Medi-Cal Managed Care Program
Quality Improvement Projects Status Report
January 1, 2010 – March 31, 2010

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

September 2010

Purpose of Report

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

This QIPs Status Report provides a summary of QIPs validated during the period of January 1, 2010, through March 31, 2010, and presents recommendations for improvement.

Scope of External Quality Review Activities Conducted

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

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

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

Summary of Overall Findings

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

HSAG provided an overall validation status of *Met, Partially Met,* or *Not Met* for each QIP submission. The DHCS requires that QIPs receive an overall *Met* validation status; therefore, plans must resubmit their QIP until it achieves a *Met* validation status.

During this review period, January 1, 2010, through March 31, 2010, HSAG began validating county-level data for all new QIP proposals for plans operating in multiple counties. The DHCS allows plans operating in multiple counties to select the same QIP topic for all of their counties; however, plans must report county-level data and account for geographic differences.

The initiation of the county-level validation process presented challenges. HSAG's QIP summary form did not support a single QIP submission with multi-county data; therefore, plans' QIP submissions lacked enough county-level information within each activity to meet CMS requirements. In addition, HSAG lacked a methodology to produce validation results for each county.

To resolve the challenges with multi-county QIP validation, HSAG:

- Modified its QIP summary form to accommodate multi-county data within a single submission.
- Developed a validation methodology to produce validation results for each county (one QIP validation tool per county).
- Provided the DHCS with recommendations for implementation.

HSAG made these change to comply with the DHCS's requirement for plans to report QIP data at the county level and for the EQRO to validate QIPs at the county level. The DHCS supported HSAG's recommendation to apply this requirement to new QIPs.

HSAG validated 37 plan QIP submissions from January 1, 2010, through March 31, 2010. The 37 submissions represented 4 annual submissions, 4 annual resubmissions, 1 annual second resubmission, 24 proposals, and 4 proposal resubmissions.

Of the 37 QIPs validated, 9 received an overall *Met* validation status, 24 received an overall *Partially Met* validation status, and 4 received an overall *Not Met* validation status. As of March 31, 2010, 4 projects remained with a *Not Met* or *Partially Met* status, requiring resubmission. HSAG will include these resubmission results in the next QIPs status report.

HSAG, with approval from the DHCS, allowed many plans that had QIP proposals with a *Partially Met* status (22 out of 24) to address areas of noncompliance as part of their next annual QIP submission instead of requiring a resubmission. HSAG made this recommendation because the overall structure of these QIP proposals were appropriate but needed enhanced documentation to fully meet CMS requirements. These plans will submit their next annual submission by August 31, 2010, to allow for baseline project data, namely HEDIS®[3] 2010 results, to be available. Plans will have the opportunity to address *Partially Met* and *Not Met* areas at that time.

Plans achieved an average score of 79 percent for evaluation elements *Met* and an average score of 70 percent for critical elements *Met*. HSAG identifies critical elements as essential for producing a valid and reliable QIP. These validation scores will help plans compare performance over time.

A total of eight QIPs validated during the review period progressed to the point of a least one remeasurement period, allowing HSAG to assess for statistically significant improvement, considered real improvement, between the baseline and remeasurement rates. Two of the three emergency room (ER) collaborative QIP resubmissions demonstrated a statistically significant decrease in the rate of avoidable ER visits. The small-group collaborative (SGC) QIP submission/resubmission showed improvement for all its study indicators related to improving care for members with chronic obstructive pulmonary disease (COPD), with one of its study indicators showing statistically significant improvement for all remeasurement periods. Finally, four individual QIP submissions were assessed for real improvement, with three of the four demonstrating statistically significant improvement for some of the study indicators.

A total of three QIPs validated during the review period progressed to a second remeasurement period in which HSAG assessed the QIPs for sustained improvement. Two of three QIPs showed sustained improvement for all study indicators. The remaining project showed sustained improvement for one of its study indicators.

[3] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

Conclusions

HSAG noted ongoing improvement in plan compliance with CMS' protocol for conducting QIPs. As of March 31, 2010, all statewide collaborative QIPs received an overall *Met* validation status for the first remeasurement period.

The overall percentage of evaluation elements *Met* was 79 percent for this review period, January 1, 2010, through March 31, 2010. This percentage was slightly lower than the score of 82 percent from the prior review period, which was from October 1, 2009, through December 31, 2009. This was due primarily to the high number of QIP proposals submitted that received an overall *Partially Met* validation status without a requirement to resubmit, which would have increased this score.

HSAG's phase-in of validation at the county level for plans submitting new QIP proposals will provide the DHCS and plans with greater information about the impact of QIPs on quality outcomes at the county level. This information should help increase a plan's accountability for its Medi-Cal managed care membership in all counties in which it operates.

Care 1st's SGC final QIP submission demonstrated sustained improvement for all three of its study indicators aimed at improving care for its Medi-Cal members with COPD.

AHF Healthcare Centers (AHF), a specialty plan that provides health care services to Medi-Cal managed care members diagnosed with HIV/AIDS in Los Angeles County, achieved sustained improvement for both of its study indicators. The plan successfully decreased both systolic and diastolic blood pressure measurements for its members with a diagnosis of hypertension. Additionally, AHF's second QIP, targeting the reduction of adverse reactions to Coumadin for patients with HIV/AIDS, achieved sustained improvement for reducing the proportion of patients with International Normalized Ratio (INR) values of less than 4.0. The plan did not demonstrate sustained improvement for its other two indicators, but the plan did have meaningful improvement with a reduction of hospitalizations to zero for both remeasurement periods.

Finally, Santa Clara Family Health Plan and Central California Alliance for Health both showed promise for sustained improvement of their QIPs based on their ability to achieve statistically significant improvement for at least one of their study indicators at their first remeasurement.

QIPs validated during this review period showed that many plans continue to have the same areas of noncompliance as their other, previously validated QIPs. Plans have an opportunity to improve their documentation when using a manual data collection process to ensure they

have captured all the required elements. Additionally, plans that target a disparity within their QIP have an opportunity to include data to support evidence of the disparity. Finally, plans have an opportunity to use their data to help drive quality improvement decisions.

Recommendations

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

- Plans need to apply prior validation feedback to future QIP submissions. The DHCS and EQRO may consider trending patterns of noncompliance.
- Plans need to ensure that they include all required elements as part of their design for QIPs that use a manual data collection process. The *Quality Improvement Assessment Guide for Plans* available on the DHCS Web site is a resource for required elements.
- Plans should seek technical assistance for QIPs involving disparities. The DHCS may consider having the EQRO provide some basic training to plans on how to use data to identify disparities and how to document a disparity within a QIP.
- Plans should use their data to determine areas of low performance and/or health disparities, then conduct causal/barrier analysis and select intervention strategies that address one or more of the identified barriers.

Organization of Report

This report has six sections:

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

QIP Requirements

QIPs are a federal requirement. The Code of Federal Regulations (CFR) at 42 CFR 438.240[4] requires that all states operating a Medicaid managed care program ensure that their contracted plans conduct QIPs.

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

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

Description of the QIP Validation Process

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

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

Federal regulations also require that plans conduct and that an EQRO validate QIPs in a manner consistent with the CMS protocols for conducting and validating QIPs.[5]

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

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

QIP validation ensures that:

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

Evaluating the Overall Validity and Reliability of Study Results

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

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

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

QIP Validation Activities

HSAG reviewed 37 QIPs for the period of January 1, 2010, through March 31, 2010. Of the 37 submissions, 4 represented annual submissions, 4 were annual resubmissions, 1 was an annual second resubmission, 24 were proposals, and 4 were proposal resubmissions.

Of the 37 QIPs validated, 9 received an overall *Met* validation status, 24 received an overall *Partially Met* validation status, and 4 received an overall *Not Met* validation status. As of March 31, 2010, 4 projects remained with a *Not Met* or *Partially Met* status. QIPs with a *Not Met* or *Partially Met* validation status must be resubmitted. A resubmission is a plan's update of a previously submitted QIP with additional documentation.

For new QIP proposals, HSAG can recommend to the DHCS that plans forego a resubmission of a *Partially Met* QIP if the structure of the QIP is sufficient for the plan to move forward with collecting baseline data. HSAG made this recommendation for 22 of the 24 QIP proposals during this review period.

Many plans with QIPs that achieved an overall *Met* validation status with at least two remeasurement periods retired those QIPs and are submitting new QIP proposals. HSAG typically recommends that plans terminate their QIPs once they have completed two remeasurement periods and target new areas for improvement.

The DHCS has taken a more active role in reviewing QIP proposals prior to sending them to HSAG for validation. The Medical Policy Section of the DHCS reviews each QIP to ensure that it includes the appropriate counties covered by the plan, addresses population differences between counties, and includes a plan for establishing the baseline and remeasurement by county, a contract requirement. The Medical Policy Section also reviews the QIP for clinical merit, as appropriate, focuses on the specific needs of the plan's Medi-Cal population, and ensures that the QIP is aligned with the plan's improvement needs, such as those identified through quality and performance measurement results.

