

Medi-Cal Managed Care Program
Quality Improvement Projects Status Report
January 1, 2011 – March 31, 2011

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

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1.	EXECUTIVE SUMMARY.....	1
	Purpose of Report	1
	Scope of External Quality Review Activities Conducted	1
	Summary of Overall Validation Findings.....	2
	Summary of Overall QIP Outcomes	3
	Conclusions and Recommendations.....	4
2.	INTRODUCTION.....	5
	Organization of Report.....	5
	QIP Requirements	5
	Description of the QIP Validation Process.....	6
	Evaluating the Overall Validity and Reliability of Study Results.....	6
3.	QUARTERLY QIP ACTIVITY.....	7
	QIP Validation Activities.....	7
4.	SUMMARY OF FINDINGS.....	9
	Findings Specific to the DHCS Statewide Collaborative Quality Improvement Project.....	10
	Study Design	11
	Study Implementation	11
	Quality Outcomes Achieved.....	11
	Statewide Collaborative QIP Strengths and Opportunities for Improvement	12
	Statewide Collaborative QIP Recommendations	13
	Findings Specific to Small-Group Collaborative Quality Improvement Projects.....	13
	Findings Specific to Internal Quality Improvement Projects	14
	Study Design	14
	Study Implementation	15
	Quality Outcomes Achieved.....	15
	Internal QIP Strengths and Opportunities for Improvement.....	16
	Internal QIP Recommendations	16
<i>APPENDIX A.</i>	STATUS OF ACTIVE QIPs	A-1
<i>APPENDIX B.</i>	EVALUATION ELEMENT SCORING TABLES.....	B-1

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, 2011, through March 31, 2011, 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 QIPs¹ 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 Validation 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, unless otherwise specified.

For the period of January 1, 2011, through March 31, 2011, HSAG reviewed six QIPs. Four QIPs were statewide collaborative submissions for *Reducing Avoidable Emergency Room (ER) Visits* and two were internal QIPs, one which addressed advanced directives and the other that related to reducing hospital admissions for members with congestive heart failure (CHF) and members with diabetes.

Three statewide collaborative QIP submissions were resubmissions from the prior review period, October 1, 2010 through December 31, 2010 and one was an annual submission. One of the internal QIPs was a project proposal resubmission while the other was an annual submission.

Five of the six QIPs validated received an overall *Met* validation status and one received an overall *Partially Met* validation status. The *Partially Met* QIP will require a resubmission during the next review period. HSAG will report the results of this resubmission in the next QIP's Status Report covering the period of April 1, 2011, through June 30, 2011.

Summary of Overall QIP Outcomes

The statewide collaborative *Reducing Avoidable Emergency Room (ER) Visits* QIPs progressed to the point of at least one remeasurement period. This allowed HSAG to assess for statistically significant improvement, which is considered real improvement, between remeasurement periods.

Two statewide collaborative QIPs, submitted by Care 1st—San Diego County and Kern Family Health Care—Kern County, demonstrated a statistically significant reduction in the avoidable ER visits rate between Remeasurement 1 and Remeasurement 2. Health Plan of San Joaquin—San Joaquin County and CalOptima—Orange County did not achieve statistically significant reductions.

Of the two internal QIP submissions, only Central California Alliance for Health—Monterey and Santa Cruz Counties' *Improving Effective Case Management* internal QIP progressed to the point for assessing real improvement. The plan did not achieve statistically significant decreases in hospital admission rates for members with CHF or members with diabetes between its first and second remeasurement period.

In addition to assessing for statistically significant improvement, HSAG also assesses QIPs for sustained improvement over comparable time periods or determined that a decline in improvement was not statistically significant. Of the four collaborative QIP submissions, only one plan, CalOptima—Orange County, demonstrated sustained improvement for reducing its avoidable ER visits rate. The plan achieved a statistically significant reduction in the avoidable ER visits rates between the baseline and first measurement period and sustained that reduction during this review period.

Only one individual QIP submission by Central California Alliance for Health progressed to the point of assessing for sustained improvement. While Central California Alliance for Health—Monterey and Santa Cruz Counties' *Improving Effective Case Management* internal QIP did not demonstrate statistically significant improvement between its first and second remeasurement periods, the plan did demonstrate sustained improvement for a reduction in the hospital readmissions rates for members with CHF. The plan did not achieve sustained improvement for members with diabetes.

