did not implement interventions.

When improvement does not occur between measurement periods, plans should include a discussion about revising or adding new interventions. When improvement does occur between measurement periods, plans should include a discussion about standardizing and monitoring interventions.

Quality Outcomes Achieved

The discussion below presents validation findings for Activities VIII through X:

Activity VIII. Sufficient Data Analysis and Interpretation

> **Activity Summary:** Plans have an opportunity to improve eight of the nine evaluation elements to demonstrate sufficient data analysis and interpretation. Plans appropriately identified the measurement of the study indicators but did not include a data analysis plan and interpretation.

For Activity VIII, no plan included a data analysis plan. Most plans need to include factors that threaten the validity of the findings and provide an interpretation of the data findings. Plans should use statistical testing between measurement periods and explain the extent of the study's success.

Feedback provided under Activity VIII of the ER collaborative regarding data analysis and interpretation also is relevant to the IQIPs.

Activity IX. Real Improvement Achieved

Activity Summary: Overall, QIPs assessed for this activity successfully used the same methodology between baseline and remeasurement. Plans have opportunities for improvement in the following areas: documenting improvement in outcomes of care, demonstrating improvement as a result of planned interventions, and using statistical evidence to show "real" improvement.

Many QIPs had multiple study indicators, with improvement demonstrated for some indicators and not for others. In addition, plans demonstrated improvement between some measurement periods and showed a decrease for others. HSAG reviewed results across all measurement periods since this was HSAG's first validation review of Medi-Cal managed care plans' QIPs. In the future, HSAG will validate only the most recent measurement period.

Some plans demonstrated statistical improvement, but they should have included the statistical test used to compare rates between measurement periods in addition to including the significance of the test.

Activity X. Sustained Improvement Achieved

Activity Summary: Of the QIPs assessed for sustained improvement, 36 percent achieved sustained improvement (or they showed a decline that was not statistically significant), while 64 percent did not demonstrate sustained improvement.

QIPs achieve sustained improvement when they have two or more remeasurement results that are better than the baseline result without a statistically significant decrease between remeasurement periods. Many plans received a *Partially Met* finding for demonstrating sustained improvement for some indicators, but they were not able to demonstrate improvement for all indicators. As plans become compliant with the CMS protocol, HSAG anticipates that the QIPs will demonstrate sustained improvement.

The typical design of a QIP includes a baseline reporting period and two remeasurement periods. Several of the internal QIPs have progressed to Activity X with additional periods of remeasurement for the third and fourth years. Results range from *Met* and *Partially Met* to *Not Met* for sustained improvement among these QIPs.

Internal QIP Strengths and Opportunities for Improvement

The plans demonstrated many strengths among their internal QIPs, presenting diverse project topics aimed at a broad spectrum of clinical services. Many of the internal QIPs have progressed to measuring for "real" and sustained improvement. Four plans have demonstrated sustained improvement in study topics that include reducing health disparities by increasing the well-child visit rate among African-American and Hispanic children, providing appropriate treatment for children with URI, improving childhood immunization rates through the use of an immunization registry for children, and improving appropriate screening and monitoring of adults with diabetes.

Opportunities exist to improve compliance with CMS protocol activities by transitioning to a reporting form that supports collection of the required elements for QIP validation. Plans also should conduct statistical testing between measurement years.

Internal QIP Recommendations

HSAG recommends that DHCS consider having plans transition from using the QIA form to a form that supports the collection of all required CMS protocol activities. *Note:* DHCS requires that plans use HSAG's QIP Summary Form beginning July 2009.

DHCS and HSAG should explore barriers to plans conducting statistical testing between measurement years to determine if plans may benefit from technical assistance. *Note:* DHCS released the *Quality Improvement Assessment Guide for Medi-Cal Managed Care Plans* in May 2009. HSAG has provided technical assistance to several plans related to statistical testing. The guide also includes resources for more information about statistical testing.