From January 1, 2010, through March 31, 2010, HSAG provided technical assistance to plans requesting additional QIP training and guidance. Two plans received feedback and technical assistance for their ER collaborative QIPs to achieve compliance with CMS requirements. HSAG provided two plans with technical assistance related to QIP proposals. In addition, HSAG provided ongoing technical assistance to Family Mosaic Project, a specialty plan, in

developing two QIP proposals, the first of which is due to the DHCS in May 2010 to comply with contractual requirements.

HSAG revised its QIP summary form for plans to use with multi-county QIP submissions. The DHCS held a quality improvement work group meeting June 1, 2010, at which HSAG presented the updated form to the plans.

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

Table 3.1—Medi-Cal Managed Care Program Quarterly Quality Improvement Program Validation Activity
January 1, 2010, through March 31, 2010

Plan Name and County	Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIPs					
Central California Alliance for Health —Monterey/Santa Cruz	*Reducing Avoidable Emergency Room Visits*	Annual Resubmission 2	100%	100%	*Met*
Community Health Group—San Diego	*Reducing Avoidable Emergency Room Visits*	Annual Resubmission 1	97%	100%	*Met*
San Francisco Health Plan—San Francisco	*Reducing Avoidable Emergency Room Visits*	Annual Resubmission 1	86%	100%	*Met*
Small-Group Collaborative QIPs					
Care 1st—San Diego	*Improving Treatment of Chronic Obstructive Pulmonary Disease (COPD)*	Annual Submission	51%	27%	*Not Met*
Care 1st—San Diego	*Improving Treatment of Chronic Obstructive Pulmonary Disease (COPD)*	Annual Resubmission 1	93%	100%	*Met*
Internal QIPs					
AHF Healthcare Centers—Los Angeles	*Controlling High Blood Pressure*	Annual Submission	47%	36%	*Not Met*
AHF Healthcare Centers—Los Angeles	*Reducing Adverse Reactions to Coumadin for Patients With HIV/AIDS*	Annual Submission	55%	45%	*Not Met*
Anthem Blue Cross—Alameda	*Improving HEDIS Postpartum Care Rates*	Proposal	71%	50%	*Partially Met*
Anthem Blue Cross—Contra Costa	*Improving HEDIS Postpartum Care Rates*	Proposal	71%	50%	*Partially Met*
Anthem Blue Cross—Fresno	*Improving HEDIS Postpartum Care Rates*	Proposal	71%	50%	*Partially Met*
Anthem Blue Cross—Sacramento	*Improving HEDIS Postpartum Care Rates*	Proposal	71%	50%	*Partially Met*
Anthem Blue Cross—San Francisco	*Improving HEDIS Postpartum Care Rates*	Proposal	71%	50%	*Partially Met*
Anthem Blue Cross—San Joaquin	*Improving HEDIS Postpartum Care Rates*	Proposal	71%	50%	*Partially Met*
Anthem Blue Cross—Santa Clara	*Improving HEDIS Postpartum Care Rates*	Proposal	71%	50%	*Partially Met*
Anthem Blue Cross—Stanislaus	*Improving HEDIS Postpartum Care Rates*	Proposal	71%	50%	*Partially Met*
Anthem Blue Cross—Tulare	*Improving HEDIS Postpartum Care Rates*	Proposal	71%	50%	*Partially Met*
CenCal Health—Santa Barbara	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children & Adolescents*	Proposal Resubmission 1	100%	100%	*Met*

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Plan Name and County	Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Central California Alliance for Health —Monterey/Santa Cruz	*Improving Effective Case Management*	Annual Resubmission 1	65%	70%	*Partially Met*
Contra Costa Health Plan—Contra Costa	*Reducing Health Disparities—Childhood Obesity*	Proposal Resubmission 1	36%	44%	*Not Met*
Health Net—Fresno	*Improving Cervical Cancer Screening Among Seniors and Persons With Disabilities*	Proposal	89%	90%	*Partially Met*
Health Net—Kern	*Improving Cervical Cancer Screening Among Seniors and Persons With Disabilities*	Proposal	89%	90%	*Partially Met*
Health Net—Los Angeles	*Improving Cervical Cancer Screening Among Seniors and Persons With Disabilities*	Proposal	89%	90%	*Partially Met*
Health Net—Sacramento	*Improving Cervical Cancer Screening Among Seniors and Persons With Disabilities*	Proposal	89%	90%	*Partially Met*
Health Net—San Diego	*Improving Cervical Cancer Screening Among Seniors and Persons With Disabilities*	Proposal	89%	90%	*Partially Met*
Health Net—Stanislaus	*Improving Cervical Cancer Screening Among Seniors and Persons With Disabilities*	Proposal	89%	90%	*Partially Met*
Health Net—Tulare	*Improving Cervical Cancer Screening Among Seniors and Persons With Disabilities*	Proposal	89%	90%	*Partially Met*
Health Plan of San Mateo—San Mateo	*Increasing Timeliness of Prenatal Care*	Proposal	87%	67%	*Partially Met*
Inland Empire Health Plan—Riverside/San Bernardino	*Attention Deficit Hyperactivity Disorder (ADHD) Management*	Proposal	100%	100%	*Met*
Kern Family Health Care—Kern	*Comprehensive Diabetes Care*	Proposal	71%	38%	*Partially Met*
Kern Family Health Care—Kern	*Comprehensive Diabetes Care*	Proposal Resubmission 1	100%	100%	*Met*
LA Care Health Plan—Los Angeles	*Improving HbA1c and Diabetic Retinal Exam Screening Rates*	Proposal	96%	100%	*Met*
Molina Healthcare—Riverside/San Bernardino	*Improving Hypertension Control*	Proposal	72%	50%	*Partially Met*
Molina Healthcare—Sacramento	*Improving Hypertension Control*	Proposal	72%	50%	*Partially Met*
Molina Healthcare—San Diego	*Improving Hypertension Control*	Proposal	72%	50%	*Partially Met*

Table 3.1—Medi-Cal Managed Care Program Quarterly Quality Improvement Program Validation Activity
January 1, 2010, through March 31, 2010

Plan Name and County	Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Partnership Health Plan—Napa/Solano/Yolo	*Improving Care and Reducing Acute Readmissions for People With COPD*	Proposal	70%	50%	*Partially Met*
Partnership Health Plan—Napa/Solano/Yolo	*Improving Care and Reducing Acute Readmissions for People With COPD*	Proposal Resubmission 1	100%	100%	*Met*
Santa Clara Family Health Plan—Santa Clara	*Adolescent Health and Obesity Prevention*	Annual Submission	86%	77%	*Partially Met*

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

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

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

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

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

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

Study Design—CMS Protocol Activities I–IV

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

Study Implementation—CMS Protocol Activities V–VII

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

Quality Outcomes Achieved—CMS Protocol Activities VIII–X

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

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

Findings Specific to the DHCS Statewide Collaborative

HSAG received three statewide collaborative QIPs resubmitted for validation due to noncompliance during the previous review period, October 1, 2009, through December 31, 2009. Of the three resubmissions, two were first resubmissions and one was a second resubmission. All QIPs received an overall *Met* validation status during this review period.

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

Table 4.1––Statewide Collaborative QIP Activity Average Rates* (N = 3 Submissions)
January 1, 2010, through March 31, 2010

QIP Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Study Design	**I: Appropriate Study Topic**	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Study Implementation	**V: Valid Sampling Techniques (if sampling is used)**	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	88%†	13%†	0%†
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	92%	8%	0%
	IX: Real Improvement Achieved	75%	0%	25%
	X: Sustained Improvement Achieved	Δ	Δ	Δ

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

† The sum may not equal 100 percent due to rounding.

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

Study Design

All QIP resubmissions met 100 percent of the criteria for the applicable evaluation elements for Activities I through IV. Plans corrected all deficiencies noted in the prior validation feedback to include documentation of all eligible populations, including evidence that members with special health care needs were not excluded. Furthermore, the submissions indicated that the project topic was selected by the DHCS as part of a statewide collaborative.

Plans also included all codes necessary to define the study indicators for the HEDIS *Ambulatory Care—Emergency Department Visits* measure and the avoidable ER visits measure.

Finally, the plans correctly documented the study population by revising the age ranges for the avoidable ER visits measure, which excludes members younger than 1 year of age.

Study Implementation

Overall, the QIP resubmissions showed good compliance with the study implementation phase covering Activities V through VII.

For the ER collaborative QIP, plans included their entire eligible population; therefore, Activity V, Valid Sampling Techniques, did not apply.

All plan resubmissions met the criteria for the evaluation elements addressing accurate and complete data collection. QIP resubmissions reflected increased compliance by plans documenting all data elements for inclusion, providing a timeline for collecting data for each measurement period, and including either a data collection flow chart or algorithm that shows the steps in producing the study indicator rates.

One plan did not achieve a *Met* status for all elements within Activity VII, Appropriate Improvement Strategies, because the QIP lacked documentation regarding the standardization and monitoring of successful interventions. Plans need to include this information if the QIP showed a decrease in the avoidable ER visits rate between the baseline and remeasurement period.

