CALIFORNIA HEALTH CARE PERFORMANCE RESULTS

2008 REPORT ON QUALITY

HEALTH CARE IN CALIFORNIA

ABOUT CCHRI

Measuring how well the health care industry is performing is a challenge. Since 1994, the California Cooperative Healthcare Reporting Initiative (CCHRI) has met this challenge. Each year, CCHRI provides the public with important information on how well health plans provide certain preventive care and other medical services that members should receive. CCHRI also shares information about members' experience with their health plans obtained from a statewide member survey of participating plans as well as information about members' experience with their physician groups obtained from a similar survey of participating physician group members.

CCHRI is a collaborative of health care purchasers, consumers, plans and providers. It is managed by one of its founding organizations, the Pacific Business Group on Health (PBGH). PBGH is a coalition of large purchasers that is committed to improving the quality of health care while moderating costs. Nine California health plans participate in a variety of CCHRI-sponsored data collection and reporting projects; because CCHRI projects are voluntary, participation may vary but most plans participate in more than one activity.

CCHRI was created to help employers and consumers make informed health care purchasing decisions. By ensuring the utilization of collaborative, standardized processes, plans and groups can be compared on an apples-to-apples basis using data that is collected in similar ways, following similar guidelines.

The CCHRI yearly report offers these advantages:

- CCHRI promotes comparability of results by providing a single process for the collection and analysis of California quality of care and member experience data. Consistent, standardized data collection makes the results more comparable.
- Performance reporting definitions are standardized, leading to meaningful rankings and better understanding of the specific measures.

CARE AND MEMBER EXPERIENCE

MEASURES OF HEALTH PLAN PERFORMANCE AND MEMBER EXPERIENCE

Health plan performance results reported by CCHRI on the following pages are part of HEDIS 2008 (Healthcare Effectiveness Data and Information Set), a set of standardized measures developed and maintained by the National Committee for Quality Assurance, NCQA. NCQA is a not-for-profit organization committed to evaluation and public reporting on the quality of health plans in the United States.

NCQA developed the effectiveness of care, access and member experience measures so health plans could use comparable tools and methods to evaluate and report the quality of health care provided to their members. Ninety percent of HMOs nationwide, a growing number of PPOs, and approximately three-quarters of large employers utilize HEDIS to measure and compare health plan outcomes and make informed health care choices.

CAUTION

Use caution when comparing results from California health plans not listed in this report with results that do appear here. CCHRI cannot ensure other data were collected under similar circumstances or that the results can be fairly and uniformly compared.

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CALIFORNIA HEALTH PLAN **REPORT CARD**

COMMERCIAL MEASURES

CCHRI'S VOLUNTARY COLLABORATIVE APPROACH TO COLLECTING AND REPORTING IMPORTANT HEALTH CARE INFORMATION HAS HELPED DRIVE QUALITY MEASUREMENT AND IMPROVEMENT IN CALIFORNIA. Health plans are able to use the results for their own quality improvement efforts and, since the start of public reporting in 1994, there have been significant advances in patient care and satisfaction according to CCHRI health plan results. All survey and clinical data are collected using uniform processes and guidelines and undergo a rigorous audit by an independent third party. As a result, the scores listed here are valid and comparisons can be made on an apples-to-apples basis. Results from other, non-CCHRI health plans may not be comparable because of differences in how data were collected or audited.

CLINICAL AND SERVICE MEASURES

Findings for the clinical and service measures were obtained from data collected by CCHRI participating health plans. Results are based on HEDIS® Effectiveness of Care and Access/Availability of Care measurement and reporting guidelines developed by the National Committee for Quality Assurance (NCQA). HEDIS is the most widely used set of performance measures in the health care industry and, when used with the NCQA-approved Member Survey, helps identify health plan successes in providing preventive care, chronic care management and other medical services for health plan members. Results were collected in 2008 and reflect the percentage of sampled members who received the specific services during 2007, or in prior years for a few of the measures.

HOW TO INTERPRET THE RESULTS

When reviewing this report card, please compare each plan to the benchmark and not to the other plans. Most ratings are based on a small sample of health plan members. As a result, small differences in the results between plans may not be statistically significant or meaningful.

Traditionally this report card pertained only to health maintenance organizations (HMOs). Beginning in 2008, information regarding PPO plans is included. Since this is the first year for reporting PPO results, only the CCHRI cross-plan averages are presented for a subset of measures. Results listed are for commercial HMO and PPO members only; Medicare or Medi-Cal beneficiaries covered under a managed care plan are not included. Use caution when comparing HMO to PPO results, since some HMO measures allow for chart review while PPO measures are based solely on claims data. In addition, not all HMO plans have a PPO product; therefore, the PPO cross-plan averages are based on a subset of the HMO plans.

CALIFORNIA HEALTH PLANS

	YOUNG FAMILIES						
	Prenatal and Postpartum Care[d]		Childhood Immunizations[d]		Testing for Children with Pharyngitis	Treatment for Children with URI	Follow-up Care - ADHD
	Timely Initiation of Prenatal Care	Postpartum Care	Combo 2	Combo 3			Initiation Phase
Aetna	94	82	83	76	37 ▼	81 ▼	17 ▼
Anthem Blue Cross	97[b] ▲	85	82	77	35 ▼	84 ▲	35
Blue Shield	97[b] ▲	84[b]	80	74	40 ▼	84	33
CIGNA	96[b] ▲	89[b] ▲	81	77	42 ▼	88 ▲	30
Health Net	95[b]	85[b]	82	78	45 ▼	85 ▲	24 ▼
Kaiser Permanente N. Cal	97 ▲	90 ▲	84 ▲	82 ▲	86 ▲	96 ▲	27 ▼
Kaiser Permanente S. Cal	87[b] ▼	79[b] ▼	84 ▲	82 ▲	84 ▲	96 ▲	31 ▼
PacifiCare	96 ▲	88 ▲	82	76	39 ▼	85 ▲	35
CCHRI Cross-Plan HMO Average[e]	**94**	**84**	**83**	**78**	**53**	**88**	**29**
CCHRI Cross-Plan PPO Average[ef]	**NP**	**NP**	**NP**	**NP**	**55**	**87**	**36**
2008 NCQA Nat'l HMO/POS Mean[a]	**92**	**82**	**81**	**76**	**75**	**84**	**34**
2008 NCQA HMO/POS 90th %ile[a]	**98**	**90**	**89**	**85**	**88**	**93**	**45**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2008
b – 2007 rates reported—rotation measure
c – Lower number reflects better performance
d – HMO measure allows for chart review
e – CCHRI Cross-Plan Averages are for 2008
f – PPO plans include: Aetna, Anthem, Blue Shield, CIGNA, Health Net, UnitedHealthcare
NP – Measure not reported for PPO
NR – Rate not reported by the plan
NE – Not publicly reported in 2007

CALIFORNIA HEALTH PLANS

	PREVENTIVE HEALTH SCREENINGS					
	Cervical Cancer Screening[d]	Breast Cancer Screening		Chlamydia Screening in Women		Colorectal Cancer Screening[d]
		Ages 42-51	Ages 52-69	Ages 16-20	Ages 21-25	
Aetna	82	57 ▼	62 ▼	38	45 ▲	51
Anthem Blue Cross	83[b]	64 ▼	70 ▼	31 ▼	37 ▼	56
Blue Shield	84	65 ▼	71	35 ▼	42 ▲	56
CIGNA	84[b]	65 ▼	70 ▼	41 ▲	50 ▲	57
Health Net	86[b]▲	66 ▼	72 ▲	40 ▲	46 ▲	60
Kaiser Permanente N. Cal	85	76 ▲	82 ▲	60 ▲	66 ▲	53
Kaiser Permanente S. Cal	86 ▲	69 ▲	87 ▲	65 ▲	69 ▲	64 ▲
PacifiCare	84[b]	66	73 ▲	36	43 ▲	58
CCHRI Cross-Plan HMO Average[e]	**84**	**66**	**74**	**43**	**50**	**57**
CCHRI Cross-Plan PPO Average[ef]	**75**	**61**	**65**	**33**	**41**	**NP**
2008 NCQA Nat'l HMO/POS Mean[a]	**82**	**66**	**72**	**36**	**39**	**56**
2008 NCQA HMO/POS 90th %ile[a]	**88**	**75**	**80**	**48**	**53**	**68**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

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CALIFORNIA HEALTH PLANS

	CHRONIC DISEASE							
	Comprehensive Diabetes Care[d]							
	HbA1c Testing	HbA1c Level ≤9.0%	Retinal Exam	LDL-C Screening	LDL-C Level of <100 mg/dL	Nephropathy Monitoring	Blood Pressure Control <130/80	Blood Pressure Control <140/90
Aetna	88	70	51	84	39	82	35	65
Anthem Blue Cross	87	72	56	82	43	79	35	68
Blue Shield	89	75 ▲	60 ▲	86	42	82	34	68
CIGNA	82 ▼	68	49 ▼	79 ▼	42	79	27 ▼	61
Health Net	91 ▲	76 ▲	61 ▲	87 ▲	49 ▲	85 ▲	32	67
Kaiser Permanente N. Cal	91 ▲	82 ▲	68 ▲	88 ▲	57 ▲	87 ▲	52 ▲	77 ▲
Kaiser Permanente S. Cal	88	71	73 ▲	88 ▲	50 ▲	94 ▲	47 ▲	79 ▲
PacifiCare	86	72	59	83	45	82	37 ▲	69 ▲
CCHRI Cross-Plan HMO Average[e]	**88**	**73**	**59**	**85**	**46**	**84**	**37**	**68**
CCHRI Cross-Plan PPO Average[ef]	**76**	**NP**	**NP**	**74**	**NP**	**63**	**NP**	**NP**
2008 NCQA Nat'l HMO/POS Mean[a]	**88**	**71**	**55**	**84**	**44**	**81**	**32**	**64**
2008 NCQA HMO/POS 90th %ile[a]	**93**	**81**	**72**	**89**	**52**	**88**	**40**	**72**

▲ Significantly Above National Mean

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CALIFORNIA HEALTH PLANS

	CHRONIC DISEASE			CARDIOVASCULAR HEALTH			
	Use of Appropriate Medications for People with Asthma			Persistence of Beta Blocker	Controlling High Blood Pressure[d]	Cholesterol Management Cardiovascular Conditions[d]	
	Ages 5-9	Ages 10-17	Ages 18-56			LDL-C Screening	LDL-C Level of <100 mg/dL
Aetna	96	92	90	68	61[b]	88	64 ▲
Anthem Blue Cross	97	91 ▼	89 ▼	67 ▼	65	90	69 ▲
Blue Shield	96	93	91	74	61	90	66 ▲
CIGNA	96	91	89	71	64[b]	87	57
Health Net	98	93	91	71	62[b]	88	65 ▲
Kaiser Permanente N. Cal	98 ▲	97 ▲	94 ▲	84 ▲	76 ▲	92 ▲	71 ▲
Kaiser Permanente S. Cal	95 ▼	92 ▼	94 ▲	85 ▲	74 ▲	96 ▲	70 ▲
PacifiCare	95 ▼	92 ▼	90 ▼	69	63	88	63
CCHRI Cross-Plan HMO Average[e]	**96**	**92**	**91**	**74**	**65**	**90**	**65**
CCHRI Cross-Plan PPO Average[ef]	**97**	**95**	**91**	**64**	**NP**	**75**	**NP**
2008 NCQA Nat'l HMO/POS Mean[a]	**97**	**94**	**91**	**72**	**62**	**88**	**59**
2008 NCQA HMO/POS 90th %ile[a]	**100**	**97**	**94**	**84**	**70**	**93**	**70**

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NR – Rate not reported by the plan
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CALIFORNIA HEALTH PLANS

	MENTAL HEALTH					
	Antidepressant Medication Management		Follow-up After Hospitalization for Mental Illness		Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	
	Effective Acute Phase Treatment	Effective Continuation Phase Treatment	Within 30 Days of Hospital Discharge	Within 7 Days of Hospital Discharge	Initiation Total	Engagement Total
Aetna	56 ▼	42 ▼	43 ▼	33 ▼	45	14
Anthem Blue Cross	58 ▼	43 ▼	75	58	34 ▼	6 ▼
Blue Shield	59 ▼	44 ▼	75	61 ▲	41 ▼	7 ▼
CIGNA	57 ▼	42 ▼	65 ▼	51	44	15
Health Net	58 ▼	43 ▼	78 ▲	57	43 ▼	14
Kaiser Permanente N. Cal	83 ▲	61 ▲	85 ▲	73 ▲	43 ▼	20 ▲
Kaiser Permanente S. Cal	85 ▲	65 ▲	82 ▲	70 ▲	41 ▼	18 ▲
PacifiCare	56 ▼	41 ▼	80 ▲	65 ▲	35 ▼	12 ▼
CCHRI Cross-Plan HMO Average[e]	**63**	**47**	**74**	**58**	**39**	**12**
CCHRI Cross-Plan PPO Average[ef]	**61**	**46**	**64**	**46**	**42**	**12**
2008 NCQA Nat'l HMO/POS Mean[a]	**63**	**46**	**74**	**56**	**44**	**15**
2008 NCQA HMO/POS 90th %ile[a]	**70**	**55**	**87**	**73**	**55**	**23**

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NOTES

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e – CCHRI Cross-Plan Averages are for 2008
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CALIFORNIA HEALTH PLANS	OTHER			
	Avoidance of Antibiotic Treatment Acute Bronchitis	Anti-Rheumatic Drug Therapy	Low Back Pain Imaging	Annual Monitoring Persistent Medications Total
Aetna	21 ▼	82	80 ▲	71 ▼
Anthem Blue Cross	21 ▼	84	74	62 ▼
Blue Shield	19 ▼	87 ▲	77 ▲	71 ▼
CIGNA	26	79 ▼	76 ▲	74 ▼
Health Net	22 ▼	82 ▼	79 ▲	72 ▼
Kaiser Permanente N. Cal	38 ▲	90 ▲	78 ▲	69 ▼
Kaiser Permanente S. Cal	17 ▼	84 ▼	82 ▲	73 ▼
PacifiCare	21 ▼	85	76 ▲	71 ▼
CCHRI Cross-Plan HMO Average[e]	**23**	**84**	**78**	**70**
CCHRI Cross-Plan PPO Average[ef]	**31**	**82**	**77**	**73**
2008 NCQA Nat'l HMO/POS Mean[a]	**25**	**85**	**75**	**77**
2008 NCQA HMO/POS 90th %ile[a]	**34**	**92**	**82**	**83**

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b – 2007 rates reported—rotation measure
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e – CCHRI Cross-Plan Averages are for 2008
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COMMERCIAL SERVICE MEASURES 1 of 1

CALIFORNIA HEALTH PLANS

	MEMBER SERVICE	
	Call Abandonment[c]	Call Answer Timeliness
Aetna	1.5 ▲	80 ▲
Anthem Blue Cross	NR	NR
Blue Shield	NR	NR
CIGNA	2.8 ▼	59 ▼
Health Net	4.1 ▼	76 ▼
Kaiser Permanente N. Cal	1.7 ▲	82 ▲
Kaiser Permanente S. Cal	1.6 ▲	82 ▲
PacifiCare	1.7 ▲	79 ▲
CCHRI Cross-Plan HMO Average[e]	**2.2**	**79**
CCHRI Cross-Plan PPO Average[ef]	**2.1**	**78**
2008 NCQA Nat'l HMO/POS Mean[a]	**2.7**	**77**
2008 NCQA HMO/POS 90th %ile[a]	**1.0**	**90**

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CALIFORNIA HEALTH PLAN **REPORT CARD**

MEMBER SURVEY

ABOUT THE MEMBER SURVEY

The results shown in the following table were collected in a member survey developed by the National Committee for Quality Assurance (NCQA). Results include the percentage of sampled members who responded favorably to questions about their health plan or medical care and are based on random samples of participating health plan members (minimum sample size per plan = 1100). The survey was conducted during 2008 but reflects information about medical care and services provided to members during 2007.