DHCS should consider requiring plans to "sunset" QIPs after two remeasurement periods. Sunsetting a QIP, or terminating it, allows plans to address new opportunities for improvement.

Conclusions—Overall QIP Validation Findings

All QIP types had similar percentages of *Met, Partially Met,* and *Not Met* evaluation elements for each of the 10 CMS protocol activities. HSAG includes a comparison chart in Appendix C.

Of the 48 QIPs reviewed from July 1, 2008, through December 31, 2008, none was fully compliant with CMS requirements. HSAG's QIP validation criteria, while aligned with the CMS protocol, are more stringent than criteria used in previous QIP validation. HSAG noted

that DHCS required plans to document and submit QIPs using a form that did not support documentation by plans to address all required CMS protocol activities.

HSAG will work with DHCS and the plans to develop an approach to help plans comply with the CMS protocol and HSAG's validation requirements. *Note:* HSAG's next quarterly QIPs status report will discuss technical assistance activities that occurred after the period covered by this report.

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

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

Table A.1––DHCS Statewide Collaborative QIPs
(See page A-8 for grid category explanations.)

	Plan Name	Plan Model Type	Clinical/ Non-Clinical*	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, Sacramento, San Diego, San Francisco, San Joaquin, Santa Clara, 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 CA 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, Sacramento, San Diego, Stanislaus, Tulare	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

Table A.1––DHCS Statewide Collaborative QIPs
(See page A-8 for grid category explanations.)

	Plan Name	Plan Model Type	Clinical/ Non-Clinical*	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
	LA Care Health Plan—Los Angeles	LI			I – IX	Remeasurement 1
	Molina Healthcare—Riverside, San Bernardino, San Diego, Sacramento	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 (SGC) QIPs

(See page A-8 for grid category explanations.)

	Plan Name	Plan Model Type*	Name of Project/Study	Clinical/ Non-Clinical*	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 – IX	Remeasurement 1
	Care 1st—San Diego	GMC				I – VIII	Baseline
	Health Net—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, Tulare	CP, GMC				I – IX	Remeasurement 1
	LA Care Health Plan—Los Angeles	LI				I – IX	Remeasurement 1
	Molina Healthcare—Riverside, San Bernardino, Sacramento, San Diego	CP, GMC				I – IX	Remeasurement 1
	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 – VIII	Baseline

Table A.3––Internal QIPs

(See page A-8 for grid category explanations.)

Plan Name	Plan Model Type*	Name of Project/Study	Clinical/ Non-Clinical*	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 hospitalizations for GI bleeds due to interaction of warfarin for active patients.	I – IX	Remeasurement 1
AHF Healthcare Centers—Los Angeles	SP	Controlling High Blood Pressure	Clinical	Increase the percentage 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 number of children ages 2–18 who visited the ER with asthma from returning to the ER with additional asthmatic events.	I – VIII	Baseline
Anthem Blue Cross—Alameda, Contra Costa, Fresno, Sacramento, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	CP, GMC, LI	Improving Diabetes Management	Clinical	Increase the HEDIS rates of HbA1c screening and diabetic retinal eye exams among adults 21–65 years of age.	I – X	Remeasurement 4
CenCal Health—Santa Barbara	COHS	Proper Antibiotic Use	Clinical	Decrease inappropriate antibiotic prescribing for children 2–18 years of age.	I – X	Remeasurement 2
Central CA Alliance for Health**—Monterey, Santa Cruz	COHS	Improving Effective Case Management	Clinical	Increase 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
Community Health Group—San Diego	GMC	Increasing Follow-up to Positive Post-Partum Screens	Clinical	Increase the percentage of women receiving a postpartum visit within six months of delivery.	I – VIII	Baseline

Table A.3––Internal QIPs

(See page A-8 for grid category explanations.)

