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

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

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Purpose of Report

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

This QIPs Status Report provides a summary of QIPs validated during the period of October 1, 2010, through December 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 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 October 1, 2010, through December 31, 2010, HSAG reviewed 53 QIPs. Twenty-four QIPs were statewide collaborative submissions for *Reducing Avoidable Emergency Room (ER) Visits,* one was a small-group collaborative QIP addressing chronic obstructive pulmonary disease (COPD), and 28 were internal QIPs initiated at the individual plan level representing many different topic areas.

QIP submissions were a mixture of proposals, proposal resubmissions, annual submissions, and annual resubmissions. All of the statewide collaborative submissions were annual submissions while most of the individual QIPs were resubmissions from the prior review period of July 1, 2010, through September 30, 2010.

Forty-three of the 53 QIPs validated received an overall *Met* validation status, ten received an overall *Partially Met* validation status, and none received an overall *Not Met* validation status. All *Partially Met* QIPs will require a resubmission during the next review period. HSAG will report the results of these resubmissions in the next QIP's Status Report covering the period of January 1, 2011, through March 31, 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 the baseline and remeasurement rates.

Five of 19 plans demonstrated a statistically significant reduction in the avoidable ER visits rate between Remeasurement 1 and Remeasurement 2. These plans include:

- Alameda Alliance for Health–Alameda County
- Care 1st–San Diego County
- Contra Costa Health Plan–Contra Costa County
- Health Net–Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties
- Health Plan of San Joaquin–San Joaquin County

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. Health Plan of San Joaquin–San Joaquin County was the only plan to show sustained improvement for its *Reducing Avoidable ER Visits* QIP during the review period. However, the QIP has not received an overall *Met* validation status; therefore, HSAG has not fully validated the result.

The small-group collaborative QIP validated during the review period progressed to a point of remeasurement. HSAG evaluated this QIP for sustained improvement.

- Community Health Group–San Diego County's *Improving Treatment for Chronic Obstructive Pulmonary Disease (COPD)* QIP had five study indicators that focused on improving management for members with COPD. The plan achieved statistically significant improvement for the two study indicators by reducing the percentage of inpatient discharges and ED visits for members with COPD. Despite statistically significant improvement noted during the review period, the plan did not demonstrate sustained improvement.
- In addition to Community Health Group–San Diego County, Care 1st–San Diego County previously participated in the COPD small-group collaborative and demonstrated sustained improvement for all three of its study indicators. The plan retired the QIP during the first quarter of 2010.

Eight individual QIP submissions validated during the review period progressed to a remeasurement period. Four QIP submissions demonstrated statistically significant improvement for at least one study indicator.

- Alameda Alliance for Health–Alameda County's *Decrease Return Emergency Room Visits for Asthmatic Exacerbations in Children 2–18* QIP had a statistically significant reduction of ER visits among children with asthma.
- Kaiser Permanente–South's (San Diego County) *Postpartum Care* QIP increased its postpartum care rate from a baseline rate of 50.52 percent to 67.90 percent at remeasurement.
- Partnership Health Plan's *Improving Care and Reducing Acute Readmissions for People with COPD* QIP for Napa, Solano, and Yolo counties achieved statistically significant improvement for one of its three study indicators, pharmacotherapy management of COPD exacerbations, with an increase in the baseline rate of 37.6 percent to 66.7 percent upon remeasurement. This plan had two QIP submissions during the review period; therefore, each QIP submission counted as statistically significant improvement.

HSAG assessed two QIPs for sustained improvement. Community Health Group–San Diego County achieved sustained improvement for its *Increasing Follow-up to Positive Postpartum Screens* QIP, which improved the rates of women screened for depression during a postpartum care visit, increased the use of a depression screening tool, and increased the percentage of women with a positive depression screen who had documented follow-up care for depression.

Conclusions

HSAG considered the following QIPs closed after validation review:

- Community Health Group–San Diego County's *Improving Treatment for COPD* QIP.
- SCAN Health Plan's *COPD* QIP for Los Angeles, Riverside, and San Bernardino counties.

These QIPs both progressed to two remeasurement periods, and the plans will retire these QIPs as formal projects, which will allow the plans to focus their efforts on other low-performance areas.

QIPs validated during the review period of October 1, 2010, through December 31, 2010, showed that plans demonstrated proficiency with the study design phase, as evidenced by the high percentage of average rates of *Met* evaluation elements. Additionally, the plans demonstrated high average rates of *Met* evaluation elements within activities for the study implementation phase across statewide collaborative, small-group collaborative and individual QIPs.

HSAG noted that many plans required a resubmission from the prior review period and did not demonstrate applied knowledge from prior review periods as they relate to critical evaluation elements. Plans also have an opportunity to increase the success of achieving their desired QIP outcomes. While plans are achieving overall *Met* validation status by structuring and implementing projects that meet validation requirements for producing valid and reliable results, the plans have experienced challenges in achieving sustained improvement.

Recommendations

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

- Plans need to review their QIP submissions and pay careful attention to the critical elements to ensure that they have documented the project adequately to achieve a *Met* validation status.
- Plans should consider limiting the number of study indicators within a project to increase the likelihood of success.
- Plans should implement evidence-based strategies when available to help enhance success with achieving improved QIP outcomes.

Organization of Report

This report has six sections:

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

QIP Requirements

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

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

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

Description of the QIP Validation Process

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

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

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

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

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

QIP validation ensures that:

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

Evaluating the Overall Validity and Reliability of Study Results

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

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

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

QIP Validation Activities

HSAG reviewed 53 QIPs for the period of October 1, 2010, through December 31, 2010. *Table 3.1—Medi-Cal Managed Care Program Quarterly Quality Improvement Program Validation Activity* on page 9 lists the QIPs by plan and subject.

Family Mosaic Project–San Francisco County submitted its first QIP during the review period. Because of this specialty plan's unique population, the plan had challenges with designing and implementing a meaningful QIP. HSAG provided intensive technical assistance to this plan during the prior year to aid in achieving contractual compliance with the Medi-Cal Managed Care Program. The plan submitted one of its two required QIPs, and HSAG provided additional technical assistance to Family Mosaic Project during the review to assist with the development of a second QIP that is due to the DHCS on January 31, 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
October 1, 2010, through December 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					
Alameda Alliance for Health—Alameda	*Reducing Avoidable Emergency Room Visits*	Annual Submission	97%	100%	*Met*
Anthem Blue Cross—Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	*Reducing Avoidable Emergency Room Visits*	Annual Submission	85%	100%	*Met*
CalOptima—Orange	*Reducing Avoidable Emergency Room Visits*	Annual Submission	92%	90%	*Partially Met*
Care 1st—San Diego	*Reducing Avoidable Emergency Room Visits*	Annual Submission	69%	80%	*Partially Met*
CenCal Health—Santa Barbara	*Reducing Avoidable Emergency Room Visits*	Annual Submission	89%	100%	*Met*
CenCal Health—San Luis Obispo	*Reducing Avoidable Emergency Room Visits*	Annual Submission	92%	100%	*Met*
Central California Alliance for Health—Monterey, Santa Cruz	*Reducing Avoidable Emergency Room Visits*	Annual Submission	82%	100%	*Met*
Community Health Group—San Diego	*Reducing Avoidable Emergency Room Visits*	Annual Submission	87%	100%	*Met*
Contra Costa Health Plan—Contra Costa	*Reducing Avoidable Emergency Room Visits*	Annual Submission	90%	90%	*Partially Met*
Contra Costa Health Plan—Contra Costa	*Reducing Avoidable Emergency Room Visits*	Annual Resubmission 1	97%	100%	*Met*
Health Net—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, Tulare	*Reducing Avoidable Emergency Room Visits*	Annual Submission	95%	100%	*Met*
Health Plan of San Joaquin—San Joaquin	*Reducing Avoidable Emergency Room Visits*	Annual Submission	95%	100%	*Met*
Health Plan of San Mateo—San Mateo	*Reducing Avoidable Emergency Room Visits*	Annual Submission	87%	100%	*Met*
Inland Empire Health Plan—Riverside, San Bernardino	*Reducing Avoidable Emergency Room Visits*	Annual Submission	84%	100%	*Met*