The survey results contain four rated questions that measure members' overall experience with their medical care. Rated questions use a 0 to 10 scale, where 0 is the worst and 10 is the best score possible.

The Report Card also includes member survey results for composite categories. Composite categories include groups of related questions designed to provide a general idea of how well a health plan meets its members' expectations in specific areas. The categories report the combined results of several questions associated with a similar subject (e.g., Getting Needed Care includes responses to questions about ease of obtaining an appointment with a specialist and getting tests and treatments).

All the responses included in a composite category are weighted equally to obtain a single score. For example, for questions with four possible answers, the results used to create a composite score include all responses that fall in the top two favorable categories (i.e., Always or Usually). Traditionally this report card pertained only to members of health maintenance organizations (HMOs). Beginning in 2008, information regarding members in PPO plans is included. Since this is the first year for reporting PPO results, only the CCHRI cross-plan averages are presented. Results listed are for commercial HMO and PPO members only; Medicare or Medi-Cal beneficiaries covered under a managed care plan are not included. Use caution when comparing HMO to PPO results since not all HMO plans have a PPO product; therefore, the PPO cross-plan averages are based on a subset of the HMO plans.

It is possible that health plan members who returned the questionnaire or participated in telephone interviews are more satisfied or less satisfied than members who did not return the questionnaire. In addition, because of differences among health plans in the numbers of members who responded to the survey, outcomes that are statistically significant (above average, average, below average) for one plan may not be statistically significant for another, even when the rates are the same. When reviewing the results, please compare each plan to the average and not to the other plans. Most scores are based on small samples of health plan members and small differences between plans may not be statistically significant or meaningful.

CALIFORNIA HEALTH PLANS

	MEMBER EXPERIENCE WITH PLAN (% of replies scoring 8, 9, or 10 on a 10-point scale)				MEMBER EXPERIENCE WITH PROVIDERS					
	Health Plan Overall	Customer Service*	Getting Needed Care*	Claims Processing	Health Care Overall	Personal Doctor Overall	Specialist Overall	How Well Doctors Communicate	Getting Care Quickly*	Shared Decision Making**
Aetna	60	76	75	82	62	78	82	88	74	48
Anthem Blue Cross	61	85	81	79	69	79	67	87	77	53
Blue Shield	61	75	77	80	66	75	80	90	80	57
CIGNA	55	78	78	73	65	76	73	88	75	56
Health Net	64	75	77	78	64	78	73	88	76	55
Kaiser Permanente N. Cal	67	77	81	79	70	78	79	91	82	59
Kaiser Permanente S. Cal	69	78	76	75	69	77	75	91	76	56
PacifiCare	61	79	79	85	67	78	74	92	79	49
Western Health Advantage	72	86	83	89	72	74	79	89	85	63
CCHRI Cross-Plan HMO Average[e]	**63**	**78**	**79**	**80**	**67**	**77**	**76**	**89**	**78**	**55**
CCHRI Cross-Plan PPO Average[ef]	**56**	**77**	**86**	**84**	**70**	**81**	**80**	**93**	**85**	**57**
2008 NCQA Nat'l HMO/POS Mean[a]	**61**	**83**	**84**	**87**	**74**	**81**	**81**	**93**	**86**	**59**
2008 NCQA HMO/POS 90th %ile[a]	**72**	**90**	**89**	**92**	**80**	**86**	**86**	**95**	**90**	**65**

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2008

* Changes were made to the question or composite in 2007, therefore comparison to prior years results should be done with caution.

** New measure in 2007

e – CCHRI Cross-Plan Averages are for 2008

f – PPO plans include: Aetna, Anthem, Blue Shield, CIGNA, Health Net, UnitedHealthcare

CALIFORNIA HEALTH PLAN **REPORT CARD**

MEDICARE

SENIOR POPULATION REPORT

In many locations, Medicare beneficiaries have the option to join an HMO managed health care plan designed exclusively for seniors. Medicare managed care plans coordinate medical services from a specific network of physicians and hospitals. Beneficiaries enrolled in senior health plans are entitled to the same services as those provided under traditional Medicare. Some HMOs also cover additional services for seniors, such as prescription medications, eyeglasses, dental care or hearing aids.

The chart below shows how well CCHRI health plans coordinated important preventive services and medical care for their senior members. Not all California health plans offered a Medicare HMO in 2007; only those that did are listed in the chart on the next page.

Several California health plans provide senior HMO services in many portions of the state while others offer services on a more limited, regional or local basis. Consumers should contact health plans directly to ask whether managed Medicare services are available in their area.

HEALTH PLANS WITH MEDICARE CONTRACTS

	PREVENTIVE HEALTH SCREENINGS			
	Breast Cancer Screening		Colorectal Cancer Screening	Osteoporosis Management in Women
	Ages 42-51	Ages 52-69		
Aetna	60	64 ▼	54	16 ▼
Anthem Blue Cross	56	64 ▼	49	14 ▼
Blue Shield	54	67	60 ▲	10 ▼
Health Net	60	77 ▲	65 ▲	18 ▼
Kaiser Permanente N. Cal	75 ▲	86 ▲	58 ▲	27 ▲
Kaiser Permanente S. Cal	66 ▲	91 ▲	74 ▲	63 ▲
PacifiCare	59	73 ▲	62 ▲	18 ▼
CCHRI Cross-Plan Average	**60**	**75**	**60**	**23**
2008 National Mean[a]	**57**	**68**	**50**	**20**
2008 HMO/POS 90th %ile[a]	**69**	**82**	**69**	**29**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

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b – 2007 rates reported—rotation measure
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HEALTH PLANS WITH MEDICARE CONTRACTS

	CHRONIC DISEASE							
	Comprehensive Diabetes Care							
	HbA1c Testing	HbA1c Level ≤9.0%	Retinal Exam	LDL-C Screening	LDL-C Level of <100 mg/dL	Nephropathy Monitoring	Blood Pressure Control <130/80	Blood Pressure Control <140/90
Aetna	90	82 ▲	74 ▲	87	52 ▲	87	30	60
Anthem Blue Cross	88	80 ▲	76 ▲	88	48	86	30	60
Blue Shield	90	83 ▲	72 ▲	89 ▲	55 ▲	88	29	63 ▲
Health Net	94 ▲	86 ▲	68 ▲	92 ▲	61 ▲	90 ▲	31	59
Kaiser Permanente N. Cal	96 ▲	91 ▲	83 ▲	95 ▲	73 ▲	95 ▲	56 ▲	78 ▲
Kaiser Permanente S. Cal	95 ▲	88 ▲	84 ▲	95 ▲	63 ▲	97 ▲	50 ▲	78 ▲
PacifiCare	92 ▲	87 ▲	75 ▲	90 ▲	59 ▲	91 ▲	34	66 ▲
CCHRI Cross-Plan Average	**91**	**84**	**73**	**90**	**57**	**90**	**40**	**68**
2008 National Mean[a]	**88**	**70**	**61**	**86**	**46**	**85**	**31**	**58**
2008 HMO/POS 90th %ile[a]	**95**	**88**	**80**	**94**	**61**	**93**	**40**	**70**

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NR – Rate not reported by the plan
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HEALTH PLANS WITH MEDICARE CONTRACTS

	CARDIOVASCULAR HEALTH			
	Persistence of Beta Blocker	Controlling High Blood Pressure	Cholesterol Management Cardiovascular Conditions	
			LDL-C Screening	LDL-C Level of <100 mg/dL
Aetna	68	61	91	61 ▲
Anthem Blue Cross	73	62 ▲	88	55
Blue Shield	84 ▲	64 ▲	88	54
Health Net	76	65 ▲	93 ▲	73 ▲
Kaiser Permanente N. Cal	87 ▲	79 ▲	95 ▲	76 ▲
Kaiser Permanente S. Cal	91 ▲	73 ▲	96 ▲	76 ▲
PacifiCare	79 ▲	60	87	62 ▲
CCHRI Cross-Plan Average	**78**	**66**	**91**	**64**
2008 National Mean[a]	**75**	**57**	**88**	**55**
2008 HMO/POS 90th %ile[a]	**87**	**68**	**95**	**72**

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b – 2007 rates reported—rotation measure
c – Lower number reflects better performance
d – HMO measure allows for chart review
NP – Measure not reported for PPO
NR – Rate not reported by the plan
NE – Not publicly reported in 2007

HEALTH PLANS WITH MEDICARE CONTRACTS

	MENTAL HEALTH					
	Antidepressant Medication Management		Follow-up After Hospitalization for Mental Illness		Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	
	Effective Acute Phase Treatment	Effective Continuation Phase Treatment	Within 30 Days of Hospital Discharge	Within 7 Days of Hospital Discharge	Initiation Total	Engagement Total
Aetna	55	47	24 ▼	15 ▼	58	8
Anthem Blue Cross	60	44	38	35	NR	NR
Blue Shield	59	45	23 ▼	11 ▼	41 ▼	0 ▼
Health Net	57 ▼	44 ▼	58	41	45 ▼	4
Kaiser Permanente N. Cal	87 ▲	66 ▲	79 ▲	63 ▲	41 ▼	6 ▲
Kaiser Permanente S. Cal	91 ▲	74 ▲	75 ▲	64 ▲	37 ▼	6 ▲
PacifiCare	61	46 ▼	31 ▼	17 ▼	38 ▼	2 ▼
CCHRI Cross-Plan Average	**65**	**51**	**47**	**35**	**39**	**4**
2008 National Mean[a]	**61**	**48**	**54**	**38**	**50**	**5**
2008 HMO/POS 90th %ile[a]	**74**	**63**	**81**	**64**	**67**	**9**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: Centers for Medicare & Medicaid Services public use file for HMO/POS plans
b – 2007 rates reported—rotation measure
c – Lower number reflects better performance
d – HMO measure allows for chart review
NP – Measure not reported for PPO
NR – Rate not reported by the plan
NE – Not publicly reported in 2007

HEALTH PLANS WITH MEDICARE CONTRACTS

	OTHER				
	Anti-Rheumatic Drug Therapy	Annual Monitoring Persistent Medications	Use of High-Risk Medications in the Elderly[c]		Potentially Harmful Drug-Disease Interactions[c]
		Total	One Prescription	Two or more Prescriptions	Total
Aetna	86 ▲	84 ▼	17 ▲	2 ▲	18 ▲
Anthem Blue Cross	74	63 ▼	22 ▼	5 ▲	21
Blue Shield	68	84 ▼	27 ▼	7 ▼	27 ▼
Health Net	75 ▲	83 ▼	22 ▲	5 ▲	20 ▲
Kaiser Permanente N. Cal	81 ▲	84 ▼	19 ▲	4 ▲	20 ▲
Kaiser Permanente S. Cal	76 ▲	85	20 ▲	5 ▲	18 ▲
PacifiCare	73 ▲	84 ▼	26 ▼	6 ▼	22
CCHRI Cross-Plan Average	**77**	**82**	**23**	**5**	**21**
2008 National Mean[a]	**69**	**85**	**23**	**6**	**22**
2008 HMO/POS 90th %ile[a]	**82**	**92**	**13**	**2**	**15**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: Centers for Medicare & Medicaid Services public use file for HMO/POS plans
b – 2007 rates reported—rotation measure
c – Lower number reflects better performance
d – HMO measure allows for chart review
NP – Measure not reported for PPO
NR – Rate not reported by the plan
NE – Not publicly reported in 2007

MEDICARE SERVICE MEASURES *1 of 1*

HEALTH PLANS WITH MEDICARE CONTRACTS

	MEMBER SERVICE	
	Call Abandonment[c]	Call Answer Timeliness
Aetna	0.9 ▲	95 ▲
Anthem Blue Cross	NR	NR
Blue Shield	NR	NR
Health Net	4.1 ▲	79 ▲
Kaiser Permanente N. Cal	1.7 ▲	82 ▲
Kaiser Permanente S. Cal	1.6 ▲	82 ▲
PacifiCare	18.8 ▼	48 ▼
CCHRI Cross-Plan Average	**4**	**82**
2008 National Mean[a]	**5.7**	**78**
2008 HMO/POS 90th %ile[a]	**1.0**	**95**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: Centers for Medicare & Medicaid Services public use file for HMO/POS plans
b – 2007 rates reported—rotation measure
c – Lower number reflects better performance
d – HMO measure allows for chart review
NP – Measure not reported for PPO
NR – Rate not reported by the plan
NE – Not publicly reported in 2007

MEASURING PHYSICIAN PERFORMANCE TO IMPROVE VALUE

INTRODUCTION

Measuring the performance of physicians is an important mechanism for improving the quality and efficiency of the health care system. The rationale for measurement at this level is as follows:

- Physicians are major drivers of care process and treatment decisions.
- Individual physician performance and practice patterns vary widely (see Figure 1 on the next page which is an actual scatter plot of individual physician performance scores developed by a Washington state health plan).
- The continued growth of health care spending combined with substantial gaps in the quality of care delivered to patients underscore the need to reduce variation in spending and quality.
- Consumers are increasingly being required to take a more active role in managing their health care, yet there is very little data to inform one of the most important decisions they have to make—selecting a physician.