Quality Outcomes Achieved

HSAG reviewed QIP resubmissions for Activities VIII and IX. The QIP has not progressed to a second remeasurement period; therefore, HSAG could not assess for sustained improvement.

Two QIP resubmissions met all evaluation elements for Activities VIII and IX. One of these plans revised its QIP documentation to include a complete data analysis plan and included appropriate statistical testing, which the QIP lacked in the initial submission.

The plan that did not meet all evaluation elements within Activity IX calculated its avoidable ER visits rate incorrectly and lacked information on the specific statistical test used along with the associated *p* value. This plan will have an opportunity to address these concerns in its next annual resubmission in October 2010.

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

Plans can achieve full compliance with this activity only by demonstrating statistically significant improvement. In the case of avoidable ER visits, a statistically significant decrease in the rate demonstrates improvement. Two of the three plans' resubmitted QIPs achieved a statistically significant decrease in their avoidable ER visits rate from baseline to the first remeasurement period.

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

Statewide Collaborative QIP Strengths and Opportunities for Improvement

As of March 31, 2010, all plans achieved an overall *Met* validation status for their collaborative QIP submissions.

The collaborative completed data collection and analysis of a provider survey from its member health education campaign, "Not Sure It's an Emergency?" that was implemented in June 2009. The collaborative developed the survey to collect outcome information about the statewide intervention, including provider participation and satisfaction.

One of the objectives of the member health education campaign was to increase communication between members and PCPs on appropriate ER use. Based on the provider survey results, providers found the member health education campaign materials helpful in talking with patients about the ER. By providing these materials, the campaign may have increased how frequently providers and patients communicate regarding appropriate ER use.

In conducting data analysis for the ER Collaborative Remeasurement Report, which the DHCS is expected to release in August 2010, HSAG noted several data discrepancies between plans' submitted QIP rates and data submitted to the DHCS. Upon further review, HSAG found that three plans calculated their avoidable ER visits rate incorrectly. These plans did not exclude members younger than 1 year of age from their avoidable ER visits denominator. HSAG used the QIP validation feedback to inform one of these plans of the calculation error, and HSAG notified the other two plans of the need to correct their data in their next annual QIP submission. Reporting results consistent with the collaborative specification for the avoidable ER visits rate continues to be an opportunity for improvement.

This calculation error may have affected these plans' avoidable ER visits rates, all of which increased between baseline and the first remeasurement period.

Statewide Collaborative QIP Recommendations

HSAG did not identify any recommendations for the statewide collaborative QIP for the current review period.

Findings Specific to Small-Group Collaboratives

Care 1st was the only plan to submit an SGC QIP for validation during the review period of January 1, 2010, through March 31, 2010. HSAG validated Care 1st's annual QIP submission and resubmission for *Improving Treatment of Chronic Obstructive Pulmonary Disease (COPD).*

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

Table 4.2––Small-Group Collaborative QIP Activity Average Rates* (N = 2 Submissions)
January 1, 2010, through March 31, 2010

QIP Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Study Design	**I: Appropriate Study Topic**	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	50%	50%	0%
	III: Clearly Defined Study Indicator(s)	79%	21%	0%
	IV: Correctly Identified Study Population	50%	50%	0%
Study Implementation	**V: Valid Sampling Techniques**	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	64%†	14%†	23%†
	VII: Appropriate Improvement Strategies	67%	33%	0%
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	69%†	19%†	13%†
	IX: Real Improvement Achieved	75%	25%	0%
	X: Sustained Improvement Achieved	100%	0%	0%

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

† The sum may not equal 100 percent due to rounding.

Study Design

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

Activity I. Appropriate Study Topic

Activity Summary: Both QIPs met all applicable evaluation elements for Activity I.

Care 1st appropriately documented selection of the QIP's study topic by documenting COPD as a high-risk condition. The plan used its Medi-Cal managed care data to support the relevance of the topic to its population. The QIP has the potential to impact member health and functional status by improving diagnosis and treatment of COPD.

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

Activity Summary: After resubmission, the QIP had three clearly defined and answerable study questions.

The plan submitted three study questions within its QIP. The study questions addressed whether extensive disease management and provider and member outreach increase the use of spirometry testing in the diagnosis and management of COPD, the rate of members with COPD obtaining the pneumonia vaccination, and the rate of members seeking smoking cessation programs. Provider and member outreach included the distribution of guidelines and educational materials.

The initial QIP submission received *Partially Met* scores for both evaluation elements because the plan's third study question did not align with the third study indicator. This study question focused on increasing members seeking smoking cessation programs while the study indicator measured members who had documentation that smoking cessation was discussed during the measurement period.

With the second resubmission, the plan revised its third study question to evaluate an increase in the rate of providers documenting a discussion with and/or referral for members with COPD regarding a smoking cessation program. This revision aligned with the study indicator and the plan achieved *Met* scores for both evaluation elements.

Activity III. Clearly Defined Study Indicator(s)

Activity Summary: Upon resubmission, the plan met all evaluation element criteria.

With its annual submission, the plan did well basing its QIP indicators on current, evidenced-based COPD practice guidelines, using available data to report study indicators, and using a nationally recognized HEDIS measure.

The plan received a *Partially Met* score for two of the elements because it lacked documentation of the year of the HEDIS specifications used and codes to identify spirometry testing. Because the third study question did not align with the study indicator, the plan did not receive a *Met* score.

Upon resubmission, the plan received *Met* scores for all elements.

Activity IV. Correctly Identified Study Population

Activity Summary: The initial QIP submission received *Partially Met* scores for all evaluation elements. Upon resubmission of the QIP, all evaluation elements received *Met* scores.

The plan's study population deviated from the HEDIS specifications. In the QIP, the plan documented inclusion of members 40 years of age and older; however, the HEDIS specifications included members 42 years of age and older. Additionally, the plan did not include continuous enrollment criteria.

The plan resubmitted a QIP revised to mirror the HEDIS specifications and included the continuous enrollment criteria.

Study Implementation

Findings for Activities V through VII of the SGC QIP included the following:

Activity V. Valid Sampling Techniques

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

Activity VI. Accurate/Complete Data Collection

Activity Summary: This activity represented the greatest opportunity for improvement for the plan, with many elements either *Partially Met* or *Not Met*.

HSAG evaluates QIP submissions to determine if plans reported accurate and complete data when reporting their rates. This QIP used administrative processes to gather claims and encounter data for the first study indicator and a manual data process to gather data for the second and third study indicators.

This activity requires that plans document the source of data for reporting all QIP study indicators. Plans must also document the data elements to be collected, such as Current Procedural Terminology (CPT) codes and manual data elements, as well as the timeline for collecting the data, activities conducted to produce the indicators, and the estimated degree of data completeness.

As mentioned in Activity IV, the initial QIP did not include the year of the HEDIS specifications used or the codes to identify spirometry testing. Additionally, the plan did not provide a copy of the manual data collection tool. For a manual data collection process, the plan needs to provide the manual data collection tool that includes the qualifications, training, and experience of the data collection staff; a description of the interrater reliability process; and clear and concise written instructions for the manual data collection tool that includes an overview of the study. The plan lacked detailed documentation related to the manual data collection process.

The plan did specify the sources of data, documented a timeline for the baseline and remeasurement periods, and provided an administrative data collection algorithm that showed the activities in the production of the indicators.

Upon resubmission, the plan achieved *Met* scores for all elements, except for the element that provides an overview of the study in the written instructions for the manual review process. The plan should incorporate this step in future QIPs that use a manual data process.

Activity VII. Appropriate Improvement Strategies

Activity Summary: Overall, the plan met the criteria for the evaluation elements, except for standardizing and monitoring successful interventions.

The plan completed a causal/barrier analysis and targeted improvement strategies related to the barriers. The plan also documented system interventions that are likely to induce permanent change. The plan documented several interventions to increase providers' knowledge of the COPD practice guidelines and COPD HEDIS measure. The plan distributed HEDIS report cards, which addressed the barrier of physicians not knowing how well they perform in meeting the standards. Additionally, the plan used its disease management program to provide education to members and facilitate care with providers as appropriate.

The plan indicated its intent to use Quality Outreach, a plan initiative to provide physicians with personalized support and tools needed to make process changes that can be sustained over time. However, the plan did not address the monitoring and standardization of its successful interventions used within its COPD QIP.

Quality Outcomes Achieved

Small-group collaborative QIP validation findings for Activities VIII through X included the following:

Activity VIII. Sufficient Data Analysis and Interpretation

Activity Summary: The plan documented clear and accurate information and provided an interpretation of the results; however, the plan had an opportunity to improve its data analysis plan.

For this activity, HSAG assesses whether the plan conducted data analysis according to its data analysis plan and provided sufficient data analysis and interpretation.

The initial QIP submission did not include a complete data analysis plan, which should include how the rates were calculated, how the rates were compared to the goals, and the statistical test used to compare the results from baseline to remeasurement and between remeasurement periods.

The QIP lacked documentation of factors that threatened the internal or external validity of results.

Upon resubmission, the QIP met all applicable evaluation elements.