Table 3.1—Medi-Cal Managed Care Program Quarterly QIP Activity
October 1, 2010, through December 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]
Kaiser Permanente (North)—Sacramento	*Reducing Avoidable Emergency Room Visits*	Annual Submission	89%	100%	*Met*
Kaiser Permanente (South)—San Diego	*Reducing Avoidable Emergency Room Visits*	Annual Submission	82%	100%	*Met*
L.A. Care Health Plan—Los Angeles	*Reducing Avoidable Emergency Room Visits*	Annual Submission	87%	100%	*Met*
Molina Healthcare—Riverside	*Reducing Avoidable Emergency Room Visits*	Annual Submission	87%	100%	*Met*
Molina Healthcare—Sacramento	*Reducing Avoidable Emergency Room Visits*	Annual Submission	90%	100%	*Met*
Molina Healthcare—San Bernardino	*Reducing Avoidable Emergency Room Visits*	Annual Submission	87%	100%	*Met*
Molina Healthcare—San Diego	*Reducing Avoidable Emergency Room Visits*	Annual Submission	90%	100%	*Met*
Partnership Health Plan—Napa, Yolo, Solano	*Reducing Avoidable Emergency Room Visits*	Annual Submission	84%	100%	*Met*
Santa Clara Family Health Plan—Santa Clara	*Reducing Avoidable Emergency Room Visits*	Annual Submission	84%	100%	*Met*
San Francisco Health Plan—San Francisco	*Reducing Avoidable Emergency Room Visits*	Annual Submission	76%	100%	*Partially Met*
Small-Group Collaborative QIPs					
Community Health Group—San Diego	*Improving Treatment for Chronic Obstructive Pulmonary Disease (COPD)*	Annual Submission	89%	100%	*Met*
Internal QIPs					
AHF Healthcare Centers—Los Angeles	*Increasing CD4 and Viral Load Testing*	Proposal	94%	100%	*Met*
AHF Healthcare Centers—Los Angeles	*Advance Directives*	Proposal	63%	50%	*Partially Met*
AHF Healthcare Centers—Los Angeles	*Advance Directives*	Proposal Resubmission	75%	63%	*Partially Met*
Alameda Alliance for Health—Alameda	*Decrease Return Emergency Room Visits for Asthmatic Exacerbations in Children 2–18*	Annual Submission	100%	100%	*Met*

Table 3.1—Medi-Cal Managed Care Program Quarterly QIP Activity
October 1, 2010, through December 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]
Anthem Blue Cross—Alameda	*Postpartum Care*	Resubmission	100%	100%	*Met*
Anthem Blue Cross—Contra Costa	*Postpartum Care*	Resubmission	100%	100%	*Met*
Anthem Blue Cross—Fresno	*Postpartum Care*	Resubmission	100%	100%	*Met*
Anthem Blue Cross—Sacramento	*Postpartum Care*	Resubmission	100%	100%	*Met*
Anthem Blue Cross—San Francisco	*Postpartum Care*	Resubmission	100%	100%	*Met*
Anthem Blue Cross—San Joaquin	*Postpartum Care*	Resubmission	100%	100%	*Met*
Anthem Blue Cross—Santa Clara	*Postpartum Care*	Resubmission	100%	100%	*Met*
Anthem Blue Cross—Stanislaus	*Postpartum Care*	Resubmission	100%	100%	*Met*
Anthem Blue Cross—Tulare	*Postpartum Care*	Resubmission	100%	100%	*Met*
Community Health Group—San Diego	*Increasing Follow-up to Positive Postpartum Screens*	Resubmission	90%	100%	*Met*
Contra Costa Health Plan—Contra Costa	*Reducing Health Disparities in Pediatric Obesity*	Resubmission	100%	100%	*Met*
Family Mosaic Project—San Francisco*	*Out-of-Home Placement*	Proposal	100%	100%	*Met*
Family Mosaic Project—San Francisco	*Out-of-Home Placement*	Annual Submission	93%	90%	*Partially Met*
Family Mosaic Project—San Francisco	*Out-of-Home Placement*	Annual Resubmission 1	96%	100%	*Met*
Health Plan of San Mateo—San Mateo	*Increasing Timeliness of Prenatal Care*	Resubmission	98%	100%	*Met*
Inland Empire Health Plan—Riverside, San Bernardino	*Attention Deficit Hyperactivity Disorder (ADHD) Management*	Resubmission	100%	100%	*Met*

Table 3.1—Medi-Cal Managed Care Program Quarterly QIP Activity
October 1, 2010, through December 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]
Kaiser Permanente (North)—San Diego	*Childhood Obesity*	Annual Submission	89%	100%	*Met*
Kaiser Permanente (South)—San Diego	*Postpartum Care*	Resubmission	89%	100%	*Met*
Kern Family Health Care—Kern	*Comprehensive Diabetes Care*	Resubmission	92%	100%	*Met*
Partnership Health Plan—Napa, Solano, Yolo	*Improving Care and Reducing Acute Readmissions for People With COPD*	Resubmission	87%	90%	*Partially Met*
Partnership Health Plan—Napa, Solano, Yolo	*Improving Care and Reducing Acute Readmissions for People With COPD*	Resubmission	92%	100%	*Met*
San Francisco Health Plan—San Francisco	*Improving the Patient Experience*	Proposal Resubmission 2	61%	54%	*Partially Met*
San Francisco Health Plan—San Francisco	*Improving the Patient Experience*	Proposal Resubmission 3	84%	77%	*Partially Met*
SCAN Health Plan—Los Angeles, Riverside, San Bernardino	*Chronic Obstructive Pulmonary Disease (COPD)*	Resubmission	92%	100%	*Met*

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

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

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

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

* Due to the timing of the data collection cycle for Family Mosaic Project's QIP, HSAG required the plan to submit both its QIP proposal and baseline data within the same validation period.

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 Quality Improvement Project

All plans submitted their *Reducing Avoidable Emergency Room (ER) Visits* collaborative QIPs for validation in October 2010, which included Remeasurement 2 data. 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.

HSAG received 25 statewide collaborative QIP submissions for validation, which represented 20 plans. Since the inception of the ER collaborative, Molina Healthcare submitted separate QIPs for each of its four counties; therefore, HSAG continued validation at the county-level for this plan. Of the 25 submissions all were annual submissions with the exception of one annual resubmission. HSAG validated 24 of the 25 QIPs submitted during the review period. The QIP submission for Kern Family Health Plan was not validated due to some data discrepancies found between the plan's QIP and *Use of Services* data reported to the DHCS. HSAG validated this QIP during the following review period and will include these validation results in the next report.