"Improving the quality of care ultimately requires changes in the behavior of individual physicians, even if systems to improve the quality of care play an important role."

Arnold Epstein MD, Thomas H. Lee MD and Mary Beth Hamel MD
New England Journal of Medicine, January 22, 2004

BACKGROUND

Studies indicate that consumers seeking health care are most interested in physician-specific quality and cost information, yet, the information available to date has mainly been focused at higher levels of aggregation, e.g. health plans, hospitals and physician groups.[1]

Health plan performance has been measured for years using standardized tools and methodologies including:

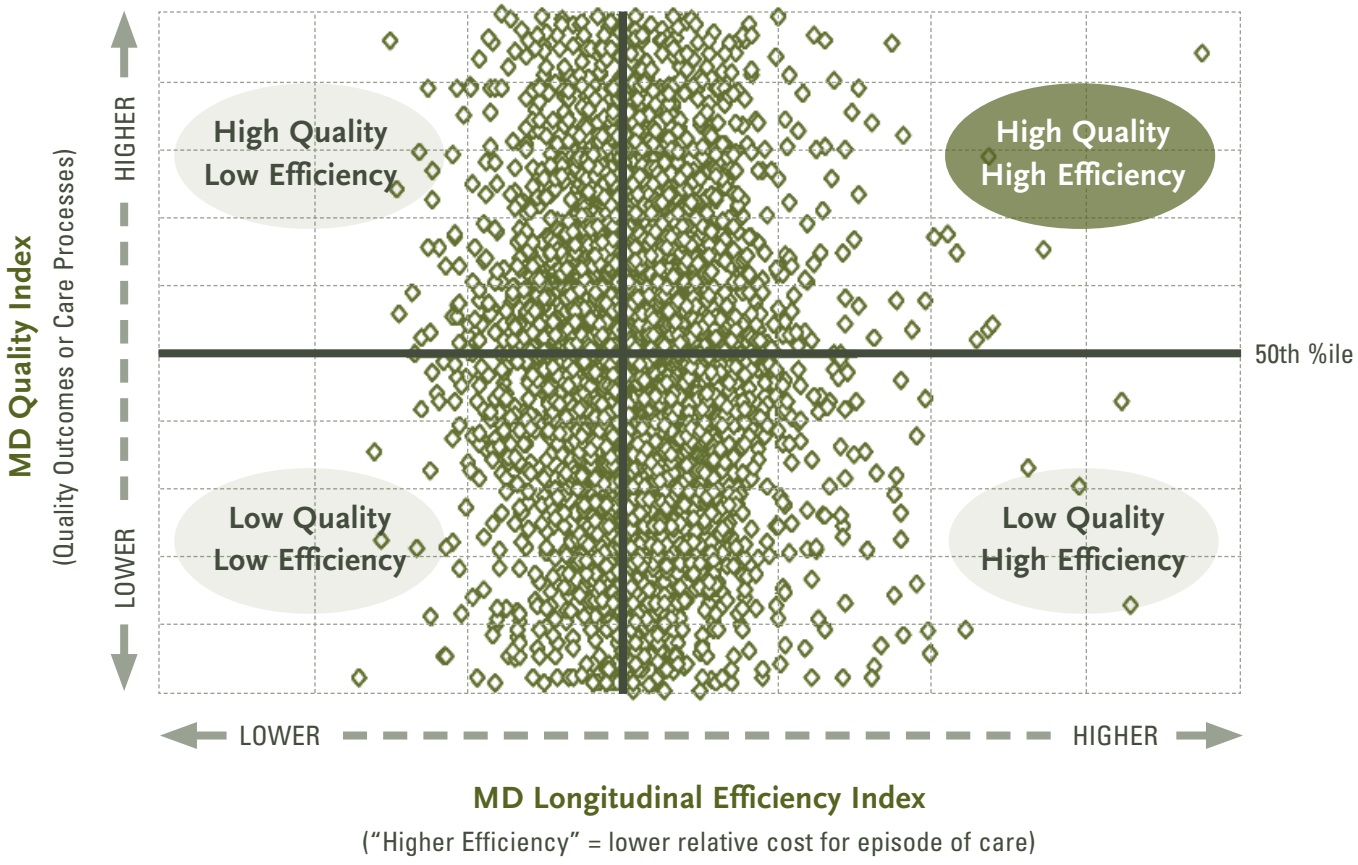
- The Health Plan Effectiveness Data and Information Set (HEDIS), a set of performance measures developed by the National Committee for Quality Assurance (NCQA) used by health plans to report data about the quality of care and services they provide.
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that provides an assessment of health plan performance from a consumer perspective regarding the plan's services and care delivery system.
- NCQA Accreditation, which evaluates not only the core systems and processes that characterize a health plan, but the actual results that the plan achieves on key dimensions of care and service as well.

NOTES

1 – Fanijang, G, von Glahn, T, Chang, Hong, Rogers, W, Safran, D, Providing Patients Web-based Data to Inform Physician Choice: If You Build It, Will They Come?, J Gen Intern Med, July 26, 2007.

MEASURING PHYSICIAN PERFORMANCE TO IMPROVE VALUE

FIGURE 1: ACTUAL DISTRIBUTION OF PHYSICIANS BY QUALITY & EFFICIENCY



Adapted from Regence Blue Shield

Under the Integrated Healthcare Association's Pay-for-Performance program, performance at the physician group-level is being evaluated based on standard clinical, patient experience, and "systemness" measures. While there is some variation in performance at the plan level, there is considerably more variation at the physician group level. As one peels back the health care system "onion" down to the individual physician level, variation in performance is much greater. The opportunities for reducing variation and improving performance are greatest at the physician level—yet physicians cannot make the necessary changes without understanding how well they are performing and knowing where improvement is needed. Currently, information about individual physician performance is limited—even within a physician's practice—and it hinders the ability of physicians to manage to excellence.

Historically, physician performance has been reported based on non-clinical measures such as physician opinion surveys or readily available public information on years in practice, board certifications, licensure sanctions, etc. There as been very little that looked at actual outcomes or practice based on evidence-based medicine. This is all changing with CCHRI's California Physician Performance Initiative (CPPI), which is working to develop and apply sound methodologies to measure and report the quality and efficiency of health care provided by physicians.

CHALLENGES OF PHYSICIAN-LEVEL MEASUREMENT

As we move towards measuring performance at the physician level there are challenges to be addressed, including:

- **Limited number of available measures** – while nationally endorsed clinical process and outcome measures are growing in number, there is still a shortage of measures that can be derived from readily available data, especially for specialty physicians.

MEASURING PHYSICIAN PERFORMANCE TO IMPROVE VALUE

- **Concerns regarding data accuracy and completeness** – the healthcare system still struggles to generate standardized, electronically available data for performance measurement. Currently, the most readily available source of useable data remains health plan claims/encounters, supplemented by pharmacy data.
- **Small sample sizes** – in order to do methodologically sound measurement at the physician level, large data sets, representing a significant portion of a physician's practice, are necessary. To achieve this level of statistical reliability, all-payer data are required, yet difficult to come by.
- **Effective communication** – California has over 65,000 active physicians. Reaching each of these individuals is a significant challenge and expense requiring effective coordination across a variety of organizations.
- **Taking action on results** – measuring and reporting performance is not enough to drive improvement; physicians may need assistance to understand and use the information in order to take necessary actions to improve the quality of care provided.

These challenges are being addressed by CCHRI, which has been working closely with the physician community to develop and validate a rigorous methodology. Visit www.cchri.org/cppi for additional information about CCHRI's physician measurement initiatives.

GUIDELINES FOR PHYSICIAN-LEVEL PERFORMANCE MEASUREMENT AND REPORTING

In response to concerns expressed by the physician community regarding early efforts to develop plan-based physician-level performance measurement programs, leading consumer, employer and labor organizations have developed a comprehensive national agreement with leading physician associations and health insurers on principles to guide how health plans measure doctors' performance and report the information to consumers. The "Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs" creates a national set of principles to guide measuring and reporting to consumers about doctors' performance. (http://healthcaredisclosure.org/)

Where embraced, the Patient Charter will ensure that both consumers and physicians will be able to understand, trust and contribute to how health plans rate doctors' performance and will ensure that:

- Consumers can make more informed decisions based on both quality and cost, with adequate guidance about how to use the information and any limitations in the data.
- Measurement is based on national standards and methodology.
- Both consumers and physicians have input into the measurement process and how results are reported. This will help ensure that information is trusted by physicians and meaningful to consumers.
- Measurement is a transparent process so that both consumers and physicians can understand the basis upon which performance is being measured and reported.
- Physicians have adequate notice and opportunity to identify any errors. There will be no surprises.
- Physicians will have information that helps them improve the quality of care they provide.

THE CALIFORNIA PHYSICIAN PERFORMANCE INITIATIVE

The California Physician Performance Initiative (CPPI), began as one of six national "Better Quality Information" (BQI) Pilots, funded by the Centers for Medicare & Medicaid Services (CMS). The focus of the initiative is to develop and apply sound methodologies to measure and report the quality and cost of health care provided by physicians.

During the CMS contract period from April 2007 through October 2008, the CPPI initiative collected and aggregated claims data from the 3 largest PPO plans in California—Anthem Blue Cross, Blue Shield of California and UnitedHealthcare—and Medicare. The combined database contained information on approximately 6.8 million Californians and 60,000 physicians. The project team identified 18 quality measures that were applicable to Medicare beneficiaries, endorsed by the National Quality Forum (NQF) and which could be derived using electronic claims and pharmacy data. A master provider list was developed to link physician records coming from the different data sources. Once the data were aggregated in standardized form, a methodology was developed and tested for attributing patients to physicians for accountability purposes. Additional work was conducted to test the reliability of physician-level scores for the 18 measures.

As part of the process to engage physicians in the measurement and reporting work, the project distributed confidential performance results to 20,000 physicians in October 2008. The report format and measurement methodology was thoroughly reviewed by the CPPI Physician Advisory Group as well as the medical directors of 74 physician groups in California.

MEASURING PHYSICIAN PERFORMANCE TO IMPROVE VALUE

FIGURE 2: OVERALL PHYSICIAN PERFORMANCE RATES FOR MEASUREMENT YEAR 2007

Measure	Mean	St. Dev.	Interquartile Range
Breast Cancer Screening	67.41%	14.14%	59% - 78%
Colorectal Cancer Screening	48.79%	13.69%	40% - 56%
Cardiovascular Conditions – LDL Screening	78.06%	12.01%	71% - 87%
CAD Patients Receiving Lipid-Lowering Therapy	49.64%	11.49%	42% - 58%
Heart Failure: Left Ventricular Ejection Fraction Testing	47.50%	13.50%	38% - 57%
CHF & Atrial Fibrillation - Warfarin Therapy	76.30%	10.56%	70% - 83%
Comprehensive Diabetes Care – HbA1c Testing	76.51%	12.68%	70% - 86%
Comprehensive Diabetes Care – LDL Screening	75.04%	13.13%	67% - 85%
Comprehensive Diabetes Care – Eye Exam	58.28%	17.78%	47% - 65%
Monitoring for Patients on Persistent Medications	91.43%	9.19%	88% - 98%
COPD - Spirometry Testing	25.59%	14.09%	16% - 32%
Arthritis Anti-Rheumatic Medication	78.48%	13.00%	74% - 86%
Glaucoma Screening	25.59%	14.09%	16% - 32%
Osteoporosis Management in Women	20.46%	11.69%	14% - 25%

EARLY RESULTS

The results from the 2007 measurement year indicate that that there is much room for improvement. Not all 18 measures could be reported due to data completeness issues. The data showed that 60 – 75% of patients get the right care for measures that have been in use for quite some time, such as breast cancer screening and cholesterol management; while only 35 – 60% of patients get the right care for newer measures. In addition to suboptimal performance, there is large variation in performance among physicians with rates varying by 20 – 25 points when comparing the 10th to 90th percentiles.

Using data for measurement year 2007, Figure 2 above shows the mean, standard deviation and the interquartile range (the range for the middle 50% of the physicians measured) for each of 12 clinical quality measures that could be reliably scored and apply to both the commercial and Medicare populations. Each measure has a fairly large standard deviation indicating a great dispersion of the individual scores around the mean. The interquartile range indicates of the amount of spread or variation in performance scores. Some of the variation in physician scores may be attributed to data issues and small sample sizes.

PUTTING PHYSICIAN PERFORMANCE RESULTS TO USE

CPPI, as a first step, is sharing the results with the physicians who were measured. We hope that through this process, CPPI will educate physicians about the measurement work, seek their engagement, and identify ways to improve our methods moving forward. In addition to use of this information by physicians for continuous quality improvement, this work creates a foundation for future use of the results by consumers, health plans and purchasers in subsequent cycles of data aggregation, measurement and reporting.

The project team is working closely with the physician community and consumers to develop a physician-level performance reporting system that will provide the right set of information to support consumers making health care decisions. In addition, the team will work closely with the California Quality Collaborative to develop information to support physician-specific quality improvement efforts.

MEASURES OF EFFECTIVENESS AND ACCESS/AVAILABILITY OF CARE

The clinical performance results displayed on the following pages use HEDIS Performance measures to evaluate three important components of quality medical care:

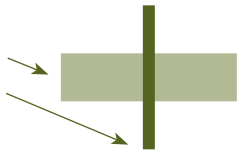
- The use of preventive services and routine screening tests, such as immunizations and mammograms, that help patients stay healthy;
- The utilization of the most up-to-date medical treatment and medication for the treatment of sudden illnesses and mental health issues such as heart attacks and depression, that help patients get better;
- The medical care for patients with chronic conditions, such as asthma and diabetes, that help patients cope with their illness.
- The members' ability to access needed care or services.

Data for these HEDIS measures are obtained from California health plans, using NCQA specified processes and guidelines that assure the accuracy and comparability of the results.

1. Health plans create lists of randomly selected members who are eligible to receive the recommended HEDIS preventive care or screening services.
2. Health plans supply data on whether or not the selected patients received the recommended service. Information is gathered from administrative (automated or electronic) records, from medical charts, or through a combination of the two methods. All results are audited by independent and impartial third parties, thereby ensuring a greater degree of comparability.
3. An independent research firm contracted with CCHRI evaluates and analyzes the data from all the participating health plans.

Ratings may reflect differences in actual clinical practice or differences in the way plans collect data. Individual plans are scored above average, average or below average using a statistical test that shows differences in plans' results. The differences are expected to be true differences, and not random chance differences, at least 95 percent of the time.