Conclusions and Recommendations

QIPs validated during the review period of January 1, 2011, through March 31, 2011, showed that overall plans continued to demonstrate strength in the study design and study implementation phases of the QIPs but struggled to achieve quality outcomes.

Plans could improve documentation in their QIPs to ensure that they include an interpretation of the study findings, as this evaluation element continues to be one of the lowest scoring validation elements. Additionally, DHCS and plans have an opportunity to determine what factors may have contributed to CalOptima—Orange County's success in reducing avoidable ER visits rate and whether the plan's actions could be replicated by others to achieve similar results.

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 438.240³ requires that all states operating a Medicaid managed care program ensure that their contracted plans conduct QIPs.

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

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

Description of the QIP Validation Process

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

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

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

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

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

QIP validation ensures that:

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

Evaluating the Overall Validity and Reliability of Study Results

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

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

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

QIP Validation Activities

HSAG reviewed six QIPs for the period of January 1, 2011, through March 31, 2011.

Table 3.1—Medi-Cal Managed Care Program Quarterly Quality Improvement Program Validation Activity on page 8 lists the QIPs by plan and subject.

During the review period, HSAG continued to provide technical assistance to Family Mosaic Project—San Francisco County related to its second QIP proposal. The plan met the DHCS January 1, 2011 deadline for submission of its QIP proposal. HSAG will conduct validation of the project proposal during the next review period, April 1, 2011, through June 30, 2011.

Table 3.1 summarizes the QIPs HSAG 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 QIP Activity
January 1, 2011, through March 31, 2011**

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					
CalOptima—Orange	<i>Reducing Avoidable Emergency Room Visits</i>	Resubmission	97%	100%	<i>Met</i>
Care 1st—San Diego	<i>Reducing Avoidable Emergency Room Visits</i>	Resubmission	89%	100%	<i>Met</i>
Health Plan of San Joaquin—San Joaquin	<i>Reducing Avoidable Emergency Room Visits</i>	Resubmission	90%	100%	<i>Met</i>
Kern Family Health Care—Kern	<i>Reducing Avoidable Emergency Room Visits</i>	Annual Submission	89%	100%	<i>Met</i>
Internal QIPs					
AHF Healthcare Centers—Los Angeles	<i>Advance Directives</i>	Proposal Resubmission 2	100%	100%	<i>Met</i>
Central California Alliance for Health—Monterey/Santa Cruz	<i>Improving Effective Case Management</i>	Annual Submission	79%	90%	<i>Partially Met</i>
<p>¹Type 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 <i>Met</i> validation status.</p> <p>²Percentage Score of Evaluation Elements Met—The percentage score is calculated by dividing the total elements <i>Met</i> (critical and non-critical) by the sum of the total elements of all categories (<i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i>).</p> <p>³Percentage Score of Critical Elements Met—The percentage score of critical elements <i>Met</i> is calculated by dividing the total critical elements <i>Met</i> by the sum of the critical elements <i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i>.</p> <p>⁴Overall Validation Status—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were <i>Met</i>, <i>Partially Met</i>, or <i>Not Met</i>.</p> <p>*Not Applicable—Percentage scores were not applied for a small number of QIPs still in the process of final QIP submission/closeout, for which a new scoring methodology had not yet been implemented.</p>					

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:

1. 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.

2. 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.

3. 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 Quality Improvement Project

All plans submitted their *Reducing Avoidable Emergency Room (ER) Visits* collaborative QIPs for validation in October 2010; therefore, HSAG validated all of the ER collaborative QIP submissions in the prior review period, October 1, 2010, through December 31, 2010, with the exception of Kern Family Health Plan—Kern County’s submission due to data discrepancies that the plan needed to resolve prior to validation. During this review period, January 1, 2011, through March 31, 2011, HSAG validated this annual QIP submission along with three QIP resubmissions.

The target of the statewide ER collaborative is to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider in an office or clinic setting among members 12 months of age and older.

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 = 4 Submissions)
January 1, 2011, through March 31, 2011**

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	Not Applicable		
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	92%	0%	8%
Quality Outcomes Achieved	VIII: Sufficient Data Analysis and Interpretation \pm	84%	9%	6%
	IX: Real Improvement Achieved	75%	0%	25%
	X: Sustained Improvement Achieved	25%	25%	50%
<p>* The activity average rate represents the average percentage of applicable elements with a <i>Met</i>, <i>Partially Met</i>, or <i>Not Met</i> finding across all the evaluation elements for a particular activity. See Appendix B for the number and a description of evaluation elements.</p> <p>\pm The sum may not equal 100 percent due to rounding.</p>				

Study Design

QIPs submitted during this review period demonstrated sound study design, with Activities I through IV receiving very high *Met* validation scores. All QIP submissions received 100 percent scores for all activities in the Study Design phase.