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 = 24 Submissions)
October 1, 2010, through December 31, 2010

QIP Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Study Design	**I: Appropriate Study Topic**	98%	1%	1%
	II: Clearly Defined, Answerable Study Question(s)	96%	4%	0%
	III: Clearly Defined Study Indicator(s)	99%	1%	0%
	IV: Correctly Identified Study Population	98%	2%	0%
Study Implementation	**V: Valid Sampling Techniques**	0%	100%	0%
	VI: Accurate/Complete Data Collection	92%	7%	1%
	VII: Appropriate Improvement Strategies	91%	9%	0%
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	89%	8%	3%
	IX: Real Improvement Achieved	49%	0%	51%
	X: Sustained Improvement Achieved	5%	0%	95%

* 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 Appendix B for the number and a description of evaluation elements.

Study Design

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

Five QIPs received *Partially Met* and *Not Met* scores for at least one evaluation element for Activity I through IV as follows:

- For Activity I, Contra Costa Health Plan–Contra Costa County and Partnership Health Plan in Napa, Solano, and Yolo counties had *Partially Met* scores and Health Plan of San Mateo–San Mateo County received a *Not Met* score. Contra Costa Health Plan–Contra Costa County did not document that the QIP topic was selected as part of a statewide collaborative. Partnership Health Plan in Napa, Solano, and Yolo counties did not apply exclusion criteria for members under 12 months of age to its second study indicator. Health Plan of San Mateo–San Mateo did not document whether members with special health care needs were included or excluded from the QIP.
- CalOptima–Orange County and Care 1st–San Diego received *Partially Met* scores for the clearly defined study question activity. CalOptima–Orange County received a *Partially Met* score for this evaluation element because the study question submitted contained ambiguous terms. Care 1st–San Diego County included a second study question that was not indicated, and HSAG made a recommendation in the prior year's validation results to remove the second study question. The plan did not remove the second study question; therefore, the plan received a *Partially Met* score.
- Care 1st–San Diego County received a *Partially Met* score for Activity III because the plan did not document the date of the Healthcare Effectiveness Data and Information Set (HEDIS®)[5] specifications and did not update the data ranges for the second remeasurement period. Providing this detail is necessary in meeting the evaluation element criteria.
- All plans correctly identified the study population with the exception of Contra Costa Health Plan–Contra Costa County, which received a *Partially Met* validation score. The plan did not include an anchor date, which is important for defining the study population.

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

Study Implementation

Similar to the study design stage, many QIPs received high validation scores for all evaluation elements in Activities V through VII.

Activity V. Valid Sampling Techniques

Activity Summary: Overall, QIPs were appropriately documented to show that sampling was not used.

While the statewide collaborative did not use sampling, two plans, Anthem Blue Cross and Central California Alliance for Health, did not appropriately document that sampling was not used; therefore, these QIPs received a *Partially Met* score for one evaluation element. The other evaluation elements under this activity were not applicable.

Activity VI. Accurate/Complete Data Collection

Activity Summary: Overall, plans documented accurate and complete data collection; however, many plans did not document the timeline for data collection for all measurement periods.

While plans met most of the evaluation element criteria for accurate and complete data collection, two plans—Health Net in Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties and Health Plan of San Joaquin in San Joaquin County—lacked inclusion of ER visit codes. Additionally, all plans are required to document the timeline for data collection for the baseline and remeasurement periods.

Eight QIPs lacked data collection documentation for all measurement periods. QIPs that lacked this information were submitted by:

- Anthem Blue Cross in Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare counties
- Care 1st–San Diego County
- Central CA Alliance for Health–Monterey and Santa Cruz counties
- Contra Costa Health Plan–Contra Costa County
- Inland Empire Health Plan–Riverside and San Bernardino counties
- Kaiser Permanente–South (San Diego County)
- Partnership Health Plan in Napa, Solano, and Yolo counties
- Santa Clara Family Health Plan–Santa Clara County

Activity VII. Appropriate Improvement Strategies

Activity Summary: Overall, QIP submissions scored lowest on this activity across implementation stage activities.

All QIP submissions met the criteria for documenting a barrier analysis and documented interventions that were likely to induce permanent change.

Plans had challenges with documenting either intervention standardization or revisions. For interventions that did not result in success, HSAG assessed whether the plan revised its interventions. For interventions that resulted in improvement, HSAG assessed whether the plan standardized and monitored its interventions. Plans that have multiple study indicators may need to provide a combination of modification and standardization to fully meet the evaluation criteria.

Care 1st–San Diego County, Kaiser Permanente–South's (San Diego County), and San Francisco Health Plan–San Francisco County did not document revision of interventions that were not successful. CalOptima–Orange County, Care 1st–San Diego County, and Molina HealthCare in Sacramento and San Diego counties did not document the standardization of effective interventions.

Quality Outcomes Achieved

All QIP submissions validated during the review period progressed to a second remeasurement period with the exception of CenCal Health in San Luis Obispo County. Only baseline data were reported for San Luis County because the plan expanded into this county after the collaborative QIP had begun. With the exception of this QIP, 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 89 percent.

The lowest scoring evaluation element under this activity related to interpretation of the study findings. Ten QIPs submissions lacked adequate documentation, which resulted in *Partially Met* scores for this element and included submissions from:

- Care 1st–San Diego County
- Central CA Alliance for Health–Monterey and Santa Cruz counties
- Kaiser Permanente–South (San Diego County)
- L.A. Care–Los Angeles County
- Molina Healthcare in Riverside, San Bernardino, San Diego, and Sacramento counties
- San Francisco Health Plan–San Francisco County
- Santa Clara Family Health Plan–Santa Clara County

Activity IX. Real Improvement Achieved

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

Five of 19 plans demonstrated a statistically significant reduction in the avoidable ER visits rate between Remeasurement 1 and Remeasurement 2. These plans include:

- Alameda Alliance for Health–Alameda County
- Care 1st–San Diego County
- Contra Costa Health Plan–Contra Costa County (two QIP submissions)
- Health Net in Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties
- Health Plan of San Joaquin–San Joaquin County

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. Health Plan of San Joaquin–San Joaquin County was the only plan to achieve sustained improvement for the statewide collaborative *Reducing Avoidable ER Visits* QIP.

Statewide Collaborative QIP Strengths and Opportunities for Improvement

All statewide collaborative QIP submissions demonstrated high validation scores for both the study design and study implementation phases. This suggests that plans structured the statewide collaborative QIP to produce valid and reliable rates.

Plan QIPs scored lowest in the study outcomes phase. Plans had challenges with interpreting study findings in terms of modifying or revising interventions. Few QIPs demonstrated statistically significant improvement between remeasurement years and only 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 Health Plan of San Joaquin–San Joaquin County upon final validation results and determine whether strategies may be applied to other plans. The DHCS and plans should continue the collaborative for an additional remeasurement period since the statewide collaborative interventions were implemented throughout 2009 and in 2010 to better assess the impact of these interventions.

Findings Specific to Small-Group Collaborative Quality Improvement Projects

HSAG received one small-group collaborative QIP submission for validation during the review period for Community Health Group's *Improving Treatment for Chronic Obstructive Pulmonary Disease (COPD)*. Care 1st–San Diego County, the other small-group collaborative plan, submitted its QIP submission during the first quarter of 2010 and formally retired the project; therefore, only Community Health Group's QIP was validated during the review period. Table 4.2 displays the validation results for the small-group collaborative QIP submission.