HOW TO READ THESE GRAPHS



The horizontal bars show scores for each California health plan. The vertical bar is the best estimate of the plan's true score based on a sample or subset, of health plan members. When the horizontal bars for two plans do not overlap, this means the health plan scores are significantly different from each other. The length of the horizontal bar is related to the size of the health plan sample. A smaller sample results in a longer horizontal bar because the exact score is less certain. The score is more accurate if the sample is larger and the bar is smaller. Plans with longer horizontal bars do not necessarily have better scores than plans with shorter bars.

PRENATAL & POSTPARTUM

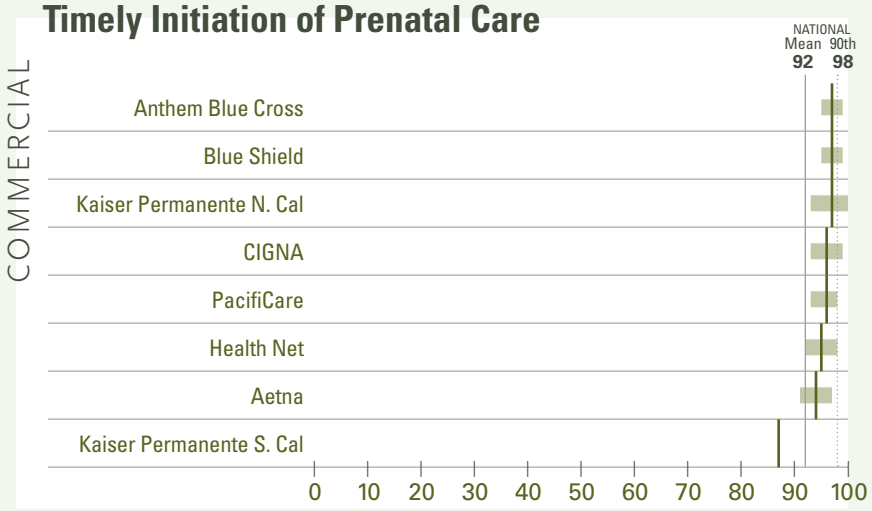
PRENATAL & POSTPARTUM CARE

Each year, there are over 4 million births in the United States. Getting early and regular prenatal care is one of the best ways to promote a healthy pregnancy and healthy babies. Prenatal care includes education and counseling about how to handle the different aspects of pregnancy, such as nutrition and physical activity plus a chance to talk to your health care provider about any questions or concerns you have related to pregnancy or birth. Regular prenatal visits can also help mothers and their physicians or midwives identify potential problems and possible complications early in the pregnancy when they can be prevented or more successfully treated.

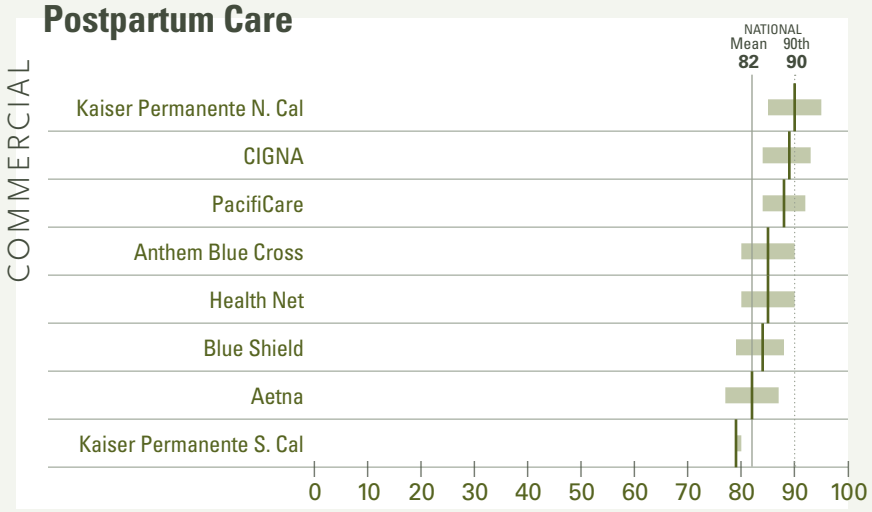
Likewise, it is very important for a new mother to have a postpartum visit with her health care provider within three to eight weeks after delivery. Since the period immediately following birth is a time of many physical and emotional adjustments, practitioners can be helpful in recognizing and discussing problems, even when a woman feels fine.

The charts on this page reflect the care women received in 2006 and 2007 during pregnancy and following the birth of their babies. The Timeliness of Prenatal Care measure reports the percentage of women who received a prenatal care visit in the first trimester or within 42 days after enrolling in their health plan if already pregnant. The Postpartum Care measure shows the percentage of women who received a postpartum visit on or between 21 and 56 days after delivery. Health plans promote pregnancy wellness by distributing educational materials in newsletters and maternity programs and by encouraging their network physicians and midwives to provide appropriate and timely pregnancy care.

Timely Initiation of Prenatal Care



Postpartum Care



CHILDHOOD IMMUNIZATIONS

CHILDHOOD IMMUNIZATION STATUS

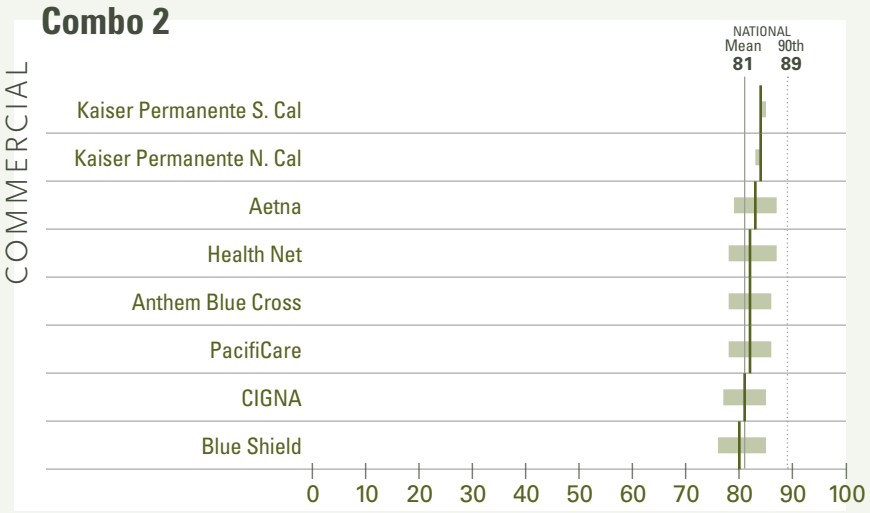
Immunizations are one of the safest and most effective ways to protect children from serious diseases.

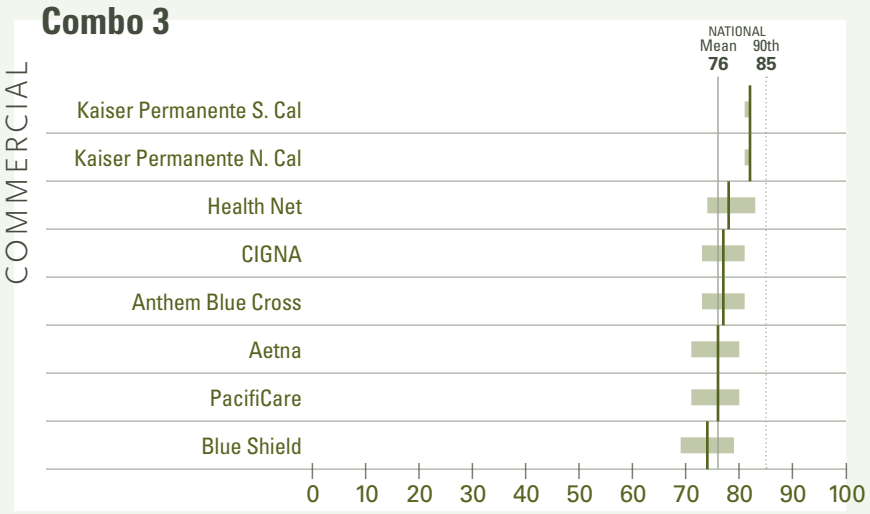
The chart for Combo 2 shows the performance of California health plans in providing all of the following immunizations.

- Four DTaP (diphtheria-tetanus-pertussis)
- Three IPV polio immunizations
- One dose of MMR (measles-mumps-rubella)
- Three HiB (H influenza type B)
- Three HepB (hepatitis B)
- One Varicella Vaccine (VZV, chicken pox) by the second birthday

Combo 3 includes all of the above plus at least four pneumococcal conjugate vaccinations on or before the child's second birthday.

Health plans promote childhood immunizations during regular well-infant and well-child visits with doctors. Some health plans assist their physicians by following up directly with families who are late in receiving their childhood immunizations.





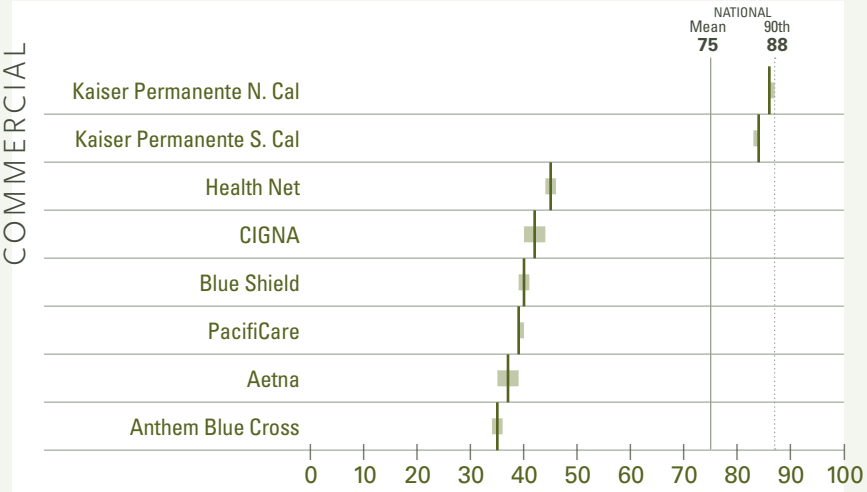
CHILDREN WITH PHARYNGITIS

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Pharyngitis, or sore throat is one of the most common conditions encountered by the family physician. Acute pharyngitis accounts for 1.1 percent of visits in the primary care setting and is ranked in the top 20 reported primary diagnoses resulting in office visits. A sore throat most often is caused by direct infection of the pharynx, primarily by viruses or bacteria. Antibiotics are needed to treat bacterial pharyngitis, but are not useful for treating viral pharyngitis. Before antibiotics are prescribed, a throat culture needs to be completed to validate bacterial origin.

This HEDIS measure assesses the adequacy of clinical management of pharyngitis by looking at the percentage of children 2-18 years of age, who were diagnosed with pharyngitis, prescribed an antibiotic and received a group A streptococcus (strep) test for the episode. Excessive use of antibiotics for pharyngitis is common, represents unecessary cost, and contributes to antibiotic resistance.

Many pediatricians and family practitioners use an office-based (rather than laboratory-based) strep test. Office-based tests frequently are not reported to health plans. The pharyngitis testing results may therefore underestimate actual performance.

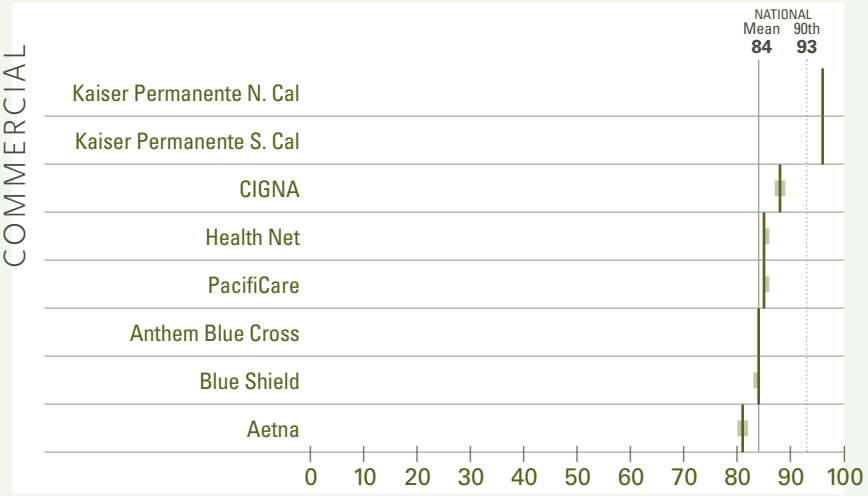


CHILDREN WITH URI

APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

Upper respiratory infections (URI), or common colds, are most prevalent among children due to their high contact with other children. Children in day care in the U.S. are estimated to have an URI approximately every 3 weeks from the age of 6 months to 2 years. The incidence decreases at the time of school entry at which time a child has about 3-6 episodes of URI per year. URI's are almost always viral, therefore antibiotics are ineffective.

This HEDIS measures looks at the percentage of children 3 months to 18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription on or within three days after the Episode Date. Excessive use of antibiotics for URI's is common, represents unecessary cost, and contributes to antibiotic resistance.



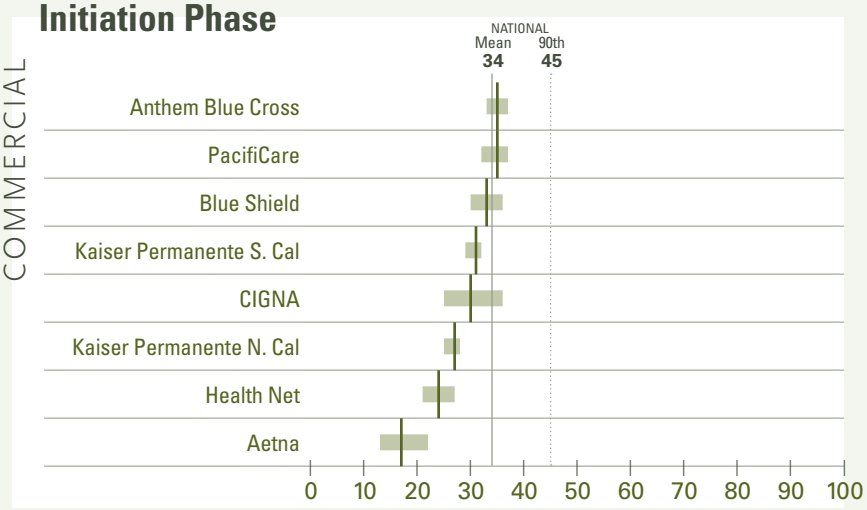
FOLLOW-UP CARE - ADHD

FOLLOW-UP CARE - ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER

ADHD is considered one of the most prevalent chronic conditions in childhood. Children with ADHD may experience significant functional problems, such as school difficulties, academic underachievement, troublesome relationships with family members and peers and behavioral problems. Given the high prevalence of ADHD among school-aged children (4 percent to 12 percent), primary care clinicians will encounter children with ADHD in their practices regularly and should have a strategy for diagnosing and long-term management of this condition. Pharmacologic treatment is one of the most widely studied treatments for ADHD.