Study Implementation

Similar to the Study Design stage, many QIPs received high validation scores for all evaluation elements in Activities V through VII. The project did not use sampling techniques; therefore all QIPs received a *Not Applicable* score for Activity V. All QIPs received 100 percent scores for accurate and complete data collection. For Activity VII, Appropriate Improvement Strategies, HSAG assessed whether the plan standardized and monitored successful interventions. Kern Family Health Care—Kern County lacked this documentation; therefore, the overall activity average was 92 percent.

Quality Outcomes Achieved

All QIP submissions validated during the review period progressed to a second remeasurement period, and HSAG assessed Activities VIII through X to determine whether the plans achieved the intended quality outcome of reducing avoidable ER visits.

Activity VIII. Sufficient Data Analysis and Interpretation

Activity Summary: Overall, QIP submissions provided sufficient data analysis and interpretation.

For this activity, HSAG assessed whether the plans had sufficient data analysis and interpretation of results between remeasurement periods. Overall, plans documented adequate data analysis and interpretation with an activity average of 84 percent.

The lowest scoring evaluation element under this activity related to interpretation of the study findings. Two of the four QIP submissions lacked adequate documentation, which resulted in *Partially Met* scores for this element and included submissions from Care 1st—San Diego County and Kern Family Health Care—Kern County. Additionally Care 1st—San Diego received *Not Met* scores under this activity because it did not identify factors that may threaten the validity of the findings and did not identify factors that may affect the ability to compare the initial measurement with remeasurement. Kern Family Health Care—Kern County received a *Partially Met* validation score for identifying statistical differences between measurement periods because it did not include an interpretation of the statistical testing.

Activity IX. Real Improvement Achieved

Activity Summary: Two QIPs achieved a statistically significant reduction in the avoidable ER visits rate between Remeasurement 1 and Remeasurement 2.

Both Care 1st—San Diego County and Kern Family Health Care—Kern County demonstrated a statistically significant reduction in the avoidable ER visits rate between Remeasurement 1 and Remeasurement 2. Health Plan of San Joaquin—San Joaquin County and CalOptima—Orange County did not achieve statistically significant reductions. In the initial QIP submission validated by HSAG in the prior review period, Health Plan of San Joaquin—San Joaquin County reported a statistically significant increase; however, upon resubmission, the plan corrected its rates which did not result in a statistically significant reduction in the ER visits rate.

Activity X. Sustained Improvement Achieved

Activity Summary: One QIP achieved sustained improvement for reducing avoidable ER visits rate.

Unlike Activity IX, which measured for statistically significant improvement, Activity X assessed for sustained improvement over comparable time periods or determined that a decline in improvement was not statistically significant.

While CalOptima did not demonstrate a statistically significant improvement between the first and second remeasurement period, the plan did achieve sustained improvement during the second remeasurement period by maintaining improvement demonstrated by the plan between the baseline and first remeasurement period. Kern Family Health Care—Kern County received a *Partially Met* score, as the plan had a statistically significant reduction between the first and second remeasurement period but had a statistically significant increase in avoidable ER visits between the baseline and first remeasurement period. Health Plan of San Joaquin—San Joaquin County's updated QIP results showed that the plan did not achieve sustained improvement.

Statewide Collaborative QIP Strengths and Opportunities for Improvement

All statewide collaborative QIP submissions validated during the review period achieved an overall *Met* validation status, demonstrating accurate and valid results. Plans had better validation performance for Study Design and Study Implementation phases and scored lowest in the Quality Outcomes Achieved phase.

Plans had challenges with interpreting study findings in terms of standardizing effective interventions. Two QIPs demonstrated statistically significant improvement between remeasurement years, and one plan had sustained improvement in reducing avoidable ER visits rates.

Statewide Collaborative QIP Recommendations

Plans need to improve their documentation with study result interpretation and intervention modification and revision.

The DHCS, plans, and HSAG should conduct further analysis to determine what factors may have contributed to the sustained improvement for Cal Optima—Orange County. This plan is the only plan to achieve sustained improvement for the reduction of ER visits.

Findings Specific to Small-Group Collaborative Quality Improvement Projects

No plans submitted small-group collaborative QIPs during the review period.

