Appendix D. Plan-specific Quality Improvement Plans as of 8/1/2014 (see abbreviations and key at end of this appendix)

Full scope plans

Alameda Alliance for Health								
Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension								
County	Indicators	QAT	Baseline MY2011	RM1 MY2012	RM2 MY2013	RM3 MY2014	SI	
Alameda	Filled one hypertension prescription***	Q, A	65.57%	63.98%	‡	‡	‡	
	1, 2, or 3 anti-hypertensive medications and a fill rate of at least 40%***		53.88%	48.29%	‡	‡	‡	
Anthem Blue Cross Partnership Plan								
Improving Diabetes Management								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
Alameda	CDC–E CDC-HT CDC–H9 (>9.0%) CDC–H8 (<8.0%) CDC–N CDC–BP	Q, A	‡	‡	‡	‡	‡	
Contra Costa			‡	‡	‡	‡	‡	
Fresno			‡	‡	‡	‡	‡	
Kings			‡	‡	‡	‡	‡	
Sacramento			‡	‡	‡	‡	‡	
San Francisco			‡	‡	‡	‡	‡	
Tulare			‡	‡	‡	‡	‡	
Improving Timeliness of Prenatal and Postpartum Care								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
Alameda	PPC–Pre PPC–Pst	Q, A, T	‡	‡	‡	‡	‡	
Contra Costa			‡	‡	‡	‡	‡	
Fresno			‡	‡	‡	‡	‡	
Kings			‡	‡	‡	‡	‡	
Madera			‡	‡	‡	‡	‡	
Sacramento			‡	‡	‡	‡	‡	
Santa Clara			‡	‡	‡	‡	‡	
Tulare			‡	‡	‡	‡	‡	

Childhood Immunization Status								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
Sacramento	CIS–3	Q, A, T	‡	‡	‡	‡	‡	
California Health and Wellness—new Plan. No QIP yet								
CalOptima								
Improvement of Prenatal Visit Rates for Pregnant Members								
County	Indicators	QAT	Historic MY2012	Baseline MY2013	RM1 MY2014	RM2 MY2015	SI	
Orange	PPC-Pre	Q,A,T	78.42%	85.07**	‡	‡	‡	
CalViva Health								
Retinal Eye Exam								
County	Indicators	QAT	Baseline MY2012	RM1 MY2013	RM2 MY2014	RM3 MY2015	SI	
Fresno	CDC–E	Q, A	48.91%	48.42%	‡	‡	‡	
Kings			**42.82%**	48.42%	‡	‡	‡	
Madera			55.72%	60.34%	‡	‡	‡	
Care1st Partner Plan								
Comprehensive Diabetes Care								
County	Indicators	QAT	Baseline MY2010	RM1 MY2011	RM2 MY2012	RM3 MY2013	SI	
San Diego	CDC–HT	Q, A	83.6%	88.8%	84.9%	81.27%	‡	
	CDC–H9 (>9.0%)		30.9%	37.0%	42.1%	51.82% **	‡	
	CDC–E		41.8%	47.4%	**40.4%**	**37.71%**	‡	
	CDC–N		87.3%	88.4%	85.4%	82.24%	‡	
CenCal Health								
Annual Monitoring for Patients on Persistent Medications								
County	Indicators	QAT	Baseline MY2012	RM1 MY2013	RM2 MY2014	RM3 MY2015	SI	
San Luis Obispo	MPM–ACE	Q	**81.0%**	**80.16%**	‡	‡	‡	
Santa Barbara			84.7%	85.79%	‡	‡	‡	
San Luis Obispo	MPM–DIG		NA	NA	‡	‡	‡	

Santa Barbara			**86.1%**	**84.85%**	‡	‡	‡	
San Luis Obispo	MPM–DIU		84.2%	84.92%	‡	‡	‡	
Santa Barbara			85.5%	86.74%	‡	‡	‡	
Central California Alliance for Health								
Improving Asthma Health Outcomes								
County	Indicators	QAT	Baseline MY2012	RM1 MY2013	RM2 MY2014	RM3 MY2015	SI	
Merced	MMA–50	Q, A	48.30%	54.14%**	‡	‡	‡	
Monterey/ Santa Cruz			49.96%	52.98%**	‡	‡	‡	
Merced	ED Utilization***		13.50%	‡	‡	‡	‡	
Monterey/ Santa Cruz			13.15%	‡	‡	‡	‡	
Merced	Inpatient Admissions***		0.85%	‡	‡	‡	‡	
Monterey/ Santa Cruz			1.20%	‡	‡	‡	‡	
Community Health Group Partnership Plan								
Increasing Postpartum Care Visits Within 6 Weeks of Delivery								
County	Indicators	QAT	Baseline MY2012	RM1 MY2013	RM2 MY2014	RM3 MY2015	SI	
San Diego	PPC–Pst	Q, T	**55.23%**	57.91%	‡	‡	‡	
Contra Costa Health Plan								
Improving Perinatal Access and Care								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
Contra Costa	PPC–Pre, PPC-Post	Q, A, T	‡	‡	‡	‡	‡	
Gold Coast Health Plan								
Increase Rate of the Annual Diabetic Eye Exam								
County	Indicators	QAT	Baseline MY2012	RM1 MY2013	RM2 MY2014	RM3 MY2015	SI	
Ventura	CDC–E	Q, A	**42.58%**	45.74%	‡	‡	‡	