Plan Name	Plan Model Type*	Name of Project/Study	Clinical/ Non-Clinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
Contra Costa Health Plan—Contra Costa	LI	Reducing Health Disparities	Clinical	Improve childhood immunization rates and well-care visits in first 15 months of life for African American and Hispanic children.	I – X	Remeasurement 4
Contra Costa Health Plan—Contra Costa	LI	Reducing Health Disparities	Clinical	Reduce health disparities in childhood obesity among children 3–11 years of age.	None	Proposal Pending
Health Plan of San Joaquin—San Joaquin	LI	Chlamydia Screening	Clinical	Increase the rate of chlamydia screening in sexually active women ages 16–25.	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 – VIII	Baseline
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	Remeasurement 2
Kaiser Permanente (North)—Sacramento	GMC	Childhood Obesity	Clinical	Identify and decrease the number of children ages 3–11 with BMI in the at-risk for overweight and overweight category.	I – VI	Proposal
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	Remeasurement 4
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

Table A.3––Internal QIPs

(See page A-8 for grid category explanations.)

Plan Name	Plan Model Type*	Name of Project/Study	Clinical/ Non-Clinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
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 under.	I – X	Remeasurement 3
Partnership Health Plan—Napa, Solano, Yolo	COHS	Asthma Spread	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	Remeasurement 2
Santa Clara Family Health—Santa Clara	LI	Adolescent Obesity Prevention: Increase Screening and Improve Adolescent Health With Timely and Appropriate Health Education Interventions	Clinical	Increase screening for adolescent obesity and timeliness of appropriate health education intervention.	I – VIII	Baseline
SCAN Health Plan—Los Angeles, Orange, San Bernardino, Riverside	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, Orange, San Bernardino, Riverside	SP	Prevention of Stroke and Transient Ischemic Attack (TIA)	Clinical	Reduce risk of stroke or Transient Ischemic Attack (TIA) and recurrence.	None	Proposal Pending
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	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 (LI)
  - Commercial plan (CP)
- Specialty plan (SP)

Clinical/Non-Clinical – designates if the QIP addresses a clinical or non-clinical area of study.

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

Level of QIP Progress – provides the current 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.

**Central Coast Alliance for Health changed its name to Central CA Alliance for Health effective July 1, 2009.

Table B.1—Statewide Collaborative QIP Activities I to IV Ratings (N = 24 QIPs)

	Evaluation Elements	Met	Partially Met/ Not Met	NA/Not Assessed
Activity I: Appropriate Study Topic				
	1. Reflects high-volume or high-risk conditions (or was selected by the State).	100%	0%	0%
	2. Is selected following collection and analysis of data (or was selected by the State).	71%	29%	0%
	3. Addresses a broad spectrum of care and services (or was selected by the State).	96%	4%	0%
	4. Includes all eligible populations that meet the study criteria.	100%	0%	0%
	5. Does not exclude members with special health care needs.	100%	0%	0%
C*	6. Has the potential to affect member health, functional status, or satisfaction.	100%	0%	0%
	Activity Average Rates**	**95%**	**5%**	**-**
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	0%	100%	0%
C*	2. Is answerable.	0%	100%	0%
	Activity Average Rates**	**0%**	**100%**	**-**
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	13%	87%	0%
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	100%	0%	0%
C*	3. Allow for the study questions to be answered.	0%	100%	0%
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	13%	87%	0%
C*	5. Have available data that can be collected on each indicator.	100%	0%	0%
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	100%	0%	0%
	7. Includes the basis on which each indicator was adopted, if internally developed.	96%	4%	0%
	Activity Average Rates**	**60%**	**40%**	-
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	87%	13%	0%
	2. Includes requirements for the length of a member's enrollment in the plan.	8%	92%	0%
C*	3. Captures all members to whom the study question applies.	0%	100%	0%
	Activity Average Rates**	**32%**	**68%**	**-**

Notes to Table:

NA is *Not Applicable*.