Findings Specific to Internal Quality Improvement Projects

Plans submitted two internal QIPs (IQIPs) for validation from January 1, 2011, through March 31, 2011. Of the two QIPs submitted, one was an annual submission and one was a proposal resubmission.

AHF Healthcare Centers—Los Angeles County’s *Advance Directives* QIP proposal resubmission received an overall *Met* validation status. Central California Alliance for Health in Monterey and Santa Cruz Counties received an overall *Partially Met* validation status for its *Improving Effective Case Management* annual QIP submission.

Table 4.2 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 4.2—Internal QIP Activity Average Rates* (N = 2 Submissions)
January 1, 2011, through March 31, 2011**

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)	75%	25%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Study Implementation	V: Valid Sampling Techniques	Not Applicable		
	VI: Accurate/Complete Data Collection	80%	20%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Quality Outcomes Achieved	VIII: Sufficient Data Analysis and Interpretation [±]	75%	13%	13%
	IX: Real Improvement Achieved	25%	50%	25%
	X: Sustained Improvement Achieved	0%	100%	0%
<p>* The activity average rate represents the average percentage of applicable elements with a <i>Met</i>, <i>Partially Met</i>, or <i>Not Met</i> finding across all the evaluation elements for a particular activity. See Appendix B for the number and a description of evaluation elements.</p> <p>[±] The sum may not equal 100 percent due to rounding.</p>				

Study Design

Overall activity average scores for the Study Design phase were high. AHF Healthcare Centers—Los Angeles County’s *Advance Directives* QIP received 100 percent scores for all study design elements.

Central California Alliance for Health in Monterey and Santa Cruz Counties received nearly all *Met* validation scores for its *Improving Effective Case Management* QIP for study design

evaluation elements. The plan received a *Partially Met* validation score under evaluation elements related to the study question because the plan did not address the prior year's point of clarification to restate the study question in terms of decreasing admission rates versus the number of admissions. HSAG made this recommendation because decreasing the number of admissions will not always result in a decreased rate due to fluctuations in the denominator.

Study Implementation

HSAG only assessed Central California Alliance for Health—Monterey and Santa Cruz Counties' *Improving Effective Case Management* QIP for activities V–VII since AHF Healthcare Centers—Los Angeles County's *Advance Directives* QIP submission was a proposal resubmission that did not progress to the point of providing study implementation information. Central California Alliance for Health did not use sampling techniques; therefore, HSAG did not assess Activity V. The plan achieved an 80 percent activity average rate for *Met* elements scored under accurate and complete data collection. The plan received a *Partially Met* score for one evaluation element because it did not include a timeline for data collection for all measurement periods. Under appropriate improvement strategies, the plan met 100 percent of the evaluation element criteria.

Quality Outcomes Achieved

HSAG only assessed Central California Alliance for Health—Monterey and Santa Cruz Counties' *Improving Effective Case Management* QIP to determine whether the plan achieved its targeted outcomes. AHF Healthcare Centers—Los Angeles County's *Advance Directives* QIP did not progress to a point of remeasurement.

Activity VIII. Sufficient Data Analysis and Interpretation

Central California Alliance for Health—Monterey and Santa Cruz Counties' *Improving Effective Case Management* QIP met all evaluation elements for providing sufficient data analysis and interpretation with the exception of including an interpretation of the findings.

Activity IX. Real Improvement Achieved

HSAG assessed whether Central California Alliance for Health—Monterey and Santa Cruz Counties' *Improving Effective Case Management* QIP had statistically significant improvement between remeasurement periods. The plan's QIP goal was to decrease hospital admission rates for members with uncontrolled diabetes and for members with congestive heart failure (CHF). The plan did not achieve statistically significant reductions in hospital admission rates for either study indicator between the first and second remeasurement periods.

Activity X. Sustained Improvement Achieved

Unlike Activity IX, which measured for statistically significant improvement, Activity X assessed for sustained improvement over comparable time periods or determined that a decline in improvement was not statistically significant. Central California Alliance for Health—Monterey and Santa Cruz Counties' *Improving Effective Case Management* QIP achieved sustained improvement for its second study indicator that reduced the hospital admission rate for members 21 years and older with CHF from a baseline rate of 71.11 to 39.80 in Remeasurement Year 1, to 38.00 in Remeasurement Year 2. The plan did not achieve a reduction in hospital admission rates for members with uncontrolled diabetes.

Internal QIP Strengths and Opportunities for Improvement

Similar to statewide collaborative QIP validation results, plans demonstrated the greatest success and proficiency with the Study Design and Study Implementation phases for internal QIP submissions.