The American Academy of Pediatrics (AAP) guidelines recommend that once a child is stable, an office visit every three to six months allows assessment of learning and behavior. Follow-up appointments should be made at least monthly until the child's symptoms have been stabilized.

This measure is used to assess the percentage of health plan members 6 to 12 years of age with an ambulatory prescription dispensed for attention-deficit/hyperactivity disorder (ADHD) medication who had one follow-up visit with a practitioner with prescriptive authority during a 30-day initiation period.

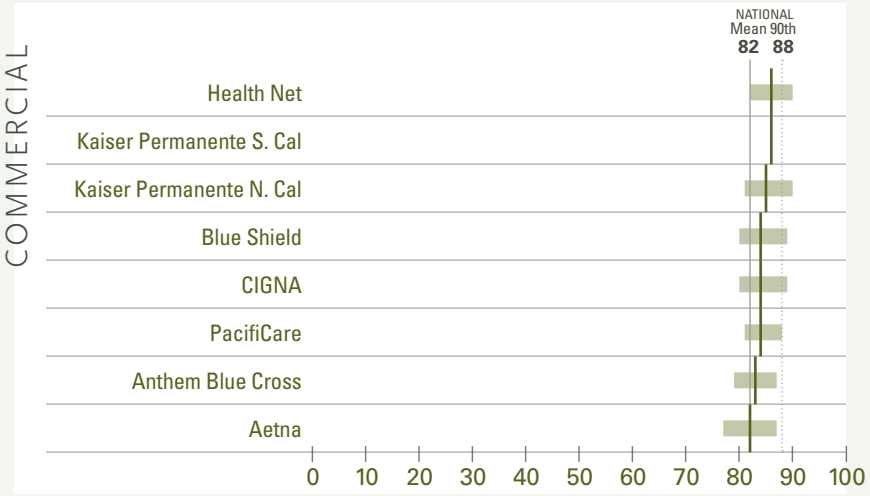


CERVICAL CANCER

CERVICAL CANCER SCREENING

The American Cancer Society estimated that in 2007, about 11,150 cases of invasive cervical cancer would be diagnosed and 3,700 deaths expected from the disease in the U.S. The number of cervical cancer deaths in the U.S. continues to decline by about 2% a year. The main reason for this decline is the increased use of the Papanicolau (Pap) test. Cervical cancer can be detected early, when it is most treatable, by the use of routine Pap tests. For this reason, all women between the ages of 21 and 64 should have a Pap test at least once every three years.

California HMOs provide coverage for regular Pap testing. The chart on this page shows the percentage of women between the ages of 21 to 64 who had at least one Pap test during the past three years. Women can help reduce the risk of cervical cancer by getting regular Pap tests according to the schedules recommended by their doctors. Most HMOs compare the frequency of Pap tests for their members to the recommended schedule for screenings and remind both women and their physicians when appointments or tests should be scheduled.



BREAST CANCER *1 of 2*

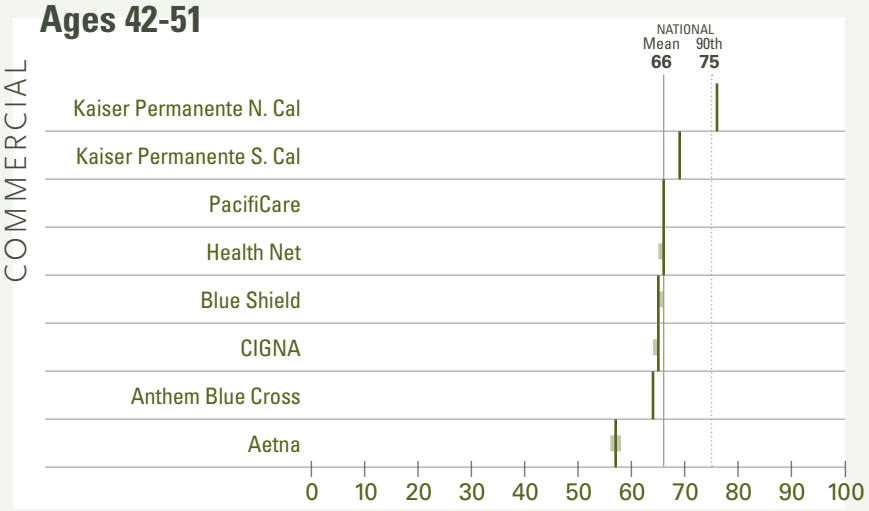
BREAST CANCER SCREENING

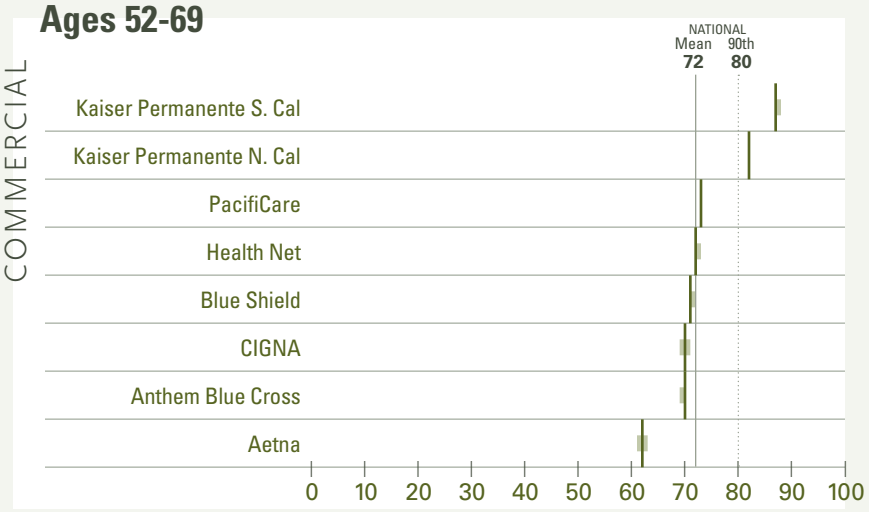
One out of every eight women will develop breast cancer in the course of a 90-year life span. In 2007 in the U.S., about 178,480 women will be diagnosed with invasive breast cancer and 40,460 will die. If detected early, the 5-year survival rate exceeds 95%. Mammograms are among the best early detection methods, increasing chances for survival and cure. Mammography screening has been shown to reduce mortality by 20 to 40% among women aged 50 and older.

The breast cancer screening rate measures the percentage of women in the HMO population, between the ages of 40 and 69, who were continuously enrolled in their health plan during 2006 and 2007 and had at least one mammogram during that two-year period.

The charts on this and the following page show the relative performance of HMOs in providing mammograms to their commercial enrollees. HMOs can encourage regular breast cancer screenings by promoting routine physical health exams and providing members with cancer awareness materials. Health plans also send women and their physician's reminders to schedule a mammogram.

Separate charts display results for commercial and Medicare members.

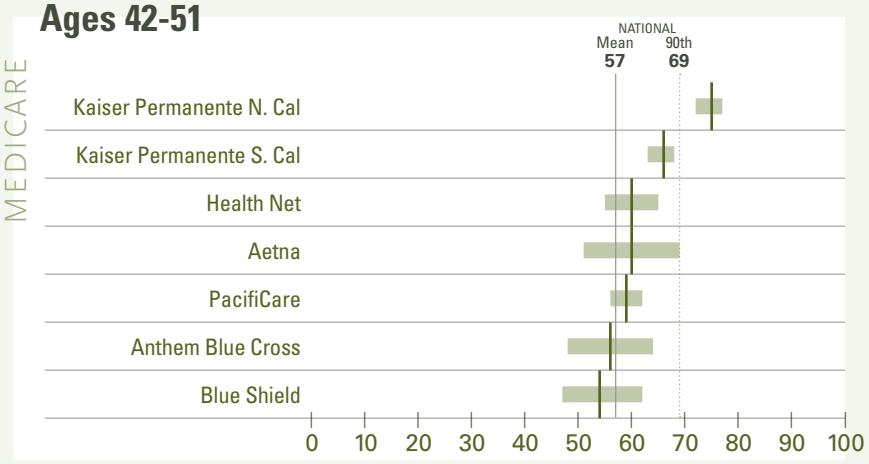




BREAST CANCER *2 of 2*

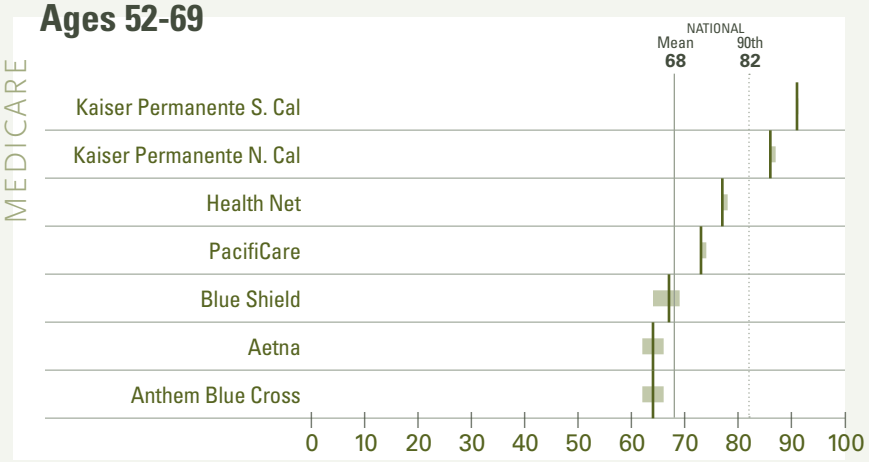
Ages 42-51

MEDICARE



Ages 52-69

MEDICARE

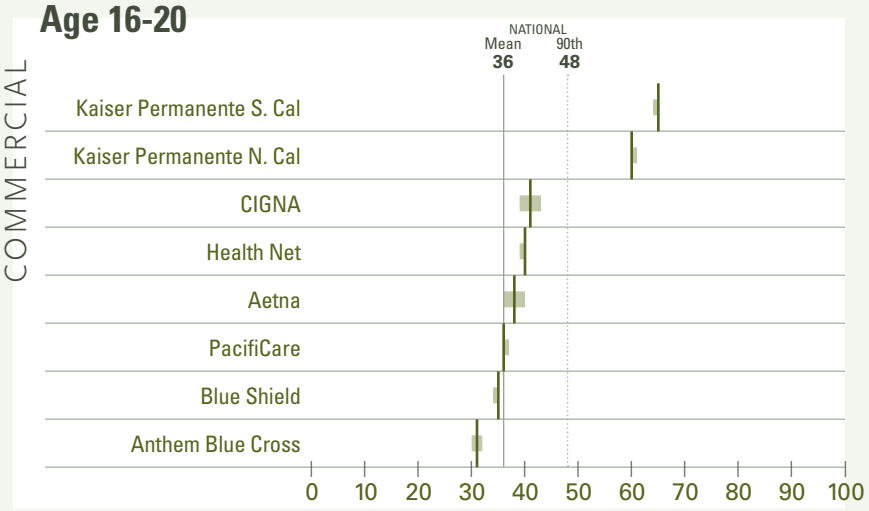


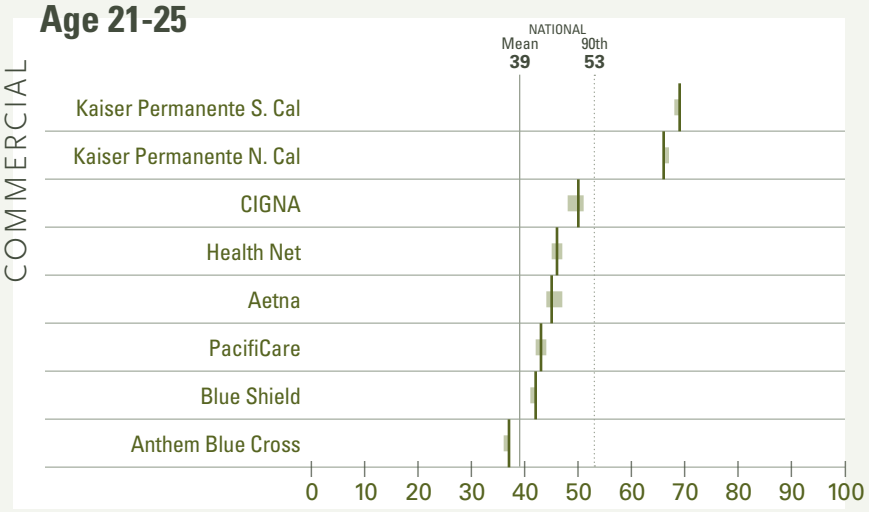
CHLAMYDIA

CHLAMYDIA SCREENING IN WOMEN

Chlamydia is currently the most commonly reported infectious sexually transmitted disease in the United States with an estimated 2.8 million cases occurring each year. Chlamydia is especially common in teenagers and young adults. Untreated infections are easily spread between sexual partners and can cause serious health complications. Chlamydia is frequently called a "hidden" disease since approximately 75% of women and 50% of men have no symptoms. Therefore, routine screening tests are very important in limiting the complications of an infection. Chlamydia can cause pelvic inflammatory disease, infertility, and tubal or ectopic pregnancies and some of these complications may be life threatening. Chlamydia infections can also cause health problems in newborns whose mothers have an undetected or untreated infection during pregnancy.

Simple, routine-screening tests identify the presence of Chlamydia infections. Treatment with antibiotics is usually successful in preventing further transmission of the disease and limiting future complications. The screening rates reported on this page are intended to measure the percentage of sexually active women between the ages of 16 and 25 who received at least one routine screening test for Chlamydia during 2007. Health plans can successfully improve Chlamydia screening rates through distribution of educational materials to both physicians and HMO members.