Table 4.2—Small-Group Collaborative QIP Activity Average Rates* (N = 1 Submissions)
October 1, 2010, through December 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**	NA	NA	NA
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	100%	0%	0%
	IX: Real Improvement Achieved	25%	75%	0%
	X: Sustained Improvement Achieved	0%	0%	100%

***** 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 Appendix B for the number and a description of evaluation elements.
± The sum may not equal 100 percent due to rounding.
NA = Not applicable.

Study Design

Community Health Group–San Diego County achieved 100 percent *Met* validation scores for all evaluation elements for Activities I through IV.

Study Implementation

Community Health Group–San Diego County achieved 100 percent *Met* validation scores for all applicable evaluation elements in Activities VI and VII. The QIP did not use sampling; therefore, Activity V scores were not applicable (NA).

Quality Outcomes Achieved

Community Health Group–San Diego County's *Improving Treatment for Chronic Obstructive Pulmonary Disease (COPD)* QIP included five study indicators. All indicators progressed to at least one period of remeasurement; therefore, HSAG assessed Activities VIII through X to determine whether the plan achieved the intended quality outcomes.

Activity VIII. Sufficient Data Analysis and Interpretation

Activity Summary: Community Health Group–San Diego County achieved 100 percent *Met* scores for this activity.

For this activity, HSAG assessed whether the plan had sufficient data analysis and interpretation of results between remeasurement periods. Community Health Group–San Diego County received *Met* scores for all evaluation elements for this activity, demonstrating adequate data analysis and interpretation.

Activity IX. Real Improvement Achieved

Activity Summary: The QIP achieved statistically significant improvement for two of five study indicators.

Community Health Group–San Diego County's *Improving Treatment for Chronic Obstructive Pulmonary Disease (COPD)* QIP contained five study indicators:

- The percentage of members 40 years of age and older with a new diagnosis of newly-active COPD who received appropriate spirometry testing to confirm the diagnosis.
- The percentage of acute inpatient hospitalization discharges of members with COPD.
- The percentage of emergency department (ED) visits for members with COPD.
- The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1–November 30 of the measurement year and who were dispensed a systemic corticosteroid within 14 days of the event.

- The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1–November 30 of the measurement year and who were dispensed a bronchodilator within 30 days of the event.

The plan achieved statistically significant improvement for the second and third study indicator by reducing the percent of inpatient discharges and ED visits for members with COPD. The plan received a *Partially Met* score for this activity since not all study indictors demonstrated statistically significant improvement.

Activity X. Sustained Improvement Achieved

Activity Summary: The QIP did not achieve sustained improvement.

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.

Despite statistically significant improvement for two of five study indicators during the review period, Community Health Group–San Diego County's *Improving Treatment for Chronic Obstructive Pulmonary Disease (COPD)* QIP did not demonstrate sustained improvement.

Small-Group Collaborative Strengths and Opportunities for Improvement

The small-group collaborative QIP submission by Community Health Group–San Diego County had statistically significant improvement for two of five study indicators during the review period demonstrating some success with reducing inpatient hospitalizations and ER visit percentages for members with COPD. The plan was less successful with improving spirometry testing to confirm a COPD diagnosis and dispensing appropriate treatment medications for members with COPD who had either an inpatient admission or an ER visit related to COPD.

Small-Group Collaborative QIP Recommendations

HSAG recommended that Community Health Group–San Diego County retire the COPD QIP as a formal project since it had progressed to multiple remeasurement periods. HSAG recommends that the plan continue to monitor its success with reducing inpatient and ER visits for members with COPD. For future QIP submissions, HSAG recommends that the plans limit the number of QIP study indicators to allow for more focused interventions and increase the likelihood of statistically significant and sustained improvement.

Findings Specific to Internal Quality Improvement Projects

Plans submitted 28 internal QIPs (IQIPs) for validation from October 1, 2010, through December 31, 2010. Of the 28 submissions, 19 were resubmissions, three were proposals, three were proposal resubmissions, and three were annual submissions. All IQIP submissions were focused on improving care with the exception of San Francisco Health Plan's *Improving the Patient Experience*, which focused on member satisfaction.

Twenty-two of the 28 QIPs validated received an overall *Met* validation status and six received an overall *Partially Met* validation status. As of September 30, 2010, two projects remained with a *Partially Met* status, requiring a resubmission to address *Partially Met* and *Not Met* areas within the QIP. HSAG will report the results of the resubmissions in the next QIPs status report.

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 = 28 Submissions)
October 1, 2010, through December 31, 2010

QIP Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Study Design	**I: Appropriate Study Topic**	97%	1%	2%
	II: Clearly Defined, Answerable Study Question(s)	96%	4%	0%
	III: Clearly Defined Study Indicator(s)	94%	6%	0%
	IV: Correctly Identified Study Population	93%	7%	0%
Study Implementation	**V: Valid Sampling Techniques**	99%	1%	0%
	VI: Accurate/Complete Data Collection	96%±	4%±	1%±
	VII: Appropriate Improvement Strategies	95%±	4%±	2%±
Quality Outcomes Achieved	**VIII: Sufficient Data Analysis and Interpretation**	89%	8%	3%
	IX: Real Improvement Achieved	63%±	16%±	22%±
	X: Sustained Improvement Achieved	50%	0%	50%

* 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 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, the plans met the criteria for the evaluation elements within Activity I.

All IQIPs met the criteria of all evaluation elements for selecting an appropriate study topic, using data to support the selection of the study topic, focusing the topic on aspects of quality of care or service, and selecting topics that have the potential to affect member health, functional status, and/or satisfaction.

The lowest-scoring evaluation elements in this activity resulted from QIP submissions that did not discuss the eligible population and the inclusion or exclusion of members with special health care needs. Plans need to explicitly state that no members with special health care needs were excluded from the study or provide supporting documentation on the reason for the exclusion. AHF Healthcare Centers–Los Angeles County's *Advance Directives* QIP and *CD4 Viral Load Testing* QIP, and Kaiser Permanente–South's (San Diego County) *Childhood Obesity* QIP lacked the required documentation for the eligible population. Kaiser Permanente–South's (San Diego County) *Childhood Obesity* QIP and San Francisco Health Plan–San Francisco County's *Improving the Patient Experience* QIP did not provide documentation for including or excluding 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.

All but one QIP submission achieved 100 percent for having a clearly defined and answerable study question. San Francisco Health Plan–San Francisco County's *Improving the Patient Experience* QIP received *Partially Met* scores for the two evaluation elements for this activity. The plan achieved compliance with these two evaluation elements upon resubmission.

Activity III. Clearly Defined Study Indicator(s)

Activity Summary: Overall, QIP submissions met the evaluation elements for clearly defined study indicators.

QIPs validated during the review period showed consistent performance from the plans in basing their study indicators on evidence-based practice guidelines, peer-reviewed literature, or consensus expert panels. Additionally, all QIPs scored 100 percent on using nationally recognized measures when appropriate or including the basis on which indicators were adopted for internally-developed indicators.