Only one QIP was assessed for quality outcomes achieved during the review period. The results showed mixed results: Central California Alliance for Health—Monterey and Santa Cruz Counties' *Improving Effective Case Management* QIP achieved sustained improvement for the reduction of hospital admissions rate among members with CHF but did not demonstrate a reduction in admissions for members with diabetes.

Internal QIP Recommendations

Central California Alliance for Health should conduct further analysis to determine what factors may have led to the significant reduction in admissions for CHF members but did not have a positive impact on members with diabetes.

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, 2011, through March 31, 2011**
(*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 – X	Remeasurement 2
Anthem Blue Cross— Alameda, Contra Costa, Fresno, San Francisco, San Joaquin, Santa Clara, Sacramento	CP			I – X	Remeasurement 2
Stanislaus, Tulare	GMC				
	LI				
CalOptima—Orange	COHS			I – X	Remeasurement 2
Care 1st Partner Plan—San Diego	GMC			I – X	Remeasurement 2
CenCal Health Plan—Santa Barbara	COHS			I – X	Remeasurement 2
CenCal Health Plan—San Luis Obispo	COHS			I – IX	Remeasurement 1
Central California Alliance for Health Monterey, Santa Cruz	COHS			I – X	Remeasurement 2
Community Health Group—San Diego	GMC			I – X	Remeasurement 2
Contra Costa Health Plan—Contra Costa	LI			I – X	Remeasurement 2
Health Net— Fresno, Kern, Los Angeles, Stanislaus, Tulare	CP			I – X	Remeasurement 2
Sacramento, San Diego	GMC				
Health Plan of San Joaquin—San Joaquin	LI			I – X	Remeasurement 2
Health Plan of San Mateo—San Mateo	COHS			I – X	Remeasurement 2
Inland Empire Health Plan—Riverside, San Bernardino	LI	I – X	Remeasurement 2		

**Table A.1—The DHCS Statewide Collaborative QIPs
January 1, 2011, through March 31, 2011**
(*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 – X	Remeasurement 2
Kaiser Permanente (South)—San Diego	GMC			I – X	Remeasurement 2
Kern Family Health Care—Kern	LI			I – X	Remeasurement 2
L A Care Health Plan—Los Angeles	LI			I – X	Remeasurement 2
Molina Healthcare— Riverside, San Bernardino	CP			I – X	Remeasurement 2
Sacramento, San Diego	GMC			I – X	Remeasurement 2
Partnership Health Plan—Napa, Solano, Yolo	COHS			I – X	Remeasurement 2
San Francisco Health Plan—San Francisco	LI			I – X	Remeasurement 2
Santa Clara Family Health Plan—Santa Clara	LI			I – X	Remeasurement 2

**Table A.2—Small-Group Collaborative QIPs
January 1, 2011, through March 31, 2011**
(*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*
Community Health Group— 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 2

Table A.3—Internal QIPs
January 1, 2011, through March 31, 2011
 (*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	Advance Directives	Clinical	Increase the percentage of members with AIDS that have an advance directive.	I – IV	Proposal
AHF Healthcare Centers— Los Angeles	SP	CD4 and Viral Load Testing	Clinical	Increase the percentage of members with AIDS that have three CD4 and Viral Load tests per year.	I – IV	Proposal
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 – IX	Remeasurement 1
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 – VIII	Baseline
CenCal Health Plan— 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 – IX	Remeasurement 1 /Baseline

Table A.3—Internal QIPs
January 1, 2011, through March 31, 2011
 (*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 – X	Remeasurement 2
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 – X Closed	Remeasurement 2
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 – VIII	Baseline
Family Mosaic Project—San Francisco	SP	Reduction of Out-of-Home Placement	Clinical	Increase the percentage of members discharged to an out-of-home placement.	I – VIII	Baseline
Family Mosaic Project—San Francisco	SP	School Attendance—pending DHCS review and approval of topic	Nonclinical	Improve school attendance for members who were determined to need intervention.		
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	Baseline
Health Plan of San Joaquin—San Joaquin	LI	<i>Project proposal pending</i>				
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	Baseline

Table A.3—Internal QIPs
January 1, 2011, through March 31, 2011
 (*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 – VIII	Baseline
Kaiser Permanente (North)—Sacramento	GMC	Childhood/Adolescent Obesity	Clinical	Increase the percentage of members 3–17 years of age who have a documented body mass index and received counseling for nutrition and physical activity.	I – VIII	Baseline
Kaiser Permanente (South)—San Diego	GMC	Postpartum Care	Clinical	Improve the rate of postpartum care.	I – IX	Remeasurement 1
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 – IX	Remeasurement 1
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 – VIII	Baseline