Activity IX. Real Improvement Achieved

Activity Summary: All three study indicators showed improvement. Study Indicator 3 showed statistically significant improvement between all remeasurement periods.

The plan showed improvement between baseline and the first remeasurement period for all study indicators, with Study Indicator 3 showing statistically significant improvement. The QIP showed statistically significant improvement between baseline and the second remeasurement period for all study indicators.

The plan received a *Partially Met* score for one evaluation element. This element remains *Partially Met* because Study Indicators 1 and 2 showed an improvement that was not significant between Remeasurements 1 and 2.

Activity X. Sustained Improvement Achieved

Activity Summary: The QIP achieved sustained improvement.

Care 1st achieved sustained improvement for this QIP because repeated measurements over comparable time periods demonstrated sustained improvement without a statistically significant decline in performance results.

The plan improved the use of spirometry testing for the diagnosis and treatment of COPD, Study Indicator 1, from 15.38 percent at baseline to 32.47 percent at Remeasurement 2, a statistically significant increase. The plan improved its performance, which was below the National Committee for Quality Assurance (NCQA) Medicaid national 25th percentile, to just below the 75th percentile of 32.9 percent.

For Study Indicator 2, the plan increased pneumonia vaccination for those diagnosed with COPD from 54.3 percent at baseline to 70.6 percent at Remeasurement 2, a statistically significant increase.

The plan achieved a statistically significant increase between all remeasurement periods for Study Indicator 3, which increased the documentation of tobacco use and counseling for those diagnosed with COPD from 36.2 percent at baseline to 75.8 percent at Remeasurement 2.

Small-Group Collaborative Strengths and Opportunities for Improvement

Care 1st's COPD SGC project showed sustained improvement for all three of its study indicators, which translated into improved care for its Medi-Cal members with COPD.

Upon resubmission, the plan achieved a 93 percent score for evaluation elements *Met* and a 100 percent score for critical elements *Met*.

Many evaluation elements receiving *Partially Met* and *Not Met* scores during the initial validation had similar results and validation feedback in submissions of other QIPs. The plan has an opportunity to apply validation feedback across QIPs to increase compliance with CMS protocols for conducting QIPs.

Small-Group Collaborative Recommendations

Since the plan's QIP progressed to two remeasurement periods and demonstrated sustained improvement, HSAG considered the plan's QIP closed and recommended that the plan submit a new QIP proposal that focuses on an actionable area in need of improved performance.

Given the success of the project, the plan should evaluate whether intervention strategies can be applied to other improvement projects.

The plan should incorporate previous validation feedback into the initial submissions of its other QIPs to improve compliance with validation requirements and reduce the need for resubmissions.

Findings Specific to Internal Quality Improvement Projects

Plans submitted 32 internal QIPs (IQIPs) for validation from January 1, 2010, through March 31, 2010. Three were annual submissions, 1 was an annual resubmission, 24 were proposals, and 4 were proposal resubmissions.

During this review period HSAG began validating county-level data for all new QIP proposals for plans operating in multiple counties. Anthem Blue Cross, Health Net, and Molina Healthcare all had QIP proposals across the counties in which they operate, which HSAG validated.

HSAG typically validates QIP proposals through Activity IV, or Activity V if the plan used sampling techniques, prior to the plan submitting baseline data. This allows HSAG to provide feedback in time for plans to adjust their QIP's study design before the QIP is too far along to modify.

Table 4.3 provides average rates for each activity within the CMS protocols. Appendix B includes a table of scores for each evaluation element within the activities.

Table 4.3––Internal QIP Activity Average Rates* (N = 32 Submissions)
January 1, 2010, through March 31, 2010

QIP Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Study Design	**I: Appropriate Study Topic**	93%	5%	2%
	II: Clearly Defined, Answerable Study Question(s)	75%	19%	6%
	III: Clearly Defined Study Indicator(s)	71%	28%	1%
	IV: Correctly Identified Study Population	71%	27%	2%
Study Implementation	**V: Valid Sampling Techniques**	77%†	7%†	17%†
	VI: Accurate/Complete Data Collection	76%	13%	11%
	VII: Appropriate Improvement Strategies	90%	7%	3%
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	70%	29%	2%
	IX: Real Improvement Achieved	50%	44%	6%
	X: Sustained Improvement Achieved	50%	50%	0%

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

† The sum may not equal 100 percent due to rounding.

Study Design

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

Activity I. Appropriate Study Topic

Activity Summary: Overall, plans met the criteria for the evaluation elements within Activity I.

Most QIPs met the criteria of all evaluation elements for selecting an appropriate study topic. All QIPs reflected either a high-volume or high-risk condition that has the potential to affect member health or functional status.

Several QIPs lacked data collection and analysis to support selection of the study topic. Through the validation process, HSAG noted that plans had difficulty documenting a disparity when proposing a project to reduce disparities. Plans should not assume that a disparity exists or assume that a disparity exists for a minority population. For the Medi-Cal managed care population, HSAG has reviewed many projects in which the data showed that a disparity existed among Whites compared to all other ethnic/racial groups, yet the plan's interventions targeted a minority group that was not supported as a disparate population by the plan's data. Plans need to use their data to drive program decisions for QIPs and interventions.

Two QIP submissions lacked documentation of including all eligible populations that meet the study criteria and the inclusion/exclusion of members with special health care needs.

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

Activity Summary: Overall, QIPs had a clearly defined and answerable study question.

Most QIPs had appropriate documentation of the study question in the CMS format. Two QIPs did not include a study question. Six QIPs lacked an additional study question to align with the multiple study indicators.

Activity III. Clearly Defined Study Indicator(s)

Activity Summary: QIP submissions had mixed results for clearly defined study indicators, with both strengths and opportunities for improvement.

Approximately half of the QIP submissions did not include study indicators that were well-defined, objective, and measureable. Plans can improve compliance by ensuring that their study indicators align with the HEDIS specifications if they are using a HEDIS measure. Some plans lacked complete date ranges for all measurement periods. For disparity QIPs, plans need to include a study population that it can stratify by race/ethnicity if the plan intends to identify the variance within the QIP.

All but one QIP documented study indicators that were based on current, evidence-based practice guidelines; pertinent, peer-reviewed literature; or consensus expert panels. Two QIPs lacked documentation to support the basis on which each indicator was adopted for its internally developed indicators.

QIP submissions received the lowest scores for having a study indicator(s) that allowed for the study question(s) to be answered. QIPs could not receive credit for this element if they lacked a study question or the study question was not clearly defined and answerable in Activity II.

Fifty percent of QIP submissions measured changes in health or functional status or valid process alternatives. Some QIP submissions had indicators that did not align with the HEDIS technical specifications. For example, HEDIS specifications define normal blood pressure as equal to or less than 140 mmHg/90 mmHg; however, some plans had separate study indicators for systolic and diastolic measurements. For other QIPs without clearly defined study indicators, HSAG could not determine if the QIP measured changes in health or functional status or valid process alternatives.

All QIPs had data that could be collected on each indicator.

Activity IV. Correctly Identified Study Population

Activity Summary: Many QIP submissions lacked an accurate and completely defined study population.

Thirteen of the 32 QIP submissions received a *Partially Met* score for accurately and completely defining the study population. The most common reasons that plans did not achieve compliance in this area was that they omitted or provided incomplete codes for identifying the

eligible population, did not include age ranges and anchor dates, and lacked documentation of the year of the HEDIS specifications used.

All but one plan included requirements for the length of a member's enrollment in the plan.

Since not all plans had clearly defined and answerable study questions, HSAG could not determine if the study population captured all members to whom the study question applied. Additionally, QIPs that did not have accurate and completely defined study populations could not meet this evaluation element.

Study Implementation

The DHCS and HSAG require that plans complete QIP proposals through Activity IV or V if the plans used sampling techniques. Many QIP proposals received during the review period did not include additional documentation for the activities in the study implementation and quality outcomes phases. For plans that submitted additional documentation within their QIP proposal, HSAG validated the information provided. Findings for IQIP Activities V through VII included the following:

Activity V. Valid Sampling Techniques

Activity Summary: Overall, QIPs that used sampling showed valid sampling techniques.

Only five QIP submissions used sampling of the eligible population to conduct the QIP. For this evaluation element, HSAG determined whether plans used valid sampling techniques.

QIP documentation needs to include the true or estimated frequency of occurrence. Two QIP submissions lacked this information.

Four of the five plans using sampling techniques met the remaining criteria for identifying the sample size, specifying the confidence interval, specifying the acceptable margin of error, ensuring a representative sample of the eligible population, and using generally accepted principles of research design and statistical analysis.

One plan identified a sample size that HSAG determined was too small. Having a small sample size leads to greater variance and could compromise the ability to measure a statistically significant change. HSAG recommended the plan change its sample size. This plan did not include the other required elements.

Activity VI. Accurate/Complete Data Collection

Activity Summary: Overall, QIPs had accurate and complete data collection for those using administrative processes. QIPs using a manual data collection process had an opportunity to improve documentation.

HSAG evaluated 14 QIP submissions during the review period to determine if plans reported accurate and complete data when reporting their rates. All but 4 of these submissions used administrative data processes to collect data.