COLORECTAL CANCER

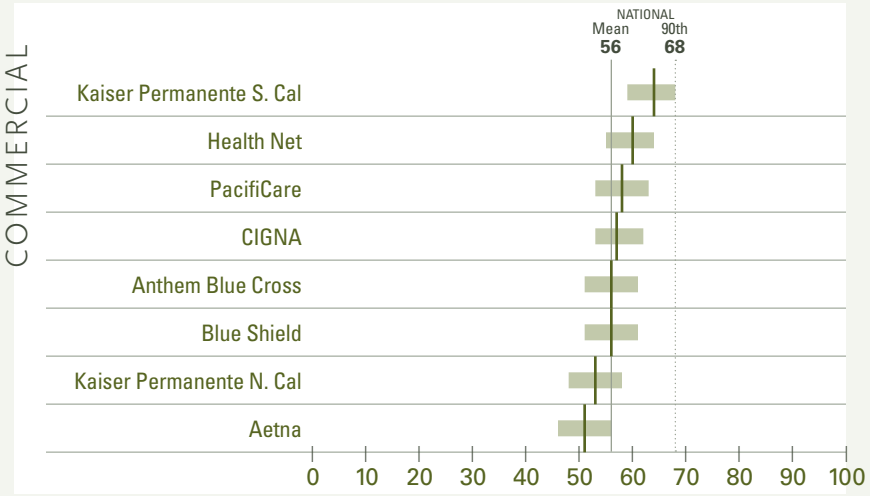
COLORECTAL CANCER SCREENING

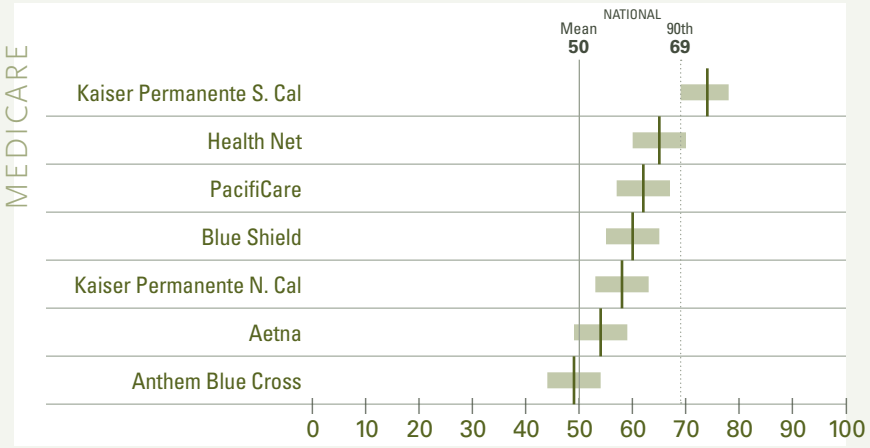
Colorectal cancer—cancer of the colon or rectum—is the second leading cause of cancer-related deaths in the U.S. The American Cancer Society estimates that 49,960 Americans will die of colorectal cancer in 2008. Colorectal cancer is also one of the most commonly diagnosed cancers in the U.S.; approximately 148,810 new cases will be diagnosed in 2008. Colorectal cancer is the third most common cancer in men and in women. The risk of developing colorectal cancer increases with advancing age, with more than 90% of cases occurring in persons aged 50 years or older.

Reducing the number of deaths from colorectal cancer depends on detecting and removing precancerous colorectal polyps, as well as detecting and treating the cancer in its early stages. Colorectal cancer can be prevented by removing precancerous polyps or growths, which can be present in the colon for years before invasive cancer develops. Findings from the National Health Interview Survey indicate that in 2000, only 42.5% of U.S. adults aged 50 years or older had undergone a sigmoidoscopy or colonoscopy within the previous 10 years or had used an FOBT home test kit within the preceding year.

This HEDIS measure estimates the percentage of adults 50-80 years of age who had appropriate screening for colorectal cancer. The screening criteria can be met with any one of four tests: a fecal occult blood test (FOBT) during 2007; a flexible sigmoidoscopy within the last four years prior to 2007; a double contrast barium enema within the last four years prior to 2007; or a colonoscopy within the last nine years prior to the measurement year. Screening for colorectal cancer lags far behind screening for breast and cervical cancers.

Separate charts display results for commercial and Medicare members.





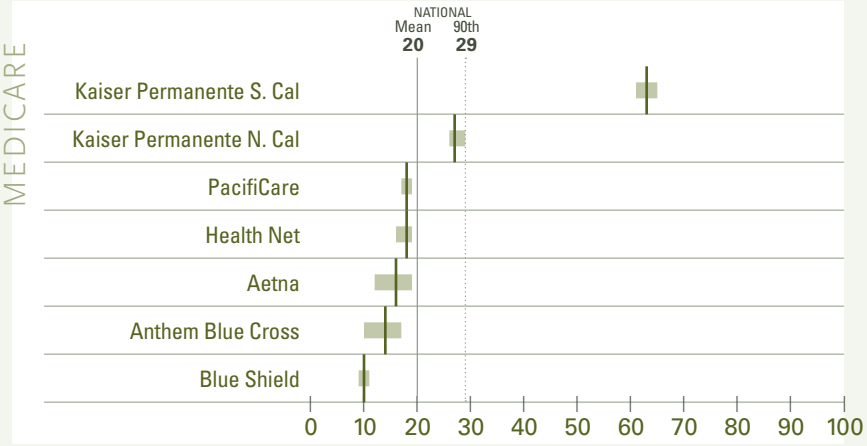
OSTEOPOROSIS

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE

Osteoporosis is a disease characterized by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increased susceptibility to fractures, especially of the hip, spine, and wrist, although any bone can be affected. Osteoporosis is a major public health threat for an estimated 44 million Americans or 55% of the people 50 years of age or older. In the U.S. today, 10 million individuals are estimated to already have the disease and almost 34 million more are estimated to have low bone mass, placing them at risk for osteoporosis. Eighty percent of those affected by osteoporosis are women.

Osteoporosis is responsible for more than 1.5 million fractures annually. A balanced diet rich in calcium and vitamin D, weight-bearing exercise, a healthy lifestyle with no smoking or excessive alcohol intake, and bone density testing and medication (when appropriate) completed together can optimize bone health and help prevent osteoporosis.

This HEDIS measure estimates the percentage of women 67 years of age and older who suffered a fracture, and who had either a bone mineral density test or prescription for a drug to treat or prevent osteoporosis in the six months after the date of fracture during the Intake Period.



DIABETES *1 of 7*

COMPREHENSIVE DIABETES CARE

Diabetes is the fifth leading cause of death in the United States. There are 20.8 million people in the U.S., or 7% of the population, who have diabetes. While an estimated 14.6 million have been diagnosed with diabetes, 6.2 million are unaware. Diabetes also contributes to higher rates of morbidity – people with diabetes are at higher risk for heart disease, blindness, kidney failure, extremity amputations and other chronic conditions.

HEMOGLOBIN A1C TEST & LEVELS

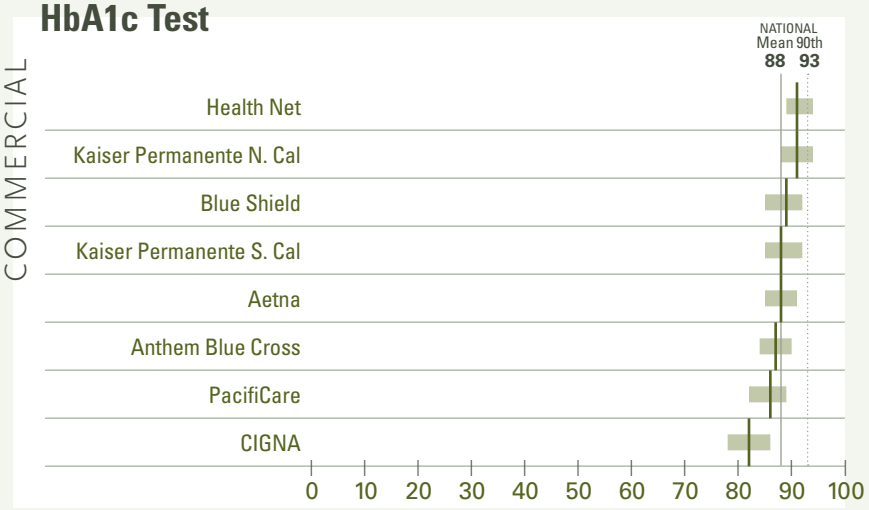
High levels of sugar in the blood are one common finding in patients with diabetes. Frequent testing for glycated hemoglobin, also known as hemoglobin A1c (HbA1c), measures a patient's average blood sugar level.

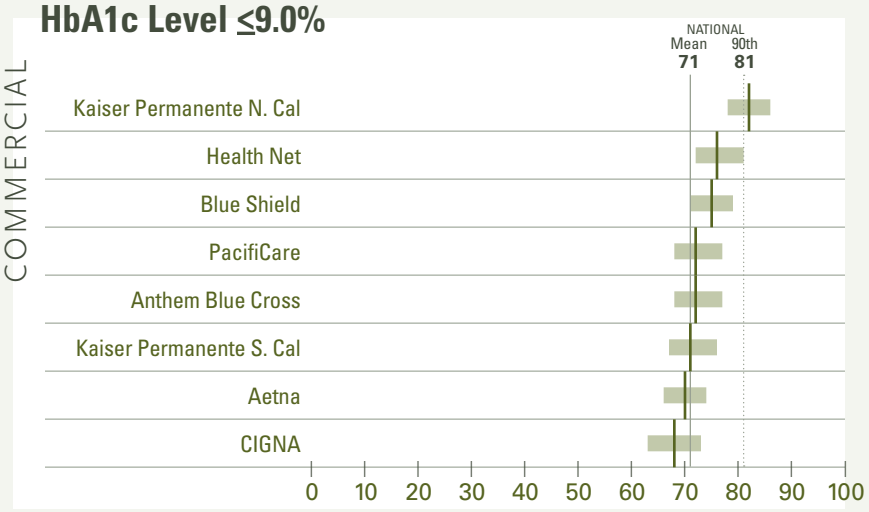
People with poorly controlled diabetes as shown by high blood sugar levels are more likely to develop high blood pressure, high cholesterol and fat levels, heart disease, eye and nerve problems, and kidney problems.

Although HbA1c test results mean different things for different patients depending upon their overall health status and age, most physicians believe, based on current medical evidence, that levels above 9.0 mean poor overall diabetes control.

The first table displayed on this page measures the percentage of patients ages 18-75 with diabetes who received at least one screening test for HbA1c during 2007. A higher screening rate can suggest that a health plan works with its provider network to promote more frequent and appropriate blood tests for patients. The second table displays the percentage of patients with HbA1c results less than or equal to 9.0.

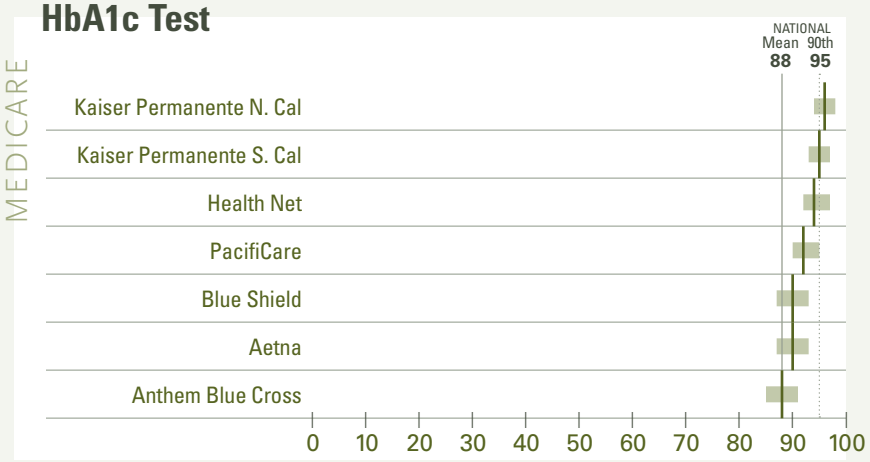
Separate charts display results for commercial and Medicare members.



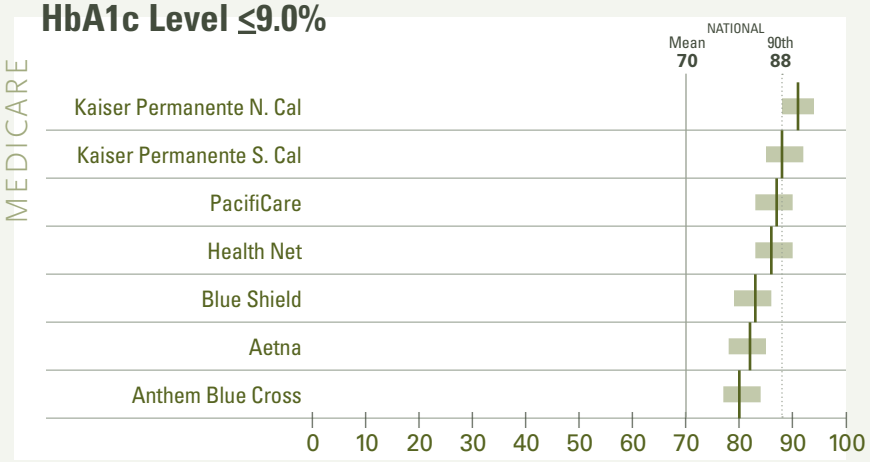


DIABETES *2 of 7*

HbA1c Test



HbA1c Level ≤9.0%



DIABETES *3 of 7*

RETINAL EXAM

Diabetes is the leading cause of new cases of blindness in people 20-74. Every year 12,000-24,000 people lose their sight because of diabetes. Experts recommend that people with diabetes have an examination of their retina every year because diabetes-related eye disease can be present even if a person has no problem seeing. When doctors find eye disease in diabetic patients early, they can start treatment in time to save vision for most people.

The HEDIS Comprehensive Diabetes Care measure reports how many people with diabetes had an examination by an eye care professional during 2007. For some patients, depending upon their over-all health status and how well their diabetes is controlled, an eye exam performed during 2006 was also counted in the results for this measure. A higher rate could mean the health plan works harder to promote regular exams or makes exams easier to obtain. More exams mean earlier medical treatment and less blindness in the diabetic population.