Table A.3—Internal QIPs
January 1, 2011, through March 31, 2011
 (*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 – VIII	Baseline
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 – IX	Remeasurement 1
San Francisco Health Plan—San Francisco	LI	Improving the Patient Experience	Nonclinical	Increase the percentage of members selecting the top response for the communication composite on a patient satisfaction survey.	I – IX	Remeasurement 1
Santa Clara Family Health Plan—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 – X Closed	Remeasurement 2

**Table A.3—Internal QIPs
January 1, 2011, through March 31, 2011**

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	Remeasurement 1

*Grid category explanations:

Plan Model Type—designated plan model type:

- ◆ County-Organized 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 = 4 Submissions)
January 1, 2011, through March 31, 2011**

	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% (4/4)	0% (0/4)	0% (0/4)
	2. Is selected following collection and analysis of data (or was selected by the State).	100% (4/4)	0% (0/4)	0% (0/4)
	3. Addresses a broad spectrum of care and services (or was selected by the State).	100% (4/4)	0% (0/4)	0% (0/4)
	4. Includes all eligible populations that meet the study criteria.	100% (4/4)	0% (0/4)	0% (0/4)
	5. Does not exclude members with special health care needs.	100% (4/4)	0% (0/4)	0% (0/4)
C*	6. Has the potential to affect member health, functional status, or satisfaction.	100% (4/4)	0% (0/4)	0% (0/4)
	Activity Average Rates**	100% (24/24)	0% (0/24)	0% (0/24)
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	100% (4/4)	0% (0/4)	0% (0/4)
C*	2. Is answerable.	100% (4/4)	0% (0/4)	0% (0/4)
	Activity Average Rates**	100% (8/8)	0% (0/8)	0% (0/8)
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	100% (4/4)	0% (0/4)	0% (0/4)
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	100% (4/4)	0% (0/4)	0% (0/4)
C*	3. Allow for the study questions to be answered.	100% (4/4)	0% (0/4)	0% (0/4)
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	100% (4/4)	0% (0/4)	0% (0/4)
C*	5. Have available data that can be collected on each indicator.	100% (4/4)	0% (0/4)	0% (0/4)
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	100% (4/4)	0% (0/4)	0% (0/4)
	7. Includes the basis on which each indicator was adopted, if internally developed.	100% (4/4)	0% (0/4)	0% (0/4)
	Activity Average Rates**	100% (28/28)	0% (0/28)	0% (0/28)
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	100% (4/4)	0% (0/4)	0% (0/4)
	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% (4/4)	0% (0/4)	0% (0/4)
	Activity Average Rates**	100% (8/8)	0% (0/8)	0% (0/8)
<p>Note: Activity evaluation element columns represent the average percentage for <i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i> elements. All <i>Not Applicable</i> and <i>Not Assessed</i> elements are excluded.</p> <p>**“C” in this column denotes a critical element in HSAG’s validation protocol. Plans must receive a <i>Met</i> score for these elements for a QIP to receive a <i>Met</i> validation status.</p> <p>**The activity average rate represents the average percentage of elements with a <i>Met</i>, <i>Partially Met</i>, or <i>Not Met</i> finding across all the evaluation elements for a particular activity. All <i>Not Applicable</i> or <i>Not Assessed</i> findings are excluded.</p>				

**Table B.2—Statewide Collaborative QIP Activities V to VII Ratings (N = 4 Submissions)
January 1, 2011, through March 31, 2011**