Two plans did not meet all evaluation elements for this activity. San Francisco Health Plan–San Francisco County experienced challenges with its *Improving the Patient Experience* QIP. The plan selected a topic related to member satisfaction and had some significant challenges with structuring the QIP to meet HSAG's validation criteria for producing valid rates. The plan received *Partially Met* scores for both QIP submissions. HSAG recommended that the study indicator be revised to include only the members who responded to the survey question measures. Additionally, the plan needed to change its selection criteria of favorable responses from a numeric number to "yes, definitely" to be consistent with the actual survey instrument.

AHF Healthcare Centers–Los Angeles County's *Advance Directives* QIP did not include the year of the HEDIS specifications used. Additionally, the plan only included members 66 years of age and older and the study question included all members. The plan needs to ensure that the study question and study indicators align.

Activity IV. Correctly Identified Study Population

Activity Summary: Overall, QIP submissions correctly identified the study population.

Twenty-six of 28 QIP submissions met the criteria of all evaluation elements for correctly identifying the study population. AHF Healthcare Centers–Los Angeles County's two *Advance Directives* QIP submissions validated during the review period received *Partially Met* validation scores for this activity. The plan did not completely define the eligible population and did not discuss continuous enrollment criteria.

Study Implementation

HSAG assessed all QIP submissions through Activity V. Since four of the 28 QIPs were QIP proposals or proposal resubmissions, these submissions did not progress beyond Activity V; therefore, HSAG did not assess these projects for Activity VI through Activity X.

Activity V. Valid Sampling Techniques

Activity Summary: Overall, QIPs using sampling demonstrated valid sampling techniques.

Fifteen of the 28 QIPs used sampling, and HSAG evaluated whether plans used valid techniques. Overall, plans achieved 99 percent compliance with evaluation elements related to sampling.

Health Plan of San Mateo-San Mateo County's *Increasing Timeliness of Prenatal Care* received a *Partially Met* validation score for its reported margin of error that was not consistent with the HEDIS specifications and reduced sample size.

Activity VI. Accurate/Complete Data Collection

Activity Summary: Overall, QIPs demonstrated accurate and completed data collection.

All 24 QIP submissions assessed for accurate and completed data collection appropriately identified the data elements to be collected, the source of data, the process for collecting data and the estimated degree of data completeness. Kaiser Permanente–South's (San Diego County) *Childhood Obesity* QIP, Kaiser Permanente–North's (Sacramento County) *Postpartum Care* QIP and San Francisco Health Plan–San Francisco County's *Improving the Patient Experience* QIP lacked a timeline for the collection of baseline and remeasurement data.

Plans can collect and report data using one of two methods—administratively or manually. Fifteen plans used a manual data process, which requires that plans provide documentation about the manual data collection process including instructions provided to abstraction staff, qualifications of abstraction staff, tools used to abstract the information, and a description of the interrater reliability process. San Francisco Health Plan–San Francisco County's *Improving the Patient Experience* QIP lacked documentation of most of these criteria.

Activity VII. Appropriate Improvement Strategies

Activity Summary: Overall, QIP submissions demonstrated appropriate improvement strategies.

All 24 QIPs submitted during the review period had documentation of the causal/barrier analysis process and documented interventions that were likely to induce permanent change.

Of the 24 QIPs submitted, eight progressed to the point of at least one remeasurement period.

Two evaluation elements within this activity relate to modifying or revising interventions after a plan has evaluated remeasurement results. For interventions that did not result in success, HSAG assessed whether the plan revised its interventions. For interventions that resulted in improvement, HSAG assessed whether the plan standardized and monitored its interventions. Plans that have multiple study indicators may need to provide a combination of modification and standardization.

During the review period, four QIPs needed to show revised interventions. Community Health Group–San Diego County's *Increasing Follow-up to Positive Postpartum Screens* did not revise interventions in a timely manner and therefore did not fully meet the evaluation element criteria.

Five QIPs demonstrated success with their interventions and three of those QIP submissions included the appropriate documentation for standardizing and monitoring these interventions. However, two QIP submissions—including Kern Family Health Care–Kern County's *Comprehensive Diabetes Care* QIP and Partnership Health Plan's *Improving Care and Reducing Acute Readmissions for People with COPD* QIP for Napa, Solano, and Yolo counties—lacked documentation of standardizing and monitoring interventions.

Quality Outcomes Achieved

Eight of the 28 IQIP submissions validated during the review period progressed to a remeasurement period and include:

- Alameda Alliance for Health–Alameda County's *Decrease Return Emergency Room Visits for Asthmatic Exacerbations in Children 2–18*
- Community Health Group–San Diego *County's Increasing Follow-up to Positive Postpartum Screens*
- Kaiser Permanente–South's (San Diego County) *Childhood Obesity*
- Kern Family Health Care–Kern County's *Comprehensive Diabetes Care*
- Partnership Health Plan–Napa, Solano, and Yolo counties' *Improving Care and Reducing Acute Readmissions for People with COPD* (two IQIP submissions)
- San Francisco Health Plan–San Francisco County's *Improving the Patient Experience*
- SCAN Health Plan–Los Angeles, Riverside, and San Bernardino counties' *Chronic Obstructive Pulmonary Disease (COPD)*

The other 20 IQIP submissions were QIP proposals, proposal resubmissions, or annual submissions of baseline rates that did not reach the point of remeasurement; therefore, HSAG did not assess these QIP proposals for quality outcomes beyond applicable evaluation elements in Activity VIII.

Activity VIII. Sufficient Data Analysis and Interpretation

Activity Summary: QIP submissions had mixed results for providing sufficient data analysis and interpretation.

For this activity, HSAG assessed whether the plans had sufficient data analysis and interpretation of results between remeasurement periods. The overall average rate for this activity was 89 percent. This represented an increase from the rate of 68 percent for the prior review period, July 1, 2010, through September 30, 2010.

All 24 QIP submissions had documentation of the initial baseline and remeasurement study indicators. All plans that used sampling provided documentation that allows for the generalization of the results to the population.

Low-scoring evaluation elements were related to a lack of documentation of factors that threaten the internal or external validity of the findings, lack of an interpretation of the findings and of presenting data analysis and interpretation in a way that provides accurate, clear, and easily understood information.

For the eight QIPs that progressed to a point of remeasurement, all included data analysis and interpretation of the initial measurement and remeasurement of the study indicators. HSAG could not replicate the statistical testing used by San Francisco Health Plan–San Francisco County for its *Improving the Patient Experience* QIP. Kern Health Plan–Kern County's *Comprehensive Diabetes Care* QIP did not provide a complete interpretation of the extent to which the study was successful.

Activity IX. Real Improvement Achieved

Activity Summary: Two of the eight QIPs assessed for real improvement achieved statistical significance, two had *Partially Met* scores for statistical significance, and four QIPs did not achieve statistical significance.

Eight QIP submissions validated during the review period progressed to a remeasurement period. Partnership Health Plan's *Improving Care and Reducing Acute Readmissions for People with*

COPD QIP for Napa, Solano, and Yolo counties accounted for two of the eight QIP submissions.

Alameda Alliance for Health–Alameda County's *Decrease Return Emergency Room Visits for Asthmatic Exacerbations in Children 2–18* achieved statistically significant improvement. The QIP targeted the reduction of ER visits among children with asthma. The project reached its second remeasurement period and had a decrease over the initial baseline rate.

Kaiser Permanente–South's (San Diego County) *Postpartum Care* focused on increasing the percentage of women who had a postpartum visit on or between 21 and 56 days after delivery. The plan experienced a statistically significant increase from the baseline rate of 50.52 percent to the first remeasurement period rate of 67.90.