Most QIPs included the identification of data elements to be collected, a timeline for baseline and remeasurement periods, administrative data collection algorithms in the production of the indicators, and the estimated degree of data completeness. All QIPs identified the specified sources of data.

Of the four QIPs that used a manual process for data collection, two had opportunities to improve documentation of the manual data collection process. These QIPs need to include a manual data collection tool that specifies the qualifications, training, and experience of the data collection staff; a description of the interrater reliability process; and clear and concise written instructions for the manual data collection tool that include an overview of the study.

Activity VII. Appropriate Improvement Strategies

Activity Summary: QIPs included appropriate improvement strategies, but plans have the opportunity to include documentation that they revised interventions that were not successful or standardized and monitored interventions that were successful.

All QIPs included a causal/barrier analysis and targeted improvement strategies that related to the barriers. The QIPs also had documented system interventions that were likely to induce permanent change.

Plans' QIPs lacked documentation that the plan revised interventions that were not successful between remeasurement periods, or that the plan standardized and monitored successful interventions to increase the likelihood of sustained improvement.

Quality Outcomes Achieved

Many of the QIP submissions validated during the review period were QIP proposals that did not reach the point of remeasurement; therefore, HSAG did not assess these QIPs for quality outcomes. Validation findings for Activities VIII through X included the following:

Activity VIII. Sufficient Data Analysis and Interpretation

Activity Summary: Activity VIII presented both strengths and opportunities for improvement.

For this activity, HSAG assesses whether the plan had sufficient data analysis and interpretation of results between remeasurement periods.

Some QIPs included baseline data but did not progress to a remeasurement period; therefore, HSAG assessed only the applicable elements for each QIP.

Plans showed strength in documenting factors threatening the internal or external validity of results; presenting information in an accurate, clear, and easily understood manner; identifying the initial measurement and remeasurement of the study indicators; and including an interpretation of the extent to which the study was successful.

The greatest opportunity for improvement was for plans to conduct the data analysis and interpretation according to the data analysis plan and include an interpretation of the findings that compares the results to the previous period and goal.

Activity IX. Real Improvement Achieved

Activity Summary: Three of the four projects assessed for real improvement achieved *Partially Met* scores for statistical significance.

Four QIP submissions progressed to a remeasurement period and three had statistically significant improvement for some of the study indicators. One of the four projects showed improvement.

AHF Healthcare Centers (AHF), a specialty plan that provides health care services to Medi-Cal managed care members diagnosed with HIV/AIDS in Los Angeles County, achieved improvement of its study indicators for its QIP focused on controlling blood pressure.

The QIP targeted reducing both systolic blood pressure of less than 140 mm/Hg and diastolic blood pressure of less than 90 mm/Hg for members diagnosed with hypertension.

The plan had statistically significant improvement, from 66.5 percent to 78.8 percent, for reducing systolic blood pressure between baseline and Remeasurement 1, but the plan did not have an increase between Remeasurement 1 and Remeasurement 2. AHF did not have an increase between baseline and Remeasurement 1 for reducing diastolic blood pressure, but the plan had a statistically significant increase between Remeasurement 1 and Remeasurement 2, from 71.4 percent to 79.8 percent.

AHF submitted its second QIP, which sought to decrease Coumadin-related complications for members on the drug by improving the frequency of INR-level monitoring, increasing the number of INR values less than 4.0, and reducing the hospital admissions rate. The plan's rate increased for the first study indicator that measured the proportion of patients with 7 or more INR results for those on continuous Coumadin from a baseline rate of 40.1 percent to 47.4 percent. This change was not significant. The plan's rate decreased below the baseline rate at the second remeasurement. For Study Indicator 2, AHF had a statistically significant improvement for the proportion of members with INR values less than 4.0, increasing from a baseline rate of 86.4 percent to 95.1 percent. At Remeasurement 2, the plan's rate was 91.5 percent. Study Indicator 3, which measured the rate of hospital admissions, decreased from 85.7/1,000 to zero for both remeasurement periods, although the change was not statistically significant.

Santa Clara Family Health Plan targeted adolescent health and obesity prevention for its IQIP. The QIP progressed to the first remeasurement period in which the plan had statistically significant improvement for one of its two study indicators. The plan was successful with increasing the rate of documentation of body mass index (BMI) by a primary care provider, obstetrician, or gynecologist as either a BMI percentile or BMI percentile plotted on an age-growth chart. The plan improved its baseline rate from 23.4 percent to 33.0 percent upon remeasurement. The plan's second study indicator measured documentation in the medical record of counseling for nutrition and physical activity for members with a documented BMI. While the plan had a slight increase from its baseline rate of 33.6 percent to 35.5 percent at Remeasurement 2, the change was not significant.

Central California Alliance for Health initiated an IQIP to improve effective case management to reduce the rate of admissions for its Medi-Cal managed care members with uncontrolled diabetes and for members with congestive heart failure (CHF). At Remeasurement 1, the plan had not reduced the rate of hospital admissions for members with uncontrolled diabetes; however, the rate of admission for members with CHF had a statistically significant decrease from a baseline rate of 71.11 percent to 39.80 percent.

Activity X. Sustained Improvement Achieved

Activity Summary: Two QIPs progressed to the point of assessment for sustained improvement. One achieved sustained improvement and the other achieved sustained improvement for one of its study indicators.

Unlike Activity IX, which measures for statistically significant improvement, Activity X assesses for sustained improvement over comparable time periods or determines that a decline in improvement is not statistically significant. Both of AHF's projects progressed to a second remeasurement period in which HSAG could assess for sustained improvement.

AHF's controlling high blood pressure QIP achieved sustained improvement for both of its study indicators. The plan successfully decreased both systolic and diastolic blood pressure measurements for its members with a diagnosis of hypertension.

For AHF's QIP targeting the reduction of adverse reactions to Coumadin for patients with HIV/AIDS, the plan achieved sustained improvement for reducing the proportion of patients with INR values less than 4.0. The plan did not demonstrate sustained improvement for its other two indicators. The plan did reduce hospitalizations from three at its baseline measurement to zero at both remeasurements. While this change was not statistically significant, the reduction demonstrates meaningful improvement.

Internal QIP Strengths and Opportunities for Improvement

Plans demonstrated proficiency with IQIP study design and study implementation as evidenced by high average rates of *Met* evaluation elements for this review period, January 1, 2010, through March 31, 2010.

Many QIP submissions during the review period were new QIP proposals with multiple study questions and study indicators. Meeting CMS' documentation requirements for these proposals can be challenging. HSAG provided feedback and recommendations to plans to help them strengthen their study design to increase the likelihood of success.

Plans that used a manual data collection process have an opportunity to improve documentation related to Activity VI, Accurate and Complete Data Collection. In addition, plans may benefit from having greater technical assistance with selecting a QIP related to disparities and documenting disparities within a QIP.

Finally, plans have an opportunity to use their data to help drive program decisions. Plans should use their data to identify areas of low performance and/or health disparities, then conduct causal/barrier analysis and select intervention strategies focused on one or more of the identified barriers. HSAG has noted that plans often select intervention strategies before the causal/barrier analysis is done; and frequently, the strategies do not address an identified barrier.

Internal QIP Recommendations

Plans need to ensure that when conducting a QIP that requires a manual data collection process, the QIP should include all required elements as part of its design.

Plans should seek technical assistance for QIPs involving disparities. The State may consider having the EQRO provide some basic training on how to use plan data to identify disparities and how to document a disparity within a QIP.

Plans should use their data to determine areas of low performance and disparities, then conduct causal/barrier analysis and select intervention strategies focused on one or more of the identified barriers. This should help increase the likelihood that plans achieve real and sustained improvement.

Conclusions—Overall QIP Validation Findings

The 37 QIPs validated between January 1, 2010, and March 31, 2010, showed ongoing improvement of plan documentation to increase compliance with CMS' protocol for conducting QIPs.

As of March 31, 2010, all statewide collaborative QIP submissions achieved an overall *Met* validation status for the first remeasurement period.

Care 1st's COPD SGC project showed sustained improvement for all three of its study indicators, which translates into improved care for its Medi-Cal members with COPD. HSAG has noted that plans participating in SGC QIPs have succeeded in showing real and sustained improvement.

AHF Healthcare, a specialty plan, demonstrated sustained improvement for controlling high blood pressure for members with hypertension. The plan also had sustained improvement for reducing INR levels for members on Coumadin. The plan showed meaningful improvement by having no hospitalizations for adverse reactions to Coumadin for its members during both

remeasurement periods. These results indicate that the plan is able to provide targeted, quality care to its specialty population of members diagnosed with HIV/AIDS.

The plans still have an opportunity to apply prior validation feedback provided by the EQRO to subsequent QIP submissions.

Plans need to use their data to drive quality improvement initiatives and interventions instead of selecting QIP topics and interventions prior to analyzing the data. This will increase the likelihood that plans design a study that achieves quality outcomes.

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

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

Table A.1––The DHCS Statewide Collaborative QIPs
January 1, 2010, through March 31, 2010
(*See page A-9 for grid category explanations.)