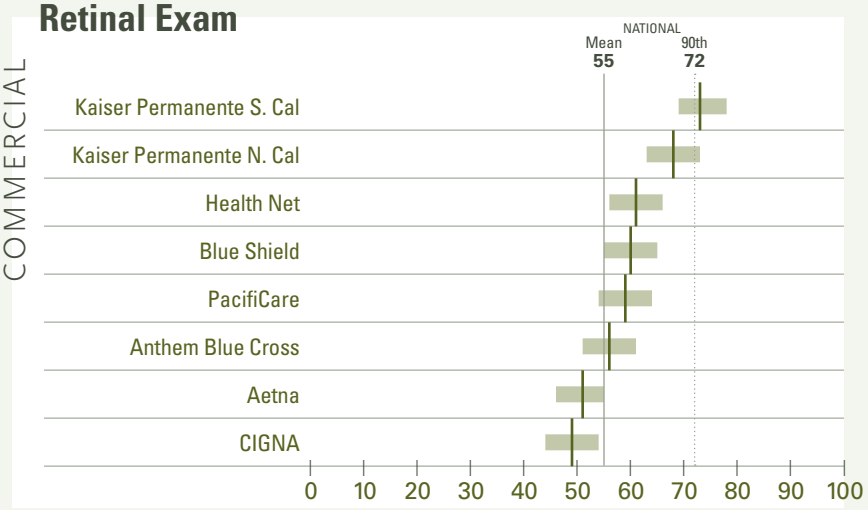
CHOLESTEROL MANAGEMENT

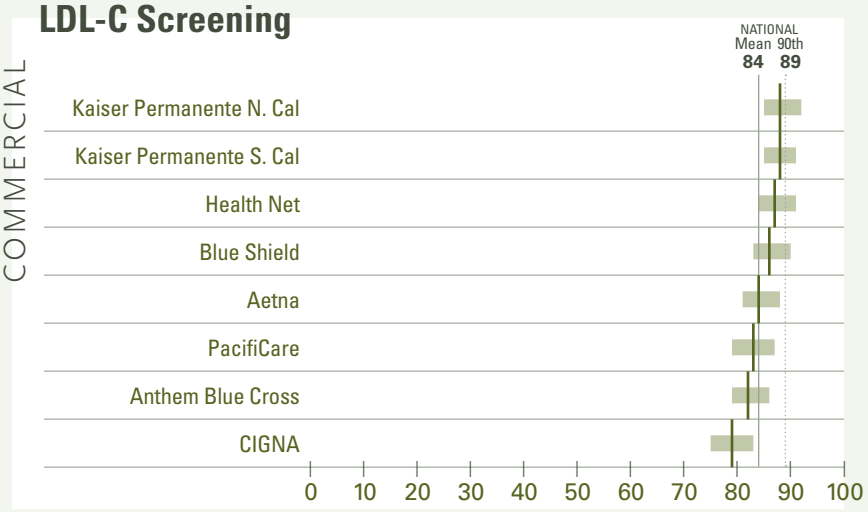
LDL Screening

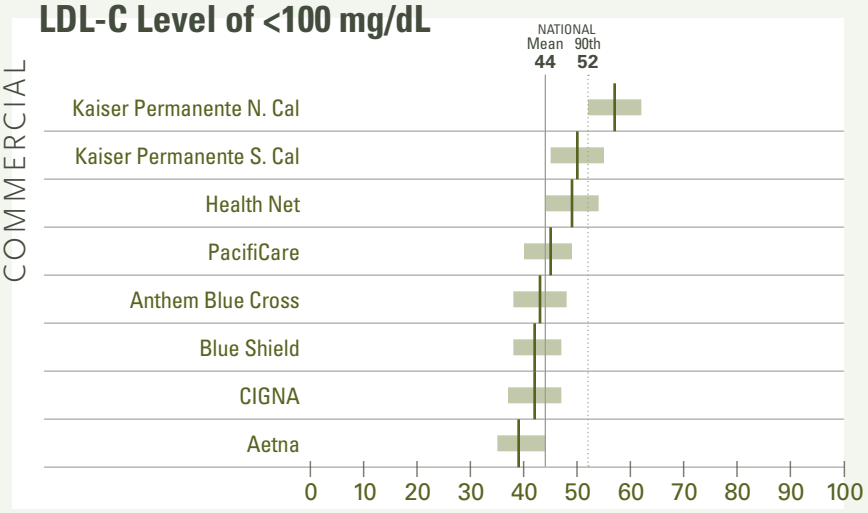
Heart disease strikes people with diabetes twice as often as people without diabetes and is one of the most common medical complications. Higher levels of cholesterol and fat in the blood greatly contribute to the increased incidence of coronary artery disease and heart disease.

It is very important that LDL cholesterol levels be measured at least yearly in patients with diabetes. Efforts should be made, depending upon the patient, to maintain LDL cholesterol at levels lower than 100 mg/dL. The HEDIS Comprehensive Diabetes Care measure calculates the percentage of patients with diabetes who received an LDL cholesterol screening during 2007 or 2006 and the percentage of those who had cholesterol levels below 100 mg/dL. A higher screening rate of LDL cholesterol could indicate that a health plan is working hard to promote regular medical exams for patients with diabetes.

Separate charts display results for commercial and Medicare members.

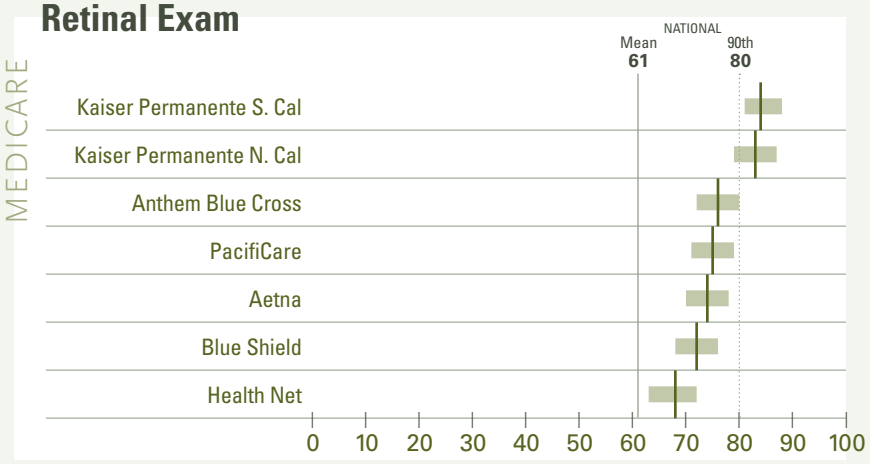




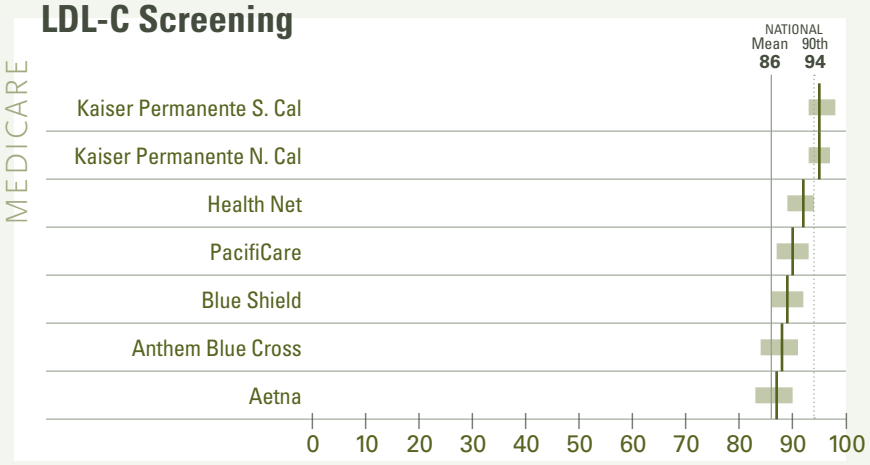


DIABETES *4 of 7*

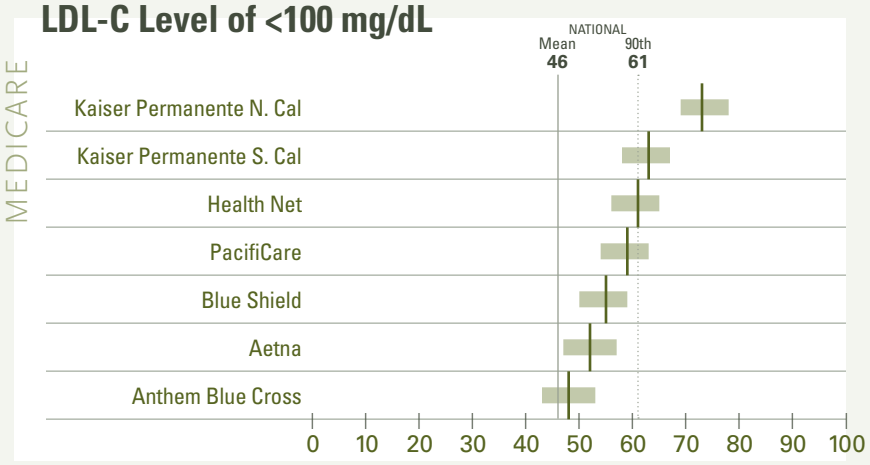
Retinal Exam



LDL-C Screening



LDL-C Level of <100 mg/dL



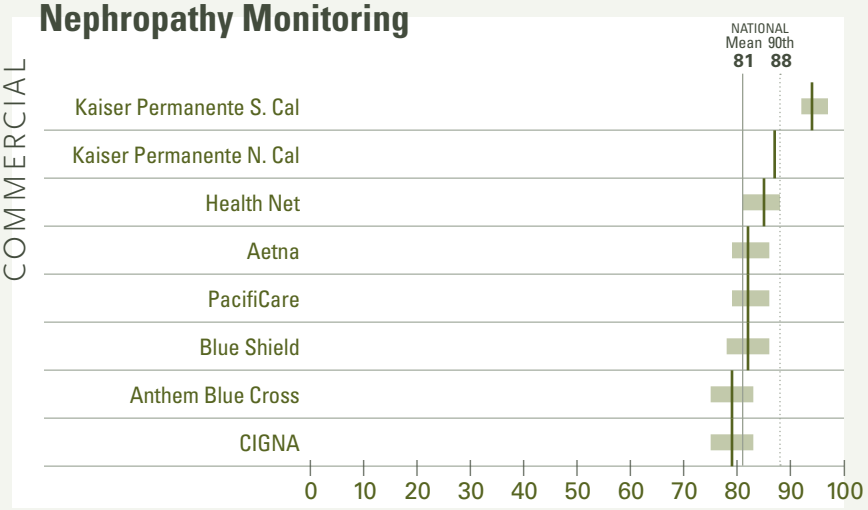
DIABETES *5 of 7*

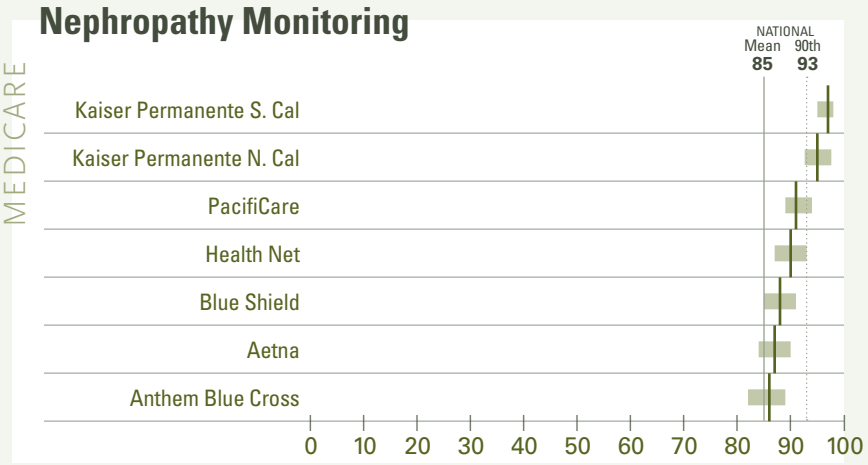
KIDNEY DISEASE MONITORING
Nephropathy Monitoring

Diabetes is the leading cause of end-stage renal disease accounting for 44% of new cases. People with diabetes are much more likely than the general population to develop acute and chronic kidney problems, such as renal insufficiency, end-stage renal disease and diabetic nephropathy. These serious complications can require long-term kidney dialysis or kidney transplant. Importantly, early detection of kidney disorders can lead to earlier treatment, and slow or prevent further deterioration of the kidneys and help avoid dialysis or transplant.

One of the first signs of kidney problems is protein in the urine. It is therefore very important that patients with diabetes have a test at least once a year that measures microalbuminuria. The HEDIS Comprehensive Diabetes Care measure reports the percentage of health plan members with diabetes ages 18-75, who received a screening for microalbuminuria during 2007.

Separate charts display results for commercial and Medicare members.





DIABETES *6 of 7*

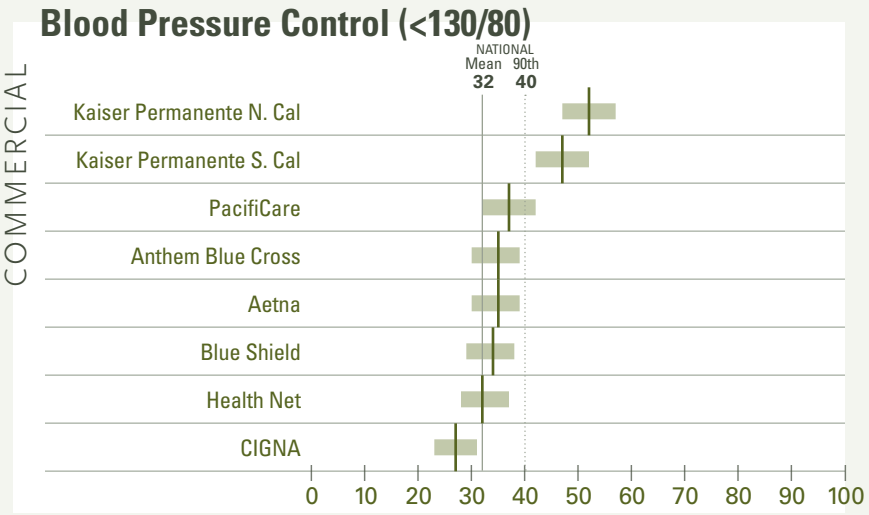
BLOOD PRESSURE CONTROL

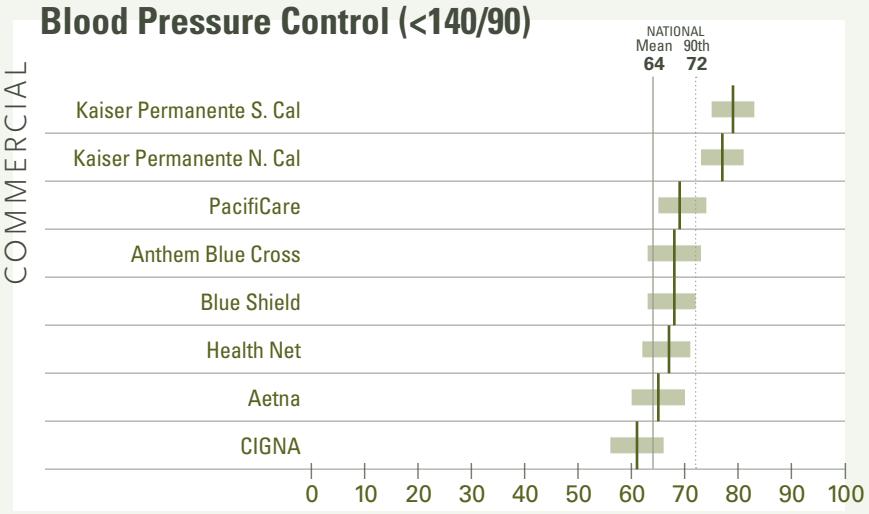
According to the American Diabetes Association "more than 65% of people with diabetes die from heart disease or stroke. With diabetes, heart attacks occur earlier in life and often result in death." Much of the burden of illness and cost of diabetes treatment is attributed to potentially preventable long-term complications including heart disease, blindness, kidney disease and stroke. Appropriate and timely screening and treatment can significantly reduce the disease burden.