Partnership Health Plan's *Improving Care and Reducing Acute Readmissions for People with COPD* QIP for Napa, Solano, and Yolo counties achieved statistically significant improvement for one of its three study indicators. The plan achieved statistically significant improvement for pharmacotherapy management of COPD exacerbations, with an increase in the baseline rate of 37.6 percent to 66.7 percent upon remeasurement. Despite the plan's slight increase from 21.4 percent at baseline to 23.6 percent at remeasurement for its indicator that measured the use of spirometry testing in the assessment and diagnosis of COPD, the increase was not statistically significant. Finally, the plan had a statistically significant decline in performance for its COPD readmission rate within 30 days.

Community Health Group–San Diego County's *Increasing Follow-up to Positive Postpartum Screens* QIP targeted improving the rate of women who were seen for a postpartum care visit and were screened for depression. Of the women screened for depression, the QIP measured those women who were screened for depression through the use of a screening tool. For those women with a positive depression screening, the QIP measured the percentage of women with documented follow-up care for depression. This QIP had progressed to a second year of remeasurement in which HSAG found that, while the plan had statistically significant improvement for all three indicators between baseline and the first remeasurement period, its results from the first remeasurement period to the second remeasurement period did not yield improvement for any of the three measures. All three rates decreased slightly between Remeasurement 1 and Remeasurement 2.

Kern Family Health Care–Kern County's *Comprehensive Diabetes Care* QIP focused on increasing hemoglobin A1c testing, LDL-C (cholesterol) testing, and retinal eye exam rates for members with diabetes. Despite a slight increase in all three study indicators between the baseline and first remeasurement period, the increases were not statistically significant.

San Francisco Health Plan–San Francisco County's *Improving the Patient Experience* QIP focused on improving patient satisfaction scores related to provider communication and whether the member would recommend their provider. The QIP did not achieve statistically significant improvement for either study indicator; however, HSAG determined the plan's rates were not valid since it could not replicate the numerator and denominator counts. HSAG will reassess once with the plan's next resubmission after the plan revises its numerator and denominator counts and can replicate the statistical testing.

SCAN Health Plan's *Chronic Obstructive Pulmonary Disease (COPD)* QIP for Los Angeles, Riverside and San Bernardino counties targeted improving the use of spirometry testing in the assessment and diagnosis of COPD. The plan did not demonstrate statistically significant improvement between Remeasurement 1 and Remeasurement 2.

Activity X. Sustained Improvement Achieved

Activity Summary: Two QIPs progressed to the point of assessment for sustained improvement. One achieved sustained improvement, while one did not achieve sustained improvement.

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. Two QIPs, Community Health Group–San Diego County's *Increasing Follow-up to Positive Postpartum Screens* QIP and SCAN Health Plan's *Chronic Obstructive Pulmonary Disease (COPD)* QIP for Los Angeles, Riverside and San Bernardino counties, reached the point of at least two remeasurement periods, which allowed HSAG to assess for sustained improvement.

Community Health Group–San Diego County achieved sustained improvement for its *Increasing Follow-up to Positive Postpartum Screens* QIP, which improved the rates of women screened for depression during a postpartum care visit, increased the use of depression screening using a screening tool, and increased the percentage of women with a positive depression screen who had documented follow-up care for depression.

SCAN Health Plan in Los Angeles, Riverside, and San Bernardino counties did not demonstrate improvement for its *Chronic Obstructive Pulmonary Disease (COPD)* QIP during the first remeasurement period; therefore, the plan could achieve sustained improvement for the second remeasurement period. The plan showed a decrease between its baseline rate and first remeasurement period. While the plan was able to increase its rate to just above the baseline rate during the second remeasurement period, no real improvement or sustained improvement was achieved.

Internal QIP Strengths and Opportunities for Improvement

Plans demonstrated proficiency with the study design phase for IQIPs, as evidenced by the high percentage of average rates of *Met* evaluation elements for this review period, October 1, 2010, through December 31, 2010. Additionally, the plans demonstrated high average rates of *Met* evaluation elements within activities for the study implementation phase.

During the review period, the plans had mixed success with demonstrating improved outcomes and statistically significant results for some or all study indicators. Four of eight QIPs reviewed during the period achieved statistically significant improvement for at least one study indicator. One of the two QIPs that progressed to at least two remeasurement periods demonstrated sustained improvement. SCAN Health Plan's *Chronic Obstructive Pulmonary Disease (COPD)* QIP in Los Angeles, Riverside, and San Bernardino counties did not achieve sustained improvement. Many interventions used by this plan were not systems interventions and may have contributed to the lack of improvement. Additionally, the timing of the intervention activities did not take place until late in the remeasurement year, and therefore may not have been in place long enough to make a substantial impact.

Internal QIP Recommendations

Plans need to improve their initial QIP submissions to achieve a *Met* validation status. Many plans required a resubmission from the prior review period and did not demonstrate applied knowledge from prior review periods as they relate to critical evaluation elements.

Plans need to increase the success of achieving their desired QIP outcomes. While plans are achieving overall *Met* validation status by structuring and implementing projects that meet validation requirements for producing valid and reliable results, the plans have experienced challenges with achieving sustained improvement. Plans may have a greater likelihood of success by limiting the number of study indicators for each project and implementing targeted interventions. Additionally, plans should be implementing evidence-based strategies whenever possible.

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

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

Table A.1––The DHCS Statewide Collaborative QIPs
October 1, 2010, through December 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 – X	Remeasurement 2
Anthem Blue Cross—				I – X	Remeasurement 2
Alameda, Contra Costa, Fresno, San Francisco, San Joaquin, Santa Clara,	CP				
Sacramento	GMC				
Stanislaus, Tulare	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				I – X	Remeasurement 2
Monterey, Santa Cruz	COHS				
Community Health Group—San Diego	GMC			I – X	Remeasurement 2
Contra Costa Health Plan—Contra Costa	LI			I – X	Remeasurement 2
Health Net—				I – X	Remeasurement 2
Fresno, Kern, Los Angeles, Stanislaus, Tulare	CP				
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
October 1, 2010, through December 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 – 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 Sacramento, San Diego	 CP 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
October 1, 2010, through December 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*
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
October 1, 2010, through December 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	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
October 1, 2010, through December 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 – 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	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	*Project pending – 1/31/2011*				
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	*Project proposal pending*				
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
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