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

Table A.1––The DHCS Statewide Collaborative QIPs
January 1, 2010, through March 31, 2010
(*See page A-9 for grid category explanations.)

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

Table A.2––Small-Group Collaborative QIPs
January 1, 2010, through March 31, 2010
(*See page A-9 for grid category explanations.)

Plan Name and County	Plan Model Type*	Name of Project/Study	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
CalOptima—Orange	COHS	Appropriate Treatment for Children With Upper Respiratory Infection	Clinical	Decrease inappropriate use of antibiotics in children 3 months–18 years of age.	I – X	Remeasurement 2
Care 1st—San Diego	GMC				I – VIII	Baseline
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 – X closed	Remeasurement 1
Community Health Group—San Diego	GMC				I – IX	Remeasurement 1

Table A.3––Internal QIPs
January 1, 2010, through March 31, 2010
(*See page A-9 for grid category explanations.)

Plan Name and County	Plan Model Type*	Name of Project/Study	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
AHF Healthcare Centers— Los Angeles	SP	Reducing Adverse Reactions to Coumadin for Patients With HIV/AIDS	Clinical	Reduce the number of hospitalizations for members on Coumadin therapy as a result of adverse reactions.	I – X	Remeasurement 2
AHF Healthcare Centers— Los Angeles	SP	Controlling High Blood Pressure	Clinical	Increase the percentage of cases of controlled blood pressure among adults diagnosed with hypertension.	I – X	Remeasurement 2
Alameda Alliance for Health— Alameda	LI	Decrease Return Emergency Room Visits for Asthmatic Exacerbations in Children	Clinical	Reduce the number of children 2–18 years of age who visit the ER with asthma and return to the ER with additional asthmatic events.	I – VIII	Baseline
Anthem Blue Cross— Alameda, Contra Costa, Fresno, San Francisco, San Joaquin, Santa Clara, Sacramento Stanislaus, Tulare	CP GMC LI	Improving HEDIS Postpartum Care Rates	Clinical	Improve the rate of postpartum care visits for female Medi-Cal members.	I – IV	Proposal
CenCal Health— Santa Barbara San Luis Obispo	COHS	Weight Assessment and Counseling Nutrition and Physical Activity for Children/Adolescents	Clinical	Increase body mass index (BMI) documentation for child/adolescent members (ages 3–17) and referrals to counseling for nutrition education and physical activity.	I – VIII	Proposal

Table A.3––Internal QIPs
January 1, 2010, through March 31, 2010
(*See page A-9 for grid category explanations.)

Plan Name and County	Plan Model Type*	Name of Project/Study	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
Central California Alliance for Health**—Monterey, Santa Cruz	COHS	Improving Effective Case Management	Clinical	Increase the effectiveness of case management to reduce hospitalizations related to diabetes and congestive heart failure among adults 21 years of age and older.	I – IX	Remeasurement 1
Community Health Group—San Diego	GMC	Increasing Follow-up to Positive Postpartum Screens	Clinical	Increase the percentage of women receiving a postpartum visit within six months of delivery.	I – IX	Remeasurement 1
Contra Costa Health Plan—Contra Costa	LI	Reducing Health Disparities in Pediatric Obesity	Clinical	Reduce health disparities in childhood obesity among children 3–11 years of age.	I – V	Proposal
Family Mosaic Project—San Francisco	SP	*Project pending – 5/31/2010*				
Family Mosaic Project—San Francisco	SP	*Project pending – 12/31/2010*				
Health Net— Fresno, Kern, Los Angeles, Stanislaus, Tulare Sacramento, San Diego	 CP GMC	Improve Cervical Cancer Screening Among Seniors and Persons With Disabilities	Clinical	Improve cervical cancer screening among female seniors and persons with disabilities 21 through 64 years of age.	I – VIII	Proposal
Health Plan of San Joaquin—San Joaquin	LI	Chlamydia Screening	Clinical	Increase the rate of chlamydia screening in sexually active women 16–25 years of age.	I – IX	Remeasurement 1
Health Plan of San Mateo—San Mateo	COHS	Increasing Timeliness of Prenatal Care	Clinical	Increase the rate of prenatal visits during the first trimester of pregnancy.	I – VIII	Proposal
**Central Coast Alliance for Health changed its name to Central California Alliance for Health effective July 1, 2009.						

Table A.3––Internal QIPs
January 1, 2010, through March 31, 2010
(*See page A-9 for grid category explanations.)

Plan Name and County	Plan Model Type*	Name of Project/Study	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
Inland Empire Health Plan—Riverside, San Bernardino	LI	Attention Deficit Hyperactivity Disorder (ADHD) Management	Clinical	Provide appropriate management for ADHD-identified child members 6–12 years of age.	I – IV	Proposal
Kaiser Permanente (North)—Sacramento	GMC	*Project pending*				
Kaiser Permanente (South)—San Diego	GMC	*Project pending*				
Kaiser PHP—Marin, Sonoma	PHP	Cervical Cancer Screening	Clinical	Increase cervical cancer screening among women 18–64 years of age.	I – X	Remeasurement 3
Kaiser PHP—Marin, Sonoma	PHP	Smoking Prevention	Clinical	Increase the percentage of members 18 years of age and older receiving advice to quit smoking.	I – X	Remeasurement 4
Kern Family Health Care—Kern	LI	Comprehensive Diabetes Care	Clinical	Improve case management of members with diabetes 18–75 years of age by increasing the percentage of members receiving an HbA1c test, LDL-C screening, and retinal eye exams.	I – V	Proposal
L A Care Health Plan—Los Angeles	LI	Improving HbA1c and Diabetic Retinal Exam Screening Rates	Clinical	Improving care and reducing complications for diabetic members 18–75 years of age by increasing the percentage of members who receive screening with HbA1c testing and retinal exams.	I – V	Proposal

Table A.3––Internal QIPs
January 1, 2010, through March 31, 2010
(*See page A-9 for grid category explanations.)

Plan Name and County	Plan Model Type*	Name of Project/Study	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
Molina Healthcare— Riverside, San Bernardino Sacramento, San Diego	CP GMC	Improving Hypertension Control	Clinical	Increase the percentage of members with hypertension ages 18–85 years of age who have controlled blood pressure (systolic blood pressure of <140 mm Hg and diastolic blood pressure of < 90 mm Hg).	I – V	Proposal
Partnership Health Plan— Napa, Solano, Yolo	COHS	Improving Care and Reducing Acute Readmissions for People With COPD	Clinical	Reducing acute readmissions for people with COPD.	I – VII	Proposal
San Francisco Health Plan— San Francisco	LI	*Project pending*				
Santa Clara Family Health— Santa Clara	LI	Adolescent Obesity Prevention	Clinical	Increase screening for adolescent obesity and timeliness of appropriate health education intervention.	I – IX	Remeasurement 1
SCAN Health Plan—Los Angeles, Riverside, San Bernardino	SP	Chronic Obstructive Pulmonary Disease (COPD)	Clinical	Improve treatment for adults 40 years of age and older with COPD.	I – VIII	Baseline

Table A.3––Internal QIPs
January 1, 2010, through March 31, 2010

Plan Name and County	Plan Model Type*	Name of Project/Study	Clinical/ Nonclinical*	QIP Description*	Level of QIP Progress*	
					Steps Validated*	Measurement Completion*
SCAN Health Plan—Los Angeles, Riverside, San Bernardino	SP	Prevention of Stroke and Transient Ischemic Attack (TIA)	Clinical	Reduce the risk and recurrence of stroke or TIA.	I – VIII	Baseline

*Grid category explanations:

Plan Model Type—designated plan model type:

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

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

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

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

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

Table B.1—Statewide Collaborative QIP Activities I to IV Ratings (N = 3 Submissions)
January 1, 2010, through March 31, 2010

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

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

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

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

Table B.2—Statewide Collaborative QIP Activities V to VII Ratings (N = 3 Submissions)
January 1, 2010, through March 31, 2010