Studies have shown that up to 60% of adults with diabetes have high blood pressure. Individuals with both diabetes and hypertension have approximately twice the risk of cardiovascular disease as nondiabetic people with hypertension. In the United Kingdom Prospective Diabetes Study (UKPDS), each 10-mmHg decrease in mean systolic blood pressure was associated with a reduction in risk of 12% for any complication related to diabetes, 15% for deaths related to diabetes, 11% for myocardial infarction, and 13% for microvascular complications

There are two different measures of blood pressure control based on different thresholds. The most stringent is the percent of members achieving a blood pressure under 130/80. The second measure establishes a threshold of 140/90. Caution should be used in evaluating the results for the 130/80 measure as there is less evidence to support more stringent control and it may not be appropriate for all specified individuals due to issues such as complications, lack of office visits, etc.

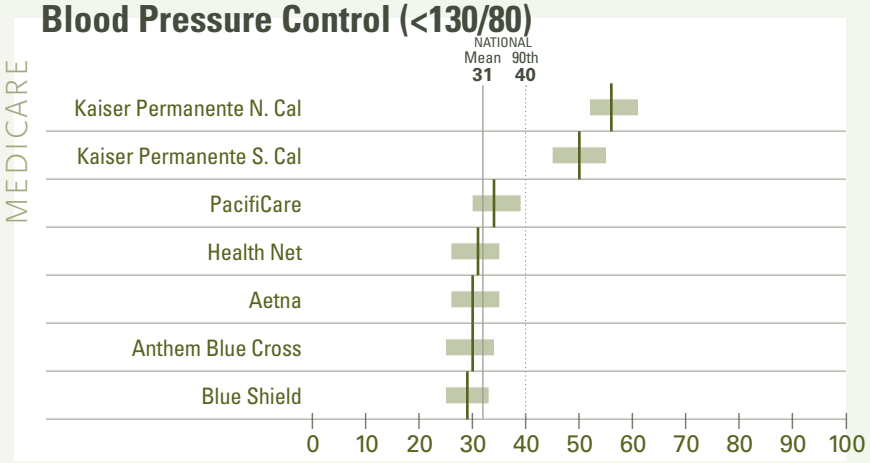
Separate charts display results for commercial and Medicare members.



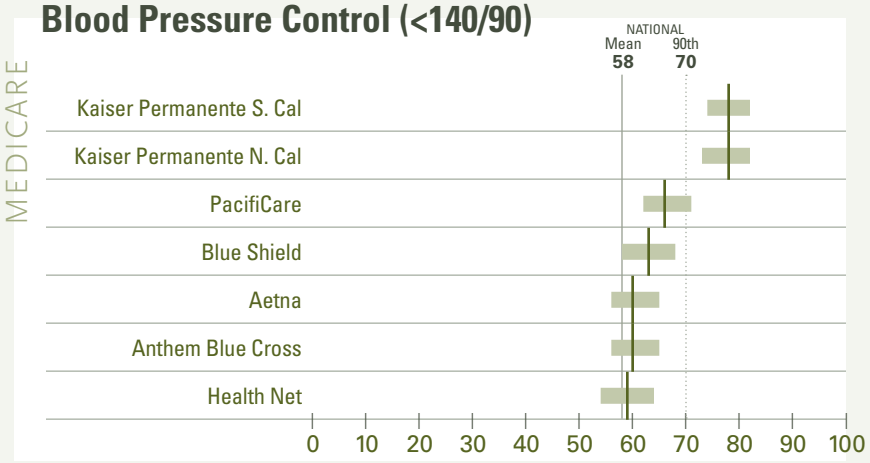


DIABETES *7 of 7*

Blood Pressure Control (<130/80)



Blood Pressure Control (<140/90)



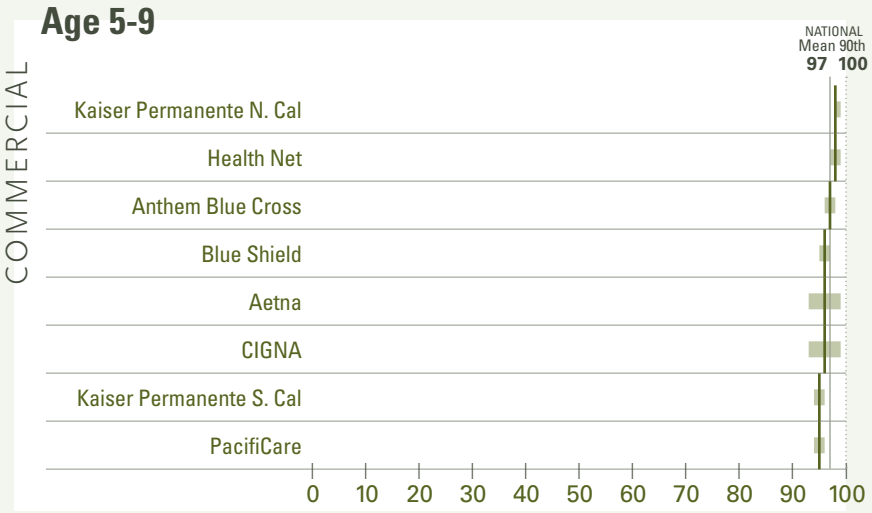
ASTHMA

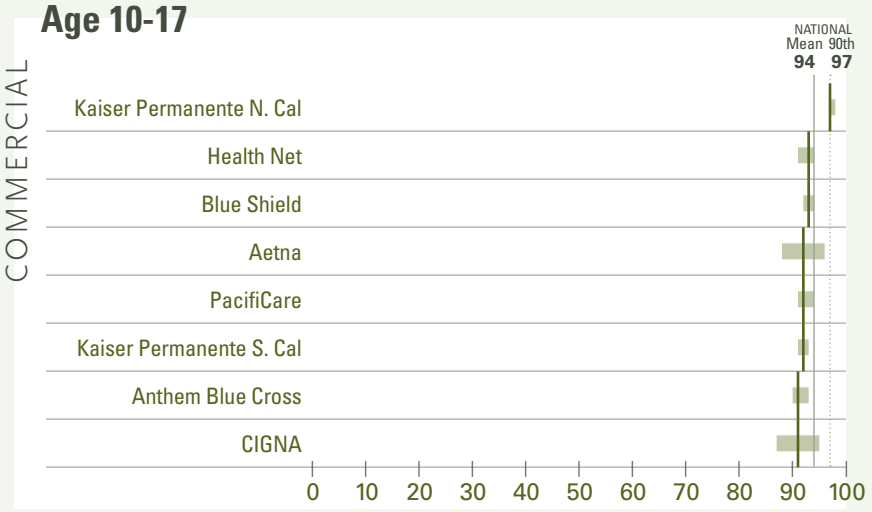
USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

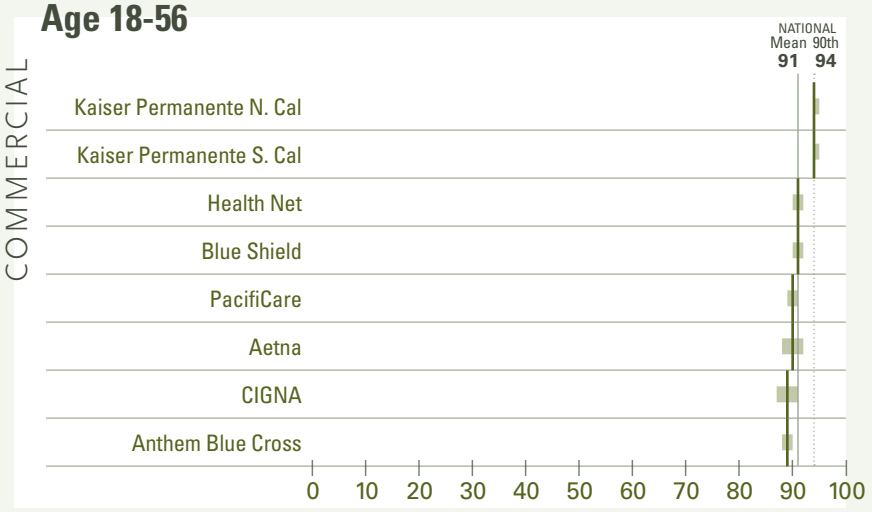
Asthma is a chronic lung disease and a rapidly growing public health problem. It is the most common chronic respiratory disease in children and can result in life-threatening episodes of illness for both adults and children. Asthma is the leading cause of school absenteeism from a chronic childhood condition. Unfortunately, asthma is becoming more common and currently affects more than 20 million Americans, including almost 9 million children.

The recommended treatment for most patients with persistent asthma emphasizes daily, long-term prevention therapy that improves the underlying airway inflammation. Appropriate preventive treatment can result in fewer episodes of wheezing and coughing and a decrease in the use of medications needed to treat these symptoms. Commonly used preventive medications include anti-inflammatory prescriptions such as inhaled corticosteroids, Cromolyn Sodium and Nedocromil as well as other alternative oral medications.

Measuring whether health plan members with persistent asthma receive the recommended medications for long-term control of their asthma is very important. Because the challenges in accurately diagnosing and caring for children with persistent asthma are very different from the identification and treatment of asthma in adults, separate rates were calculated in those age groups. This measure reports the percentage of members diagnosed with asthma who received appropriate medication management during 2007.







BETA BLOCKER TREATMENT

PERSISTENCE OF BETA BLOCKER TREATMENT AFTER HEART ATTACK

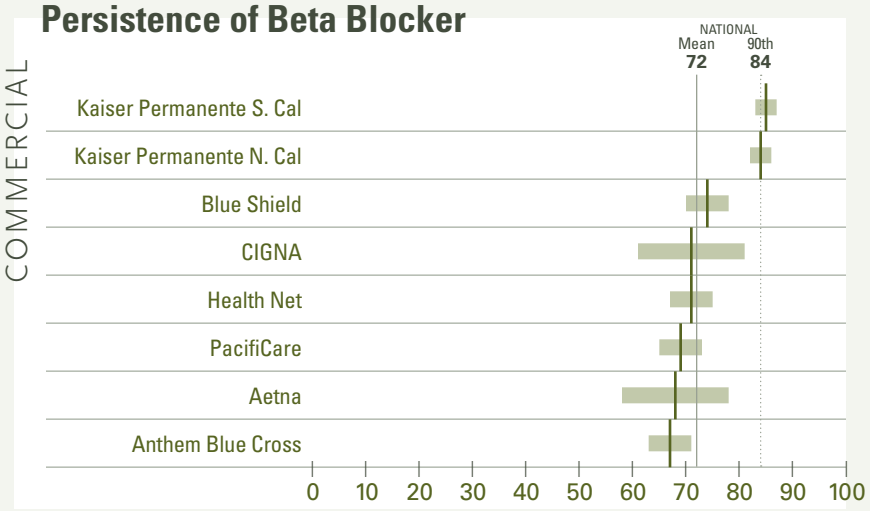
Heart attacks, also known as acute myocardial infarctions or AMI, occur in approximately 1.2 million Americans each year. Unfortunately, patients who have had a heart attack are at higher risk than the general public to have another one.

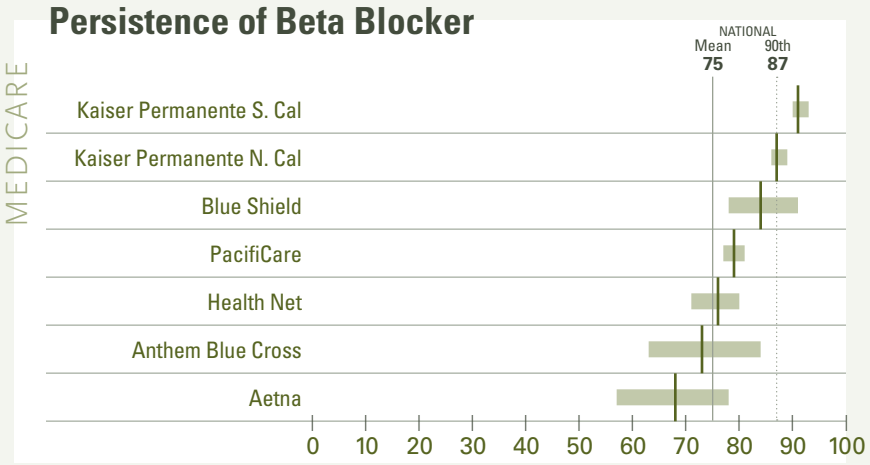
Medications called beta blockers are an important part of follow-up treatment after a heart attack. When taken shortly after a heart attack by patients without other heart problems, beta blockers can help prevent another heart attack by lowering blood pressure and decreasing how hard the heart has to work. Long term administration of beta blockers following a heart attack has been shown to improve survival and reduce the risk of future heart attacks.

While beta blockers were appropriately prescribed to over 93.5% of heart attack patients in 2002, evidence suggests that fewer than half of patients still took these medications six months later. This measure shows the rates at which patients stay on beta blocker therapy for the six months following a heart attack.

This measure calculates the percentage of members 18 years and older who were discharged from the hospital with a diagnosis of a heart attack and who received beta-blocker treatment for 6 months after the discharge.

Separate charts display results for commercial and Medicare members.