Table A.3––Internal QIPs
October 1, 2010, through December 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*
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
October 1, 2010, through December 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 – 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	Baseline
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
October 1, 2010, through December 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	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 = 24 Submissions)
October 1, 2010, through December 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).	96% (23/24)	4% (1/24)	0% (0/24)
	2. Is selected following collection and analysis of data (or was selected by the State).	100% (24/24)	0% (0/24)	0% (0/24)
	3. Addresses a broad spectrum of care and services (or was selected by the State).	100% (24/24)	0% (0/24)	0% (0/24)
	4. Includes all eligible populations that meet the study criteria.	96% (23/24)	4% (1/24)	0% (0/24)
	5. Does not exclude members with special health care needs.	96% (23/24)	0% (0/24)	4% (1/24)
C*	6. Has the potential to affect member health, functional status, or satisfaction.	100% (24/24)	0% (0/24)	0% (0/24)
	Activity Average Rates**	**98% (141/144)**	**1% (2/144)**	**1% (1/144)**
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	92% (22/24)	8% (2/24)	0% (0/24)
C*	2. Is answerable.	100% (24/24)	0% (0/24)	0% (0/24)
	Activity Average Rates**	**96% (46/48)**	**4% (2/48)**	**0% (0/48)**
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	96% (23/24)	4% (1/24)	0% (0/24)
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	100% (24/24)	0% (0/24)	0% (0/24)
C*	3. Allow for the study questions to be answered.	100% (24/24)	0% (0/24)	0% (0/24)
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	100% (24/24)	0% (0/24)	0% (0/24)
C*	5. Have available data that can be collected on each indicator.	100% (24/24)	0% (0/24)	0% (0/24)
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	100% (24/24)	0% (0/24)	0% (0/24)
	7. Includes the basis on which each indicator was adopted, if internally developed.	100% (24/24)	0% (0/24)	0% (0/24)
	Activity Average Rates**	**99% (167/168)**	**1% (1/168)**	**0% (0/168)**
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	96% (23/24)	4% (1/24)	0% (0/24)
	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% (24/24)	0% (0/24)	0% (0/24)
	Activity Average Rates**	**98% (47/48)**	**2% (1/48)**	**0% (0/48)**

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 = 24 Submissions)
October 1, 2010, through December 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.	0% (0/2)	100% (2/2)	0% (0/2)
	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**	**0% (0/2)**	**100% (2/2)**	**0% (0/2)**
Activity VI: Accurate/Complete Data Collection				
	1. The identification of data elements to be collected.	92% (22/24)	8% (2/24)	0% (0/24)
	2. The identification of specified sources of data.	100% (24/24)	0% (0/24)	0% (0/24)
	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.	67% (16/24)	29% (7/24)	4% (1/24)
	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% (24/24)	0% (0/24)	0% (0/24)
	11. An estimated degree of automated data completeness.	100% (24/24)	0% (0/24)	0% (0/24)
	Activity Average Rates**	**92% (111/121)**	**7% (9/121)**	**1% (1/121)**
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	100% (24/24)	0% (0/24)	0% (0/24)
	2. System changes that are likely to induce permanent change.	100% (24/24)	0% (0/24)	0% (0/24)
	3. Revised if original interventions are not successful.	86% (19/22)	14% (3/22)	0% (0/22)
	4. Standardized and monitored if interventions were successful.	56% (5/9)	44% (4/9)	0% (0/9)
	Activity Average Rates**	**91% (72/79)**	**9% (7/79)**	**0% (0/79)**

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.3—Statewide Collaborative QIP Activities VIII to X Ratings (N = 24 Submissions)
October 1, 2010, through December 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% (24/24)	0% (0/24)	0% (0/24)
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.	92% (22/24)	0% (0/24)	8% (2/24)
	4. Includes an interpretation of the findings.	58% (14/24)	42% (10/24)	0% (0/24)
	5. Is presented in a way that provides accurate, clear, and easily understood information.	100% (24/24)	0% (0/24)	0% (0/24)
	6. Identifies initial measurement and remeasurement of study indicators.	96% (23/24)	4% (1/24)	0% (0/24)
	7. Identifies statistical differences between initial measurement and remeasurement.	88% (21/24)	13% (3/24)	0% (0/24)
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	88% (21/24)	0% (0/24)	13% (3/24)
	9. Includes interpretation of the extent to which the study was successful.	92% (22/24)	8% (2/24)	0% (0/24)
	Activity Average Rates**	**89% (171/192)**	**8% (16/192)**	**3% (5/192)**
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	100% (24/24)	0% (0/24)	0% (0/24)
	2. There is documented improvement in processes or outcomes of care.	38% (9/24)	0% (0/24)	63% (15/24)
	3. The improvement appears to be the result of planned intervention(s).	35% (8/23)	0% (0/23)	65% (15/23)
	4. There is statistical evidence that observed improvement is true improvement.	25% (6/24)	0% (0/24)	75% (18/24)
	Activity Average Rates**	**49% (47/95)**	**0% (0/95)**	**51% (48/95)**
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.	9% (2/22)	0% (0/22)	91% (20/22)
	Activity Average Rates**	**5% (1/22)**	**0% (0/22)**	**95% (21/22)**

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.4—Small-Group Collaborative QIP Activities I to IV Ratings (N = 1 Submission)
October 1, 2010, through December 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% (1/1)	0% (0/1)	0% (0/1)
	2. Is selected following collection and analysis of data (or was selected by the State).	100% (1/1)	0% (0/1)	0% (0/1)
	3. Addresses a broad spectrum of care and services (or was selected by the State).	100% (1/1)	0% (0/1)	0% (0/1)
	4. Includes all eligible populations that meet the study criteria.	100% (1/1)	0% (0/1)	0% (0/1)
	5. Does not exclude members with special health care needs.	100% (1/1)	0% (0/1)	0% (0/1)
C*	6. Has the potential to affect member health, functional status, or satisfaction.	100% (1/1)	0% (0/1)	0% (0/1)
	Activity Average Rates**	**100% (6/6)**	**0% (0/6)**	**0% (0/6)**
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	100% (1/1)	0% (0/1)	0% (0/1)
C*	2. Is answerable.	100% (1/1)	0% (0/1)	0% (0/1)
	Activity Average Rates**	**100% (2/2)**	**0% (0/2)**	**0% (0/2)**
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	100% (1/1)	0% (0/1)	0% (0/1)
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	100% (1/1)	0% (0/1)	0% (0/1)
C*	3. Allow for the study questions to be answered.	100% (1/1)	0% (0/1)	0% (0/1)
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	100% (1/1)	0% (0/1)	0% (0/1)
C*	5. Have available data that can be collected on each indicator.	100% (1/1)	0% (0/1)	0% (0/1)
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	100% (1/1)	0% (0/1)	0% (0/1)
	7. Includes the basis on which each indicator was adopted, if internally developed.	Not applicable	Not applicable	Not applicable
	Activity Average Rates**	**100% (6/6)**	**0% (0/6)**	**0% (0/6)**
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	100% (1/1)	0% (0/1)	0% (0/1)
	2. Includes requirements for the length of a member's enrollment in the plan.	100% (1/1)	0% (0/1)	0% (0/1)
C*	3. Captures all members to whom the study question applies.	100% (1/1)	0% (0/1)	0% (0/1)
	Activity Average Rates**	**100% (3/3)**	**0% (0/3)**	**0% (0/3)**

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 = 1 Submission)
October 1, 2010, through December 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% (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.	100% (1/1)	0% (0/1)	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**	**100% (5/5)**	**0% (0/5)**	**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)**

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.6—Small-Group Collaborative QIP Activities VIII to X Ratings (N = 1 Submission)
October 1, 2010, through December 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% (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.	100% (1/1)	0% (0/1)	0% (0/1)
	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.	100% (1/1)	0% (0/1)	0% (0/1)
	9. Includes interpretation of the extent to which the study was successful.	100% (1/1)	0% (0/1)	0% (0/1)
	Activity Average Rates**	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
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)	100% (1/1)	0% (0/1)
	Activity Average Rates**	**25% (1/4)**	**75% (3/4)**	**0% (0/4)**
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)	0% (0/1)	100% (1/1)
	Activity Average Rates**	**0% (0/1)**	**0% (0/1)**	**100% (1/1)**