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% (4/4)	0% (0/4)	0% (0/4)
	2. The identification of specified sources of data.	100% (4/4)	0% (0/4)	0% (0/4)
	3. A defined and systematic process for collecting baseline and remeasurement data.	100% (1/1)	0% (0/1)	0% (0/1)
	4. A timeline for the collection of baseline and remeasurement data.	100% (4/4)	0% (0/4)	0% (0/4)
	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% (4/4)	0% (0/4)	0% (0/4)
	11. An estimated degree of automated data completeness.	100% (4/4)	0% (0/4)	0% (0/4)
Activity Average Rates**		100% (21/21)	0% (0/21)	0% (0/21)
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	100% (4/4)	0% (0/4)	0% (0/4)
	2. System changes that are likely to induce permanent change.	100% (4/4)	0% (0/4)	0% (0/4)
	3. Revised if original interventions are not successful.	100% (2/2)	0% (0/2)	0% (0/2)
	4. Standardized and monitored if interventions were successful.	67% (2/3)	0% (0/3)	33% (1/3)
Activity Average Rates**		92% (12/13)	0% (0/13)	8% (1/13)
<p>Note: Activity evaluation element columns represent the average percentage for <i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i> elements. All <i>Not Applicable</i> and <i>Not Assessed</i> elements are excluded.</p> <p>*“C” in this column denotes a critical element in HSAG’s validation protocol. Plans must receive a <i>Met</i> score for these elements for a QIP to receive a <i>Met</i> validation status.</p> <p>**The activity average rate represents the average percentage of elements with a <i>Met</i>, <i>Partially Met</i>, or <i>Not Met</i> finding across all the evaluation elements for a particular activity. All <i>Not Applicable</i> or <i>Not Assessed</i> findings are excluded.</p>				

**Table B.3—Statewide Collaborative QIP Activities VIII to X Ratings (N = 4 Submissions)
January 1, 2011, through March 31, 2011**

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% (4/4)	0% (0/4)	0% (0/4)
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.	75% (3/4)	0% (0/4)	25% (1/4)
	4. Includes an interpretation of the findings.	50% (2/4)	50% (2/4)	0% (0/4)
C*	5. Is presented in a way that provides accurate, clear, and easily understood information.	100% (4/4)	0% (0/4)	0% (0/4)
	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**		84% (27/32)	9% (3/32)	6% (2/32)
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.	75% (3/4)	0% (0/4)	25% (1/4)
	3. The improvement appears to be the result of planned intervention(s).	75% (3/4)	0% (0/4)	25% (1/4)
	4. There is statistical evidence that observed improvement is true improvement.	50% (2/4)	0% (0/4)	50% (2/4)
Activity Average Rates**		75% (12/16)	0% (0/16)	25% (4/16)
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.	25% (1/4)	25% (1/4)	50% (2/4)
Activity Average Rates**		25% (1/4)	25% (1/4)	50% (2/4)
<p>Note: Activity evaluation element columns represent the average percentage for <i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i> elements. All <i>Not Applicable</i> and <i>Not Assessed</i> elements are excluded.</p> <p>**“C” in this column denotes a critical element in HSAG’s validation protocol. Plans must receive a <i>Met</i> score for these elements for a QIP to receive a <i>Met</i> validation status.</p> <p>**The activity average rate represents the average percentage of elements with a <i>Met</i>, <i>Partially Met</i>, or <i>Not Met</i> finding across all the evaluation elements for a particular activity. All <i>Not Applicable</i> or <i>Not Assessed</i> findings are excluded.</p>				

**Table B.4—Internal QIP Activities I to IV Ratings (N = 2 Submissions)
January 1, 2011, through March 31, 2011**

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% (1/1)	0% (0/1)	0% (0/1)
	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% (11/11)	0% (0/11)	0% (0/11)
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.	100% (2/2)	0% (0/2)	0% (0/2)
Activity Average Rates**		75% (3/4)	25% (1/4)	0% (0/4)
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	100% (2/2)	0% (0/2)	0% (0/2)
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	100% (2/2)	0% (0/2)	0% (0/2)
C*	3. Allow for the study questions to be answered.	100% (2/2)	0% (0/2)	0% (0/2)
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	100% (2/2)	0% (0/2)	0% (0/2)
C*	5. Have available data that can be collected on each indicator.	100% (2/2)	0% (0/2)	0% (0/2)
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	100% (2/2)	0% (0/2)	0% (0/2)
	7. Includes the basis on which each indicator was adopted, if internally developed.	Not applicable	Not applicable	Not applicable
Activity Average Rates**		100% (12/12)	0% (0/12)	0% (0/12)
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	100% (2/2)	0% (0/2)	0% (0/2)
	2. Includes requirements for the length of a member's enrollment in the plan.	100% (2/2)	0% (0/2)	0% (0/2)
C*	3. Captures all members to whom the study question applies.	100% (2/2)	0% (0/2)	0% (0/2)
Activity Average Rates**		100% (6/6)	0% (0/6)	0% (0/6)
<p>Note: Activity evaluation element columns represent the average percentage for <i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i> elements. All <i>Not Applicable</i> and <i>Not Assessed</i> elements are excluded.</p> <p>*"C" in this column denotes a critical element in HSAG's validation protocol. Plans must receive a <i>Met</i> score for these elements for a QIP to receive a <i>Met</i> validation status.</p> <p>**The activity average rate represents the average percentage of elements with a <i>Met</i>, <i>Partially Met</i>, or <i>Not Met</i> finding across all the evaluation elements for a particular activity. All <i>Not Applicable</i> or <i>Not Assessed</i> findings are excluded.</p>				