Health Net Community Solutions, Inc.								
Improving Postpartum Care Among Medi-Cal Women Including Seniors and Persons with Disabilities								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
Kern	PPC–Pst	Q, A, T	‡	‡	‡	‡	‡	
Los Angeles			‡	‡	‡	‡	‡	
Sacramento			‡	‡	‡	‡	‡	
San Diego			‡	‡	‡	‡	‡	
Stanislaus			‡	‡	‡	‡	‡	
Tulare			‡	‡	‡	‡	‡	
Health Plan of San Joaquin								
Improve Percentage Rate of HbA1c Testing Within Diabetic Membership								
County	Indicators	QAT	Baseline MY2010	RM1 MY2011	RM2 MY2012	RM3 MY2013	SI	
San Joaquin	CDC–HT	Q, A	80.54%	81.51%	80.66%	**79.08%**	‡	
Health Plan of San Mateo								
Increasing Timeliness of Prenatal Care								
County	Indicators	QAT	Baseline MY2009	RM1 MY2010	RM2 MY2011	RM3 MY2012	RM4 MY 2013	SI
San Mateo	PPC–Pre	Q, A, T	85.32%	83.16%	81.89%	84.18%	82.66	
Inland Empire Health Plan								
Comprehensive Diabetes Care								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
Riverside/ San Bernardino	CDC–HT (admin. rate)***	Q, A	‡	‡	‡	‡	‡	
	HbA1c Control (≤9.0%) (admin. rate)***		‡	‡	‡	‡	‡	
	CDC–E (admin. rate)***		‡	‡	‡	‡	‡	
Kaiser–Sacramento County								
Childhood Immunization Status (CIS)								
County	Indicators	QAT	Baseline MY2012	RM1 MY2013	RM2 MY2014	RM3 MY2015	SI	
Sacramento	CIS–3	Q, A, T	83.9%	86.11%	‡	‡	‡	
	CIS–10***		50.1%	‡	‡	‡	‡	

Kaiser–San Diego County								
Children's Access to Primary Care Practitioners								
County	Indicators	QAT	Baseline MY2011	RM1 MY2012	RM2 MY2013	RM3 MY2014	SI	
San Diego	CAP–256	Q, A	94.39%	94.40%	93.60%	‡	‡	
	W–34		68.55%	70.72%	73.70%**	‡	‡	
Kern Family Health Care								
Comprehensive Diabetic Quality Improvement Plan								
County	Indicators	QAT	Baseline MY2011	RM1 MY2012	RM2 MY2013	RM3 MY2014	SI	
Kern	CDC–HT	Q, A	82.12%	80.29%	80.05%	‡	‡	
	CDC–E		52.55%	45.80%**	45.01%	‡	‡	
L.A. Care Health Plan								
Improving HbA1c and Diabetic Retinal Exam Screening Rates								
County	Indicators	QAT	Baseline MY2009	RM1 MY2010	RM2 MY2011	RM3 MY2012	RM4 MY 2013	SI
Los Angeles	CDC–HT	Q, A	82.08%	85.02%	83.82%	84.30%	83.54 %	
	CDC–E		52.78%	50.72%	50.72%	49.76%	46.25 %	
Molina Healthcare of California Partner Plan, Inc.								
Improving Hypertension Control								
County	Indicators	QAT	Baseline MY2009	RM1 MY2010	RM2 MY2011	RM3 MY2012	RM4 MY 2013	SI
Riverside/ San Bernardino	CBP	Q, A	59.63%	42.62%**	53.65%**	53.83%	**47.22 %****	
Sacramento			56.61%	50.82%	53.14%	51.29%	**47.23 %**	
San Diego			66.36%	58.28%**	54.95%	52.76%	53.88 %	