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.7—Internal QIP Activities I to IV Ratings (N = 28 Submissions)
October 1, 2010, through December 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% (24/24)	0% (0/24)	0% (0/24)
	2. Is selected following collection and analysis of data (or was selected by the State).	100% (28/28)	0% (0/28)	0% (0/28)
	3. Addresses a broad spectrum of care and services (or was selected by the State).	100% (28/28)	0% (0/28)	0% (0/28)
	4. Includes all eligible populations that meet the study criteria.	89% (25/28)	7% (2/28)	4% (1/28)
	5. Does not exclude members with special health care needs.	93% (26/28)	0% (0/28)	7% (2/28)
C*	6. Has the potential to affect member health, functional status, or satisfaction.	100% (28/28)	0% (0/28)	0% (0/28)
	Activity Average Rates**	**97% (159/164)**	**1% (2/164)**	**2% (3/164)**
Activity II: Clearly Defined, Answerable Study Question(s)				
C*	1. States the problem to be studied in simple terms.	96% (27/28)	4% (1/28)	0% (0/28)
C*	2. Is answerable.	96% (27/28)	4% (1/28)	0% (0/28)
	Activity Average Rates**	**96% (54/56)**	**4% (2/56)**	**0% (0/56)**
Activity III: Clearly Defined Study Indicator(s)				
C*	1. Are well-defined, objective, and measurable.	86% (24/28)	14% (4/28)	0% (0/28)
	2. Are based on current, evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	100% (27/27)	0% (0/27)	0% (0/27)
C*	3. Allow for the study questions to be answered.	86% (24/28)	14% (4/28)	0% (0/28)
	4. Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	93% (26/28)	7% (2/28)	0% (0/28)
C*	5. Have available data that can be collected on each indicator.	100% (28/28)	0% (0/28)	0% (0/28)
	6. Are nationally recognized measures such as HEDIS specifications, when appropriate.	100% (22/22)	0% (0/22)	0% (0/22)
	7. Includes the basis on which each indicator was adopted, if internally developed.	100% (8/8)	0% (0/8)	0% (0/8)
	Activity Average Rates**	**94% (159/169)**	**6% (10/169)**	**0% (0/169)**
Activity IV: Correctly Identified Study Population				
C*	1. Is accurately and completely defined.	93% (26/28)	7% (2/28)	0% (0/28)
	2. Includes requirements for the length of a member's enrollment in the plan.	93% (26/28)	7% (2/28)	0% (0/28)
C*	3. Captures all members to whom the study question applies.	93% (26/28)	7% (2/28)	0% (0/28)
	Activity Average Rates**	**93% (78/84)**	**7% (6/84)**	**0% (0/84)**

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

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

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

Table B.8—Internal QIP Activities V to VII Ratings (N = 28 Submissions)
October 1, 2010, through December 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.	100% (15/15)	0% (0/15)	0% (0/15)
	2. Identify the sample size.	100% (15/15)	0% (0/15)	0% (0/15)
	3. Specify the confidence level.	100% (15/15)	0% (0/15)	0% (0/15)
	4. Specify the acceptable margin of error.	93% (14/15)	7% (1/15)	0% (0/15)
C*	5. Ensure a representative sample of the eligible population.	100% (15/15)	0% (0/15)	0% (0/15)
	6. Are in accordance with generally accepted principles of research design and statistical analysis.	100% (15/15)	0% (0/15)	0% (0/15)
	Activity Average Rates**	**99% (89/90)**	**1% (1/90)**	**0% (0/90)**
Activity VI: Accurate/Complete Data Collection				
	1. The identification of data elements to be collected.	100% (24/24)	0% (0/24)	0% (0/24)
	2. The identification of specified sources of data.	100% (24/24)	0% (0/24)	0% (0/24)
	3. A defined and systematic process for collecting baseline and remeasurement data.	100% (15/15)	0% (0/15)	0% (0/15)
	4. A timeline for the collection of baseline and remeasurement data.	88% (21/24)	8% (2/24)	4% (1/24)
	5. Qualified staff and personnel to abstract manual data.	100% (15/15)	0% (0/15)	0% (0/15)
C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	94% (15/16)	6% (1/16)	0% (0/16)
	7. A manual data collection tool that supports interrater reliability.	92% (12/13)	8% (1/13)	0% (0/13)
	8. Clear and concise written instructions for completing the manual data collection tool.	93% (14/15)	7% (1/15)	0% (0/15)
	9. An overview of the study in written instructions.	93% (14/15)	7% (1/15)	0% (0/15)
	10. Administrative data collection algorithms/flowcharts that show activities in the production of indicators.	96% (22/23)	4% (1/23)	0% (0/23)
	11. An estimated degree of automated data completeness.	100% (9/9)	0% (0/9)	0% (0/9)
	Activity Average Rates**	**96% (185/193)**	**4% (7/193)**	**1% (1/193)**
Activity VII: Appropriate Improvement Strategies				
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes.	100% (24/24)	0% (0/24)	0% (0/24)
	2. System changes that are likely to induce permanent change.	100% (24/24)	0% (0/24)	0% (0/24)
	3. Revised if original interventions are not successful.	75% (3/4)	25% (1/4)	0% (0/4)
	4. Standardized and monitored if interventions were successful.	60% (3/5)	20% (1/5)	20% (1/5)
	Activity Average Rates**	**95% (54/57)**	**4% (2/57)**	**2% (1/57)**

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.9—Internal QIP Activities VIII to X Ratings (N = 28 Submissions)
October 1, 2010, through December 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.	83% (20/24)	17% (4/24)	0% (0/24)
C*	2. Allows for the generalization of the results to the study population if a sample was selected.	100% (15/15)	0% (0/15)	0% (0/15)
	3. Identifies factors that threaten the internal or external validity of the findings.	92% (22/24)	0% (0/24)	8% (2/24)
	4. Includes an interpretation of the findings.	79% (19/24)	17% (4/24)	4% (1/24)
	5. Is presented in a way that provides accurate, clear, and easily understood information.	88% (21/24)	13% (3/24)	0% (0/24)
	6. Identifies initial measurement and remeasurement of study indicators.	100% (8/8)	0% (0/8)	0% (0/8)
	7. Identifies statistical differences between initial measurement and remeasurement.	88% (7/8)	13% (1/8)	0% (0/8)
	8. Identifies factors that affect the ability to compare the initial measurement with remeasurement.	100% (8/8)	0% (0/8)	0% (0/8)
	9. Includes interpretation of the extent to which the study was successful.	88% (7/8)	0% (0/8)	13% (1/8)
	Activity Average Rates**	**89% (127/143)**	**8% (12/143)**	**3% (4/143)**
Activity IX: Real Improvement Achieved				
	1. Remeasurement methodology is the same as baseline methodology.	100% (8/8)	0% (0/8)	0% (0/8)
	2. There is documented improvement in processes or outcomes of care.	63% (5/8)	25% (2/8)	13% (1/8)
	3. The improvement appears to be the result of planned intervention(s).	63% (5/8)	13% (1/8)	25% (2/8)
	4. There is statistical evidence that observed improvement is true improvement.	25% (2/8)	25% (2/8)	50% (4/8)
	Activity Average Rates**	**63% (20/32)**	**16% (5/32)**	**22% (7/32)**
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)	0% (0/2)	50% (1/2)
	Activity Average Rates**	**50% (1/2)**	**0% (0/2)**	**50% (1/2)**

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.