Table B.5—Internal QIP Activities V to VII Ratings (N = 2 Submissions)
January 1, 2011, through March 31, 2011

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% (1/1)	0% (0/1)	0% (0/1)
	2. The identification of specified sources of data.	100% (1/1)	0% (0/1)	0% (0/1)
	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.	0% (0/1)	100% (1/1)	0% (0/1)
	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% (1/1)	0% (0/1)	0% (0/1)
	11. An estimated degree of automated data completeness.	100% (1/1)	0% (0/1)	0% (0/1)
Activity Average Rates**		80% (4/5)	20% (1/5)	0% (0/5)
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	100% (1/1)	0% (0/1)	0% (0/1)
	2. System changes that are likely to induce permanent change.	100% (1/1)	0% (0/1)	0% (0/1)
	3. Revised if original interventions are not successful.	100% (1/1)	0% (0/1)	0% (0/1)
	4. Standardized and monitored if interventions were successful.	Not applicable	Not applicable	Not applicable
Activity Average Rates**		100% (3/3)	0% (0/3)	0% (0/3)
<p>Note: Activity evaluation element columns represent the average percentage for <i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i> elements. All <i>Not Applicable</i> and <i>Not Assessed</i> elements are excluded.</p> <p>*“C” in this column denotes a critical element in HSAG’s validation protocol. Plans must receive a <i>Met</i> score for these elements for a QIP to receive a <i>Met</i> validation status.</p> <p>**The activity average rate represents the average percentage of elements with a <i>Met</i>, <i>Partially Met</i>, or <i>Not Met</i> finding across all the evaluation elements for a particular activity. All <i>Not Applicable</i> or <i>Not Assessed</i> findings are excluded.</p>				

**Table B.6—Internal QIP Activities VIII to X Ratings (N = 2 Submissions)
January 1, 2011, through March 31, 2011**

	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% (1/1)	0% (0/1)	0% (0/1)
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% (1/1)	0% (0/1)	0% (0/1)
	4. Includes an interpretation of the findings.	0% (0/1)	100% (1/1)	0% (0/1)
C*	5. Is presented in a way that provides accurate, clear, and easily understood information.	100% (1/1)	0% (0/1)	0% (0/1)
	6. Identifies initial measurement and remeasurement of study indicators.	100% (1/1)	0% (0/1)	0% (0/1)
	7. Identifies statistical differences between initial measurement and remeasurement.	100% (1/1)	0% (0/1)	0% (0/1)
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	0% (0/1)	0% (0/1)	100% (1/1)
	9. Includes interpretation of the extent to which the study was successful.	100% (1/1)	0% (0/1)	0% (0/1)
	Activity Average Rates**	75% (6/8)	13% (1/8)	13% (1/8)
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	100% (1/1)	0% (0/1)	0% (0/1)
	2. There is documented improvement in processes or outcomes of care.	0% (0/1)	100% (1/1)	0% (0/1)
	3. The improvement appears to be the result of planned intervention(s).	0% (0/1)	100% (1/1)	0% (0/1)
	4. There is statistical evidence that observed improvement is true improvement.	0% (0/1)	0% (0/1)	100% (1/1)
	Activity Average Rates**	25% (1/4)	50% (2/4)	25% (1/4)
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.	0% (0/1)	100% (1/1)	0% (0/1)
	Activity Average Rates**	0% (0/1)	100% (1/1)	0% (0/1)
<p>Note: Activity evaluation element columns represent the average percentage for <i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i> elements. All <i>Not Applicable</i> and <i>Not Assessed</i> elements are excluded.</p> <p>*"C" in this column denotes a critical element in HSAG's validation protocol. Plans must receive a <i>Met</i> score for these elements for a QIP to receive a <i>Met</i> validation status.</p> <p>**The activity average rate represents the average percentage of elements with a <i>Met</i>, <i>Partially Met</i>, or <i>Not Met</i> finding across all the evaluation elements for a particular activity. All <i>Not Applicable</i> or <i>Not Assessed</i> findings are excluded.</p>				