	Evaluation Elements	*Met*	*Partially Met*	*Not Met*
Activity V: Valid Sampling Techniques				
	1. Consider and specify the true or estimated frequency of occurrence.	Not applicable	Not applicable	Not applicable
	2. Identify the sample size.	Not applicable	Not applicable	Not applicable
	3. Specify the confidence level.	Not applicable	Not applicable	Not applicable
	4. Specify the acceptable margin of error.	Not applicable	Not applicable	Not applicable
C*	5. Ensure a representative sample of the eligible population.	Not applicable	Not applicable	Not applicable
	6. Are in accordance with generally accepted principles of research design and statistical analysis.	Not applicable	Not applicable	Not applicable
	Activity Average Rates**	**Not applicable**	**Not applicable**	**Not applicable**
Activity VI: Accurate/Complete Data Collection				
	1. The identification of data elements to be collected.	100% (3/3)	0% (0/3)	0% (0/3)
	2. The identification of specified sources of data.	100% (3/3)	0% (0/3)	0% (0/3)
	3. A defined and systematic process for collecting baseline and remeasurement data.	Not applicable	Not applicable	Not applicable
	4. A timeline for the collection of baseline and remeasurement data.	100% (3/3)	0% (0/3)	0% (0/3)
	5. Qualified staff and personnel to abstract manual data.	Not applicable	Not applicable	Not applicable
C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	Not applicable	Not applicable	Not applicable
	7. A manual data collection tool that supports interrater reliability.	Not applicable	Not applicable	Not applicable
	8. Clear and concise written instructions for completing the manual data collection tool.	Not applicable	Not applicable	Not applicable
	9. An overview of the study in written instructions.	Not applicable	Not applicable	Not applicable
	10. Administrative data collection algorithms/flowcharts that show activities in the production of indicators.	100% (3/3)	0% (0/3)	0% (0/3)
	11. An estimated degree of automated data completeness.	100% (3/3)	0% (0/3)	0% (0/3)
	Activity Average Rates**	**100% (15/15)**	**0% (0/15)**	**0% (0/15)**
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	100% (3/3)	0% (0/3)	0% (0/3)
	2. System changes that are likely to induce permanent change.	100% (3/3)	0% (0/3)	0% (0/3)
	3. Revised if original interventions are not successful.	Not applicable	Not applicable	Not applicable
	4. Standardized and monitored if interventions were successful.	50% (1/2)	50% (1/2)	0% (0/2)
	Activity Average Rates**	**88% (7/8)†**	**13% (1/8)†**	**0% (0/8)†**

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

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

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

† The sum may not equal 100 percent due to rounding.

Table B.3—Statewide Collaborative QIP Activities VIII to X Ratings (N = 3 Submissions)
January 1, 2010, through March 31, 2010

	Evaluation Elements	*Met*	*Partially Met*	*Not Met*
Activity VIII: Sufficient Data Analysis and Interpretation				
C*	1. Is conducted according to the data analysis plan in the study design.	100% (3/3)	0% (0/3)	0% (0/3)
C*	2. Allows for the generalization of the results to the study population if a sample was selected.	Not applicable	Not applicable	Not applicable
	3. Identifies factors that threaten the internal or external validity of the findings.	100% (3/3)	0% (0/3)	0% (0/3)
	4. Includes an interpretation of the findings.	100% (3/3)	0% (0/3)	0% (0/3)
	5. Is presented in a way that provides accurate, clear, and easily understood information.	67% (2/3)	33% (1/3)	0% (0/3)
	6. Identifies initial measurement and remeasurement of study indicators.	100% (3/3)	0% (0/3)	0% (0/3)
	7. Identifies statistical differences between initial measurement and remeasurement.	67% (2/3)	33% (1/3)	0% (0/3)
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	100% (3/3)	0% (0/3)	0% (0/3)
	9. Includes interpretation of the extent to which the study was successful.	100% (3/3)	0% (0/3)	0% (0/3)
	Activity Average Rates**	**92% (22/24)**	**8% (2/24)**	**0% (0/24)**
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	100% (3/3)	0% (0/3)	0% (0/3)
	2. There is documented improvement in processes or outcomes of care.	67% (2/3)	0% (0/3)	33% (1/3)
	3. The improvement appears to be the result of planned intervention(s).	67% (2/3)	0% (0/3)	33% (1/3)
	4. There is statistical evidence that observed improvement is true improvement.	67% (2/3)	0% (0/3)	33% (1/3)
	Activity Average Rates**	**75% (9/12)**	**0% (0/12)**	**25% (3/12)**
Activity X: Sustained Improvement Achieved				
	1. Repeated measurements over comparable time periods demonstrate sustained improvement, or that a decline in improvement is not statistically significant.	Δ	Δ	Δ
	Activity Average Rates**	**Δ**	**Δ**	**Δ**

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

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

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

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

Table B.4—Small-Group Collaborative QIP Activities I to IV Ratings (N = 2 Submissions)
January 1, 2010, through March 31, 2010

	Evaluation Elements	Met	Partially Met	Not Met
Activity I: Appropriate Study Topic				
	1. Reflects high-volume or high-risk conditions (or was selected by the State).	100% (2/2)	0% (0/2)	0% (0/2)
	2. Is selected following collection and analysis of data (or was selected by the State).	100% (2/2)	0% (0/2)	0% (0/2)
	3. Addresses a broad spectrum of care and services (or was selected by the State).	100% (2/2)	0% (0/2)	0% (0/2)
	4. Includes all eligible populations that meet the study criteria.	100% (2/2)	0% (0/2)	0% (0/2)
	5. Does not exclude members with special health care needs.	100% (2/2)	0% (0/2)	0% (0/2)
C*	6. Has the potential to affect member health, functional status, or satisfaction.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**100% (12/12)**	**0% (0/12)**	**0% (0/12)**
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	50% (1/2)	50% (1/2)	0% (0/2)
C*	2. Is answerable.	50% (1/2)	50% (1/2)	0% (0/2)
	Activity Average Rates**	**50% (2/4)**	**50% (2/4)**	**0% (0/4)**
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	50% (1/2)	50% (1/2)	0% (0/2)
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	100% (2/2)	0% (0/2)	0% (0/2)
C*	3. Allow for the study questions to be answered.	50% (1/2)	50% (1/2)	0% (0/2)
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	50% (1/2)	50% (1/2)	0% (0/2)
C*	5. Have available data that can be collected on each indicator.	100% (2/2)	0% (0/2)	0% (0/2)
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	100% (2/2)	0% (0/2)	0% (0/2)
	7. Includes the basis on which each indicator was adopted, if internally developed.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**79% (11/14)**	**21% (3/14)**	**0% (0/14)**
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	50% (1/2)	50% (1/2)	0% (0/2)
	2. Includes requirements for the length of a member's enrollment in the plan.	50% (1/2)	50% (1/2)	0% (0/2)
C*	3. Captures all members to whom the study question applies.	50% (1/2)	50% (1/2)	0% (0/2)
	Activity Average Rates**	**50% (3/6)**	**50% (3/6)**	**0% (0/6)**

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

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

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

Table B.5—Small-Group Collaborative QIP Activities V to VII Ratings (N = 2 Submissions)
January 1, 2010, through March 31, 2010

	Evaluation Elements	*Met*	*Partially Met*	*Not Met*
Activity V: Valid Sampling Techniques				
	1. Consider and specify the true or estimated frequency of occurrence.	Not applicable	Not applicable	Not applicable
	2. Identify the sample size.	Not applicable	Not applicable	Not applicable
	3. Specify the confidence level.	Not applicable	Not applicable	Not applicable
	4. Specify the acceptable margin of error.	Not applicable	Not applicable	Not applicable
C*	5. Ensure a representative sample of the eligible population.	Not applicable	Not applicable	Not applicable
	6. Are in accordance with generally accepted principles of research design and statistical analysis.	Not applicable	Not applicable	Not applicable
	Activity Average Rates**	**Not applicable**	**Not applicable**	**Not applicable**
Activity VI: Accurate/Complete Data Collection				
	1. The identification of data elements to be collected.	50% (1/2)	50% (1/2)	0% (0/2)
	2. The identification of specified sources of data.	100% (2/2)	0% (0/2)	0% (0/2)
	3. A defined and systematic process for collecting baseline and remeasurement data.	50% (1/2)	50% (1/2)	0% (0/2)
	4. A timeline for the collection of baseline and remeasurement data.	100% (2/2)	0% (0/2)	0% (0/2)
	5. Qualified staff and personnel to abstract manual data.	50% (1/2)	50% (1/2)	0% (0/2)
C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	50% (1/2)	0% (0/2)	50% (1/2)
	7. A manual data collection tool that supports interrater reliability.	50% (1/2)	0% (0/2)	50% (1/2)
	8. Clear and concise written instructions for completing the manual data collection tool.	50% (1/2)	0% (0/2)	50% (1/2)
	9. An overview of the study in written instructions.	0% (0/2)	0% (0/2)	100% (2/2)
	10. Administrative data collection algorithms/flowcharts that show activities in the production of indicators.	100% (2/2)	0% (0/2)	0% (0/2)
	11. An estimated degree of automated data completeness.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**64% (14/22)†**	**14% (3/22)†**	**23% (5/22)†**
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	100% (2/2)	0% (0/2)	0% (0/2)
	2. System changes that are likely to induce permanent change.	100% (2/2)	0% (0/2)	0% (0/2)
	3. Revised if original interventions are not successful.	Not applicable	Not applicable	Not applicable
	4. Standardized and monitored if interventions were successful.	0% (0/2)	100% (2/2)	0% (0/2)
	Activity Average Rates**	**67% (4/6)**	**33% (2/6)**	**0% (0/6)**

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

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

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

† The sum may not equal 100 percent due to rounding.