Partnership HealthPlan of California								
Improving Timeliness of Prenatal and Postpartum Care (PPC)								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
Marin	PPC–Pre	Q, A, T	‡	‡	‡	‡	‡	
	PPC–Pst		‡	‡	‡	‡	‡	
Childhood Immunization Status–Combo 3								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
Mendocino	CIS–3	Q, A	‡	‡	‡	‡	‡	
Improving Access to Primary Care for Children and Adolescents								
County	Indicators	QAT	Baseline MY2011[5]	RM1 MY2012	RM2 MY2013	RM3 MY2014	SI	
Napa/Solano/ Yolo	CAP–1224	A	94.91%	96.49%	96.81%	‡	‡	
Sonoma			95.24%	96.25%	98.23%**	‡	‡	
Napa/Solano/ Yolo	CAP–256		82.91%	**86.42%**	87.79%**	‡	‡	
Sonoma			86.47%	88.58%	90.32%**	‡	‡	
Napa/Solano/ Yolo	CAP–711		80.35%	**83.67%**	**85.84%****	‡	‡	
Sonoma			83.26%	**85.70%**	**87.25%****	‡	‡	
Napa/Solano/ Yolo	CAP–1219		77.25%	**84.94%**	**83.8%****	‡	‡	
Sonoma			84.36%	88.23%	86.73%**	‡	‡	
San Francisco Health Plan								
Improving the Patient Experience								
County	Indicators	QAT	Baseline MY2010	RM1 MY2013	RM2 MY2016	RM3 MY2019	SI	
San Francisco	Rating of Overall Health Care***	Q, A	43.6%	‡	‡	‡	‡	
	Rating of Personal Doctor***		54.7%	‡	‡	‡	‡	

Santa Clara Family Health Plan								
Diabetic Retinopathy Improvement and Prevention by Screening								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
Santa Clara	CDC–E	Q, A	‡	‡	‡	‡	‡	

Specialty Plans

AIDS Healthcare Foundation								
Increasing CD4 and Viral Load Testing								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
Los Angeles	Stable patients receiving 2 CD4 and Viral Load tests***	Q, A	‡	‡	‡	‡	‡	
	Patients with detectable viral load in previous two years receiving 3 CD4 and Viral Load tests***		‡	‡	‡	‡	‡	
Reducing Avoidable Emergency Department Visits								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
Los Angeles	Percentage of avoidable emergency department (AED) visits for plan members during the measurement year***	Q, A	‡	‡	‡	‡	‡	
	Percentage of AED visits, with ICD-9 codes selected for persons living with HIV/AIDS***		‡	‡	‡	‡	‡	
Family Mosaic Project								
Increase Rate of School Attendance								
County	Indicators	QAT	Baseline MY2010	RM1 MY2013	RM2 MY2014	RM3 MY2015	SI	
San Francisco	CANS Initial Assessment and the Reassessment of School Attendance***	Q	‡	‡	‡	‡	‡	
Reduction of Ratings of Depression								
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI	
San Francisco	CANS Reassessment and Discharge of Depression***	Q	‡	‡	‡	‡	‡	

Senior Care Action Network Health Plan							
Patient Safety Analysis–Use of High-Risk Medication in the Elderly							
County	Indicators	QAT	Baseline MY2013	RM1 MY2014	RM2 MY2015	RM3 MY2016	SI
Los Angeles/ Riverside/ San Bernardino	Use of high risk medications***	TBD	‡	‡	‡	‡	‡

Symbol	Description
General	
SI	Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.
*	Statistically significant improvement over baseline (*p* value < 0.05).
**	A statistically significant difference between the measurement period and prior measurement period (*p* value < 0.05).
***	No comparison made to the MPL or HPL for this indicator either because the indicator is not a HEDIS measure, the indicator is a utilization measure, the indicator is for a special population, or the measure is being reported by a different method in the QIP than is reported for the HEDIS.
‡	The QIP did not progress to this stage during the review period and therefore could not be assessed.
RM	Remeasurement
N/A	The QIP was closed prior to progressing to the measurement period.
NA	A Not Applicable audit finding because the MCP's denominator was too small to report (less than 30).
Bold	Bolded rates indicate the rate was below the DCHS-established minimum performance level for that measurement year.
	Shaded rates indicate the rate was above the DCHS-established high performance level for that measurement year.
TBD	To be determined.
Indicators	
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*

CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
CBP	*Controlling High Blood Pressure*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
CIS–10	*Childhood Immunization Status—Combination 10*
DAE	*Use of High-Risk Medications in the Elderly*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W–34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Domains of Care	
Q	Quality Domain of Care: The degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.
A	Access Domain of Care: An MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries.
T	Timeliness Domain of Care: An MCP's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.