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

**The activity average rate represents the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

Table B.2—Statewide Collaborative QIP Activities V to VII Ratings (N = 24 QIPs)

	Evaluation Elements	Met	Partially Met/ Not Met	NA/Not Assessed
Activity V: Valid Sampling Techniques				
	1. Consider and specify the true or estimated frequency of occurrence.	Δ	Δ	100%
	2. Identify the sample size.	Δ	Δ	100%
	3. Specify the confidence level.	Δ	Δ	100%
	4. Specify the acceptable margin of error.	Δ	Δ	100%
C*	5. Ensure a representative sample of the eligible population.	Δ	Δ	100%
	6. Are in accordance with generally accepted principles of research design and statistical analysis.	Δ	Δ	100%
	Activity Average Rates**	Δ	Δ	-
Activity VI: Accurate/Complete Data Collection				
	1. The identification of data elements to be collected.	13%	87%	0%
	2. The identification of specified sources of data.	100%	0%	0%
	3. A defined and systematic process for collecting baseline and remeasurement data.	8%	92%	0%
	4. A timeline for the collection of baseline and remeasurement data.	96%	4%	0%
	5. Qualified staff and personnel to abstract manual data.	0%	4%	96%
C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	0%	4%	96%
	7. A manual data collection tool that supports interrater reliability.	0%	4%	96%
	8. Clear and concise written instructions for completing the manual data collection tool.	0%	4%	96%
	9. An overview of the study in written instructions.	0%	4%	96%
	10. Administrative data collection algorithms/flowcharts that show activities in the production of indicators.	4%	96%	0%
	11. An estimated degree of automated data completeness.	0%	96%	4%
	Activity Average Rates**	**36%**	**64%**	-
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	58%	42%	0%
	2. System changes that are likely to induce permanent change.	71%	29%	0%
	3. Revised if original interventions are not successful.	29%	13%	58%
	4. Standardized and monitored if interventions were successful.	4%	25%	71%
	Activity Average Rates**	**60%**	**40%**	-

Notes to Table:

NA is *Not Applicable*.

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

**The activity average rate represents the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

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

Table B.3—Statewide Collaborative QIP Activities VIII to X Ratings (N = 24 QIPs)

	Evaluation Elements	Met	Partially Met/ Not Met	NA/Not Assessed
Activity VIII: Sufficient Data Analysis and Interpretation				
C*	1. Is conducted according to the data analysis plan in the study design.	0%	100%	0%
C*	2. Allows for the generalization of the results to the study population if a sample was selected.	0%	0%	100%
	3. Identifies factors that threaten the internal or external validity of the findings.	25%	75%	0%
	4. Includes an interpretation of the findings.	50%	50%	0%
	5. Is presented in a way that provides accurate, clear, and easily understood information.	63%	37%	0%
	6. Identifies initial measurement and remeasurement of study indicators.	88%	4%	8%
	7. Identifies statistical differences between initial measurement and remeasurement.	8%	84%	8%
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	25%	67%	8%
	9. Includes interpretation of the extent to which the study was successful.	67%	25%	8%
	Activity Average Rates**	**42%**	**58%**	**-**
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	92%	0%	8%
	2. There is documented improvement in processes or outcomes of care.	42%	50%	8%
	3. The improvement appears to be the result of planned intervention(s).	25%	67%	8%
	4. There is statistical evidence that observed improvement is true improvement.	4%	88%	8%
	Activity Average Rates**	**44%**	**56%**	**-**
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	100%
	Activity Average Rates**	Δ	Δ	-

Notes to Table:

NA is *Not Applicable*.

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

**The activity average rate represents the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

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

Table B.4—Small-Group Collaborative QIP Activities I to IV Ratings (N = 6 QIPs)

	Evaluation Elements	Met	Partially Met/ Not Met	NA/Not Assessed
Activity I: Appropriate Study Topic				
	1. Reflects high-volume or high-risk conditions (or was selected by the State).	100%	0%	0%
	2. Is selected following collection and analysis of data (or was selected by the State).	67%	33%	0%
	3. Addresses a broad spectrum of care and services (or was selected by the State).	100%	0%	0%
	4. Includes all eligible populations that meet the study criteria.	100%	0%	0%
	5. Does not exclude members with special health care needs.	100%	0%	0%
C*	6. Has the potential to affect member health, functional status, or satisfaction.	100%	0%	0%
	Activity Average Rates**	**95%**	**5%**	**-**
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	17%	83%	0%
C*	2. Is answerable.	17%	83%	0%
	Activity Average Rates**	**17%**	**83%**	**-**
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	0%	100%	0%
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	100%	0%	0%
C*	3. Allow for the study questions to be answered.	0%	100%	0%
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	0%	100%	0%
C*	5. Have available data that can be collected on each indicator.	100%	0%	0%
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	100%	0%	0%
	7. Includes the basis on which each indicator was adopted, if internally developed.	17%	66%	17%
	Activity Average Rates**	**58%**	**42%**	**-**
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	17%	83%	0%
	2. Includes requirements for the length of a member's enrollment in the plan.	33%	67%	0%
C*	3. Captures all members to whom the study question applies.	0%	100%	0%
	Activity Average Rates**	**17%**	**83%**	**-**

Notes to Table:

NA is *Not Applicable*.

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

**The activity average rate represents the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

Table B.5—Small-Group Collaborative QIP Activities V to VII Ratings (N = 6 QIPs)

	Evaluation Elements	Met	Partially Met/ Not Met	NA/Not Assessed
Activity V: Valid Sampling Techniques				
	1. Consider and specify the true or estimated frequency of occurrence.	Δ	Δ	100%
	2. Identify the sample size.	Δ	Δ	100%
	3. Specify the confidence level.	Δ	Δ	100%
	4. Specify the acceptable margin of error.	Δ	Δ	100%
C*	5. Ensure a representative sample of the eligible population.	Δ	Δ	100%
	6. Are in accordance with generally accepted principles of research design and statistical analysis.	Δ	Δ	100%
	Activity Average Rates**	Δ	Δ	-
Activity VI: Accurate/Complete Data Collection				
	1. The identification of data elements to be collected.	0%	100%	0%
	2. The identification of specified sources of data.	100%	0%	0%
	3. A defined and systematic process for collecting baseline and remeasurement data.	0%	100%	0%
	4. A timeline for the collection of baseline and remeasurement data.	67%	33%	0%
	5. Qualified staff and personnel to abstract manual data.	0%	17%	83%
C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	0%	17%	83%
	7. A manual data collection tool that supports interrater reliability.	0%	17%	83%
	8. Clear and concise written instructions for completing the manual data collection tool.	0%	17%	83%
	9. An overview of the study in written instructions.	0%	17%	83%
	10. Administrative data collection algorithms/flowcharts that show activities in the production of indicators.	0%	100%	0%
	11. An estimated degree of automated data completeness.	0%	17%	83%
	Activity Average Rates**	**25%**	**75%**	-
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	50%	33%	17%
	2. System changes that are likely to induce permanent change.	83%	0%	17%
	3. Revised if original interventions are not successful.	0%	0%	100%
	4. Standardized and monitored if interventions were successful.	0%	50%	50%
	Activity Average Rates**	**62%**	**38%**	-

Notes to Table:

NA is *Not Applicable*.

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

**The activity average rate represents the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

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

Table B.6—Small-Group Collaborative QIP Activities VIII to X Ratings (N = 6 QIPs)

	Evaluation Elements	Met	Partially Met/ Not Met	NA/Not Assessed
Activity VIII: Sufficient Data Analysis and Interpretation				
C*	1. Is conducted according to the data analysis plan in the study design.	17%	83%	0%
C*	2. Allows for the generalization of the results to the study population if a sample was selected.	0%	0%	100%
	3. Identifies factors that threaten the internal or external validity of the findings.	0%	100%	0%
	4. Includes an interpretation of the findings.	17%	83%	0%
	5. Is presented in a way that provides accurate, clear, and easily understood information.	83%	17%	0%
	6. Identifies initial measurement and remeasurement of study indicators.	50%	0%	50%
	7. Identifies statistical differences between initial measurement and remeasurement.	33%	17%	50%
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	17%	33%	50%
	9. Includes interpretation of the extent to which the study was successful.	33%	17%	50%
	Activity Average Rates**	**42%**	**58%**	**-**
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	33%	0%	67%
	2. There is documented improvement in processes or outcomes of care.	17%	17%	66%
	3. The improvement appears to be the result of planned intervention(s).	33%	0%	67%
	4. There is statistical evidence that observed improvement is true improvement.	100%	0%	0%
	Activity Average Rates**	**92%**	**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	100%
	Activity Average Rates**	Δ	Δ	-

Notes to Table:

NA is *Not Applicable*.

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

**The activity average rate represents the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

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

Table B.7—Internal QIP Activities I to IV Ratings (N = 18 QIPs)

	Evaluation Elements	Met	Partially Met/ Not Met	NA/Not Assessed
Activity I: Appropriate Study Topic				
	1. Reflects high-volume or high-risk conditions (or was selected by the State).	100%	0%	0%
	2. Is selected following collection and analysis of data (or was selected by the State).	89%	11%	0%
	3. Addresses a broad spectrum of care and services (or was selected by the State).	100%	0%	0%
	4. Includes all eligible populations that meet the study criteria.	83%	17%	0%
	5. Does not exclude members with special health care needs.	72%	28%	0%
C*	6. Has the potential to affect member health, functional status, or satisfaction.	100%	0%	0%
	Activity Average Rates**	**91%**	**9%**	**-**
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	6%	94%	0%
C*	2. Is answerable.	0%	100%	0%
	Activity Average Rates**	**3%**	**97%**	**-**
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	33%	67%	0%
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	89%	11%	0%
C*	3. Allow for the study questions to be answered.	0%	100%	0%
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	39%	61%	0%
C*	5. Have available data that can be collected on each indicator.	100%	0%	0%
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	78%	0%	22%
	7. Includes the basis on which each indicator was adopted, if internally developed.	28%	5%	67%
	Activity Average Rates**	**60%**	**40%**	**-**
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	11%	89%	0%
	2. Includes requirements for the length of a member's enrollment in the plan.	22%	78%	0%
C*	3. Captures all members to whom the study question applies.	11%	89%	0%
	Activity Average Rates**	**15%**	**85%**	**-**

Notes to Table:

NA is *Not Applicable*.

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

**The activity average rate represents the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

Table B.8—Internal QIP Activities V to VII Ratings (N = 18 QIPs)

	Evaluation Elements	Met	Partially Met/ Not Met	NA/Not Assessed
Activity V: Valid Sampling Techniques				
	1. Consider and specify the true or estimated frequency of occurrence.	22%	6%	72%
	2. Identify the sample size.	22%	6%	72%
	3. Specify the confidence level.	6%	22%	72%
	4. Specify the acceptable margin of error.	6%	22%	72%
C*	5. Ensure a representative sample of the eligible population.	6%	22%	72%
	6. Are in accordance with generally accepted principles of research design and statistical analysis.	6%	22%	72%
	Activity Average Rates**	**37%**	**63%**	**-**
Activity VI: Accurate/Complete Data Collection				
	1. The identification of data elements to be collected.	11%	89%	0%
	2. The identification of specified sources of data.	100%	0%	0%
	3. A defined and systematic process for collecting baseline and remeasurement data.	28%	72%	0%
	4. A timeline for the collection of baseline and remeasurement data.	100%	0%	0%
	5. Qualified staff and personnel to abstract manual data.	0%	28%	72%
C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	0%	33%	67%
	7. A manual data collection tool that supports interrater reliability.	0%	28%	72%
	8. Clear and concise written instructions for completing the manual data collection tool.	0%	33%	67%
	9. An overview of the study in written instructions.	0%	33%	67%
	10. Administrative data collection algorithms/flowcharts that show activities in the production of indicators.	11%	89%	0%
	11. An estimated degree of automated data completeness.	0%	61%	39%
	Activity Average Rates**	**35%**	**65%**	**-**
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	56%	39%	5%
	2. System changes that are likely to induce permanent change.	89%	5%	6%
	3. Revised if original interventions are not successful.	33%	17%	50%
	4. Standardized and monitored if interventions were successful.	22%	45%	33%
	Activity Average Rates**	**64%**	**36%**	**-**

Notes to Table:

NA is *Not Applicable*.

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

**The activity average rate represents the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

Table B.9—Internal QIP Activities VIII to X Ratings (N = 18 QIPs)

	Evaluation Elements	Met	Partially Met/ Not Met	NA/Not Assessed
Activity VIII: Sufficient Data Analysis and Interpretation				
C*	1. Is conducted according to the data analysis plan in the study design.	0%	94%	6%
C*	2. Allows for the generalization of the results to the study population if a sample was selected.	17%	11%	72%
	3. Identifies factors that threaten the internal or external validity of the findings.	17%	78%	5%
	4. Includes an interpretation of the findings.	17%	78%	5%
	5. Is presented in a way that provides accurate, clear, and easily understood information.	61%	33%	6%
	6. Identifies initial measurement and remeasurement of study indicators.	72%	0%	28%
	7. Identifies statistical differences between initial measurement and remeasurement.	5%	67%	28%
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	50%	22%	28%
	9. Includes interpretation of the extent to which the study was successful.	33%	39%	28%
	Activity Average Rates**	**39%**	**61%**	**-**
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	72%	0%	28%
	2. There is documented improvement in processes or outcomes of care.	22%	50%	28%
	3. The improvement appears to be the result of planned intervention(s).	33%	39%	28%
	4. There is statistical evidence that observed improvement is true improvement.	5%	67%	28%
	Activity Average Rates**	**27%**	**73%**	**-**
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.	22%	39%	39%
	Activity Average Rates**	**36%**	**64%**	**-**

Notes to Table:

NA is *Not Applicable*.

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

**The activity average rate represents the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

Table C.1—QIP Activity Average Rates by Type*

Activity	Statewide Collaborative QIPs (N=24)		Small-Group Collaborative QIPs (N=6)		Internal QIPs (N=18)	
	Met Elements	*Partially Met/Not Met* Elements	*Met* Elements	*Partially Met/Not Met* Elements	*Met* Elements	*Partially Met/Not Met* Elements
I: Appropriate Study Topic	95%	5%	95%	5%	91%	9%
II: Clearly Defined, Answerable Study Question(s)	0%	100%	17%	83%	3%	97%
III: Clearly Defined Study Indicator(s)	60%	40%	58%	42%	60%	40%
IV: Correctly Identified Study Population	32%	68%	17%	83%	15%	85%
V: Valid Sampling Techniques	Δ	Δ	Δ	Δ	37%	63%
VI: Accurate/ Complete Data Collection	36%	64%	25%	75%	35%	65%
VII: Appropriate Improvement Strategies	60%	40%	62%	38%	64%	36%
VIII: Sufficient Data Analysis and Interpretation	42%	58%	42%	58%	39%	61%
IX: Real Improvement Achieved	44%	56%	92%	8%	27%	73%
X: Sustained Improvement Achieved	Δ	Δ	Δ	Δ	36%	64%

* The activity average rate represents the average percentage of applicable elements with a *Met* or *Partially Met/Not Met* finding across all the evaluation elements for a particular activity.

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