Table B.6—Small-Group Collaborative Activities VIII to X Ratings (N = 2 Submissions)
January 1, 2010, through March 31, 2010

	Evaluation Elements	*Met*	*Partially Met*	*Not Met*
Activity VIII: Sufficient Data Analysis and Interpretation				
C*	1. Is conducted according to the data analysis plan in the study design.	50% (1/2)	50% (1/2)	0% (0/2)
C*	2. Allows for the generalization of the results to the study population if a sample was selected.	Not applicable	Not applicable	Not applicable
	3. Identifies factors that threaten the internal or external validity of the findings.	50% (1/2)	0% (0/2)	50% (1/2)
	4. Includes an interpretation of the findings.	50% (1/2)	50% (1/2)	0% (0/2)
	5. Is presented in a way that provides accurate, clear, and easily understood information.	100% (2/2)	0% (0/2)	0% (0/2)
	6. Identifies initial measurement and remeasurement of study indicators.	100% (2/2)	0% (0/2)	0% (0/2)
	7. Identifies statistical differences between initial measurement and remeasurement.	50% (1/2)	50% (1/2)	0% (0/2)
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	50% (1/2)	0% (0/2)	50% (1/2)
	9. Includes interpretation of the extent to which the study was successful.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**69% (11/16)†**	**19% (3/16)†**	**13% (2/16)†**
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	100% (2/2)	0% (0/2)	0% (0/2)
	2. There is documented improvement in processes or outcomes of care.	100% (2/2)	0% (0/2)	0% (0/2)
	3. The improvement appears to be the result of planned intervention(s).	100% (2/2)	0% (0/2)	0% (0/2)
	4. There is statistical evidence that observed improvement is true improvement.	0% (0/2)	100% (2/2)	0% (0/2)
	Activity Average Rates**	**75% (6/8)**	**25% (2/8)**	**0% (0/8)**
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.	100% (2/2)	0% (0/2)	0% (0/2)
	Activity Average Rates**	**100% (2/2)**	**0% (0/2)**	**0% (0/2)**

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

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

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

† The sum may not equal 100 percent due to rounding.

Table B.7—Internal QIP Activities I to IV Ratings (N = 32 Submissions)
January 1, 2010, through March 31, 2010

	Evaluation Elements	Met	Partially Met	Not Met
Activity I: Appropriate Study Topic				
	1. Reflects high-volume or high-risk conditions (or was selected by the State).	100% (32/32)	0% (0/32)	0% (0/32)
	2. Is selected following collection and analysis of data (or was selected by the State).	72% (23/32)	28% (9/32)	0% (0/32)
	3. Addresses a broad spectrum of care and services (or was selected by the State).	100% (32/32)	0% (0/32)	0% (0/32)
	4. Includes all eligible populations that meet the study criteria.	94% (30/32)	3% (1/32)	3% (1/32)
	5. Does not exclude members with special health care needs.	94% (30/32)	0% (0/32)	6% (2/32)
C*	6. Has the potential to affect member health, functional status, or satisfaction.	100% (32/32)	0% (0/32)	0% (0/32)
	Activity Average Rates**	**93% (179/192)**	**5% (10/192)**	**2% (3/192)**
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	75% (24/32)	19% (6/32)	6% (2/32)
C*	2. Is answerable.	75% (24/32)	19% (6/32)	6% (2/32)
	Activity Average Rates**	**75% (48/64)**	**19% (12/64)**	**6% (4/64)**
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	47% (15/32)	53% (17/32)	0% (0/32)
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	97% (30/31)	3% (1/31)	0% (0/31)
C*	3. Allow for the study questions to be answered.	38% (12/32)	56% (18/32)	6% (2/32)
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	50% (16/32)	50% (16/32)	0% (0/32)
C*	5. Have available data that can be collected on each indicator.	100% (32/32)	0% (0/32)	0% (0/32)
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	95% (21/22)	5% (1/22)	0% (0/22)
	7. Includes the basis on which each indicator was adopted, if internally developed.	87% (13/15)	13% (2/15)	0% (0/15)
	Activity Average Rates**	**71% (139/196)**	**28% (55/196)**	**1% (2/196)**
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	59% (19/32)	41% (13/32)	0% (0/32)
	2. Includes requirements for the length of a member's enrollment in the plan.	97% (31/32)	3% (1/32)	0% (0/32)
C*	3. Captures all members to whom the study question applies.	56% (18/32)	38% (12/32)	6% (2/32)
	Activity Average Rates**	**71% (68/96)**	**27% (26/96)**	**2% (2/96)**

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

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

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

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

Table B.8—Internal QIP Activities V to VII Ratings (N = 32 Submissions)
January 1, 2010, through March 31, 2010

	Evaluation Elements	*Met*	*Partially Met*	*Not Met*
Activity V: Valid Sampling Techniques				
	1. Consider and specify the true or estimated frequency of occurrence.	60% (3/5)	20% (1/5)	20% (1/5)
	2. Identify the sample size.	80% (4/5)	20% (1/5)	0% (0/5)
	3. Specify the confidence level.	80% (4/5)	0% (0/5)	20% (1/5)
	4. Specify the acceptable margin of error.	80% (4/5)	0% (0/5)	20% (1/5)
C*	5. Ensure a representative sample of the eligible population.	80% (4/5)	0% (0/5)	20% (1/5)
	6. Are in accordance with generally accepted principles of research design and statistical analysis.	80% (4/5)	0% (0/5)	20% (1/5)
	Activity Average Rates**	**77% (23/30)†**	**7% (2/30)†**	**17% (5/30)†**
Activity VI: Accurate/Complete Data Collection				
	1. The identification of data elements to be collected.	71% (10/14)	29% (4/14)	0% (0/14)
	2. The identification of specified sources of data.	100% (14/14)	0% (0/14)	0% (0/14)
	3. A defined and systematic process for collecting baseline and remeasurement data.	50% (2/4)	50% (2/4)	0% (0/4)
	4. A timeline for the collection of baseline and remeasurement data.	86% (12/14)	14% (2/14)	0% (0/14)
	5. Qualified staff and personnel to abstract manual data.	50% (2/4)	0% (0/4)	50% (2/4)
C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	50% (2/4)	0% (0/4)	50% (2/4)
	7. A manual data collection tool that supports interrater reliability.	50% (2/4)	0% (0/4)	50% (2/4)
	8. Clear and concise written instructions for completing the manual data collection tool.	50% (2/4)	0% (0/4)	50% (2/4)
	9. An overview of the study in written instructions.	50% (2/4)	0% (0/4)	50% (2/4)
	10. Administrative data collection algorithms/flowcharts that show activities in the production of indicators.	86% (12/14)	14% (2/14)	0% (0/14)
	11. An estimated degree of automated data completeness.	85% (11/13)	15% (2/13)	0% (0/13)
	Activity Average Rates**	**76% (71/93)**	**13% (12/93)**	**11% (10/93)**
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	100% (12/12)	0% (0/12)	0% (0/12)
	2. System changes that are likely to induce permanent change.	100% (12/12)	0% (0/12)	0% (0/12)
	3. Revised if original interventions are not successful.	67% (2/3)	0% (0/3)	33% (1/3)
	4. Standardized and monitored if interventions were successful.	0% (0/2)	100% (2/2)	0% (0/2)
	Activity Average Rates**	**90% (26/29)**	**7% (2/29)**	**3% (1/29)**

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

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

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

† The sum may not equal 100 percent due to rounding.

Table B.9—Internal QIP Activities VIII to X Ratings (N = 32 Submissions)
January 1, 2010, through March 31, 2010

	Evaluation Elements	Met	Partially Met	Not Met
Activity VIII: Sufficient Data Analysis and Interpretation				
C*	1. Is conducted according to the data analysis plan in the study design.	33% (4/12)	67% (8/12)	0% (0/12)
C*	2. Allows for the generalization of the results to the study population if a sample was selected.	100% (2/2)	0% (0/2)	0% (0/2)
	3. Identifies factors that threaten the internal or external validity of the findings.	92% (11/12)	8% (1/12)	0% (0/12)
	4. Includes an interpretation of the findings.	33% (4/12)	67% (8/12)	0% (0/12)
	5. Is presented in a way that provides accurate, clear, and easily understood information.	92% (11/12)	8% (1/12)	0% (0/12)
	6. Identifies initial measurement and remeasurement of study indicators.	100% (4/4)	0% (0/4)	0% (0/4)
	7. Identifies statistical differences between initial measurement and remeasurement.	75% (3/4)	25% (1/4)	0% (0/4)
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	75% (3/4)	0% (0/4)	25% (1/4)
	9. Includes interpretation of the extent to which the study was successful.	100% (4/4)	0% (0/4)	0% (0/4)
	Activity Average Rates**	**70% (46/66)†**	**29% (19/66)†**	**2% (1/66)†**
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	100% (4/4)	0% (0/4)	0% (0/4)
	2. There is documented improvement in processes or outcomes of care.	50% (2/4)	50% (2/4)	0% (0/4)
	3. The improvement appears to be the result of planned intervention(s).	50% (2/4)	50% (2/4)	0% (0/4)
	4. There is statistical evidence that observed improvement is true improvement.	0% (0/4)	75% (3/4)	25% (1/4)
	Activity Average Rates**	**50% (8/16)**	**44% (7/16)**	**6% (1/16)**
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.	50% (1/2)	50% (1/2)	0% (0/2)
	Activity Average Rates**	**50% (1/2)**	**50% (1/2)**	**0% (0/2)**

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

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

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

† The sum may not equal 100 percent due to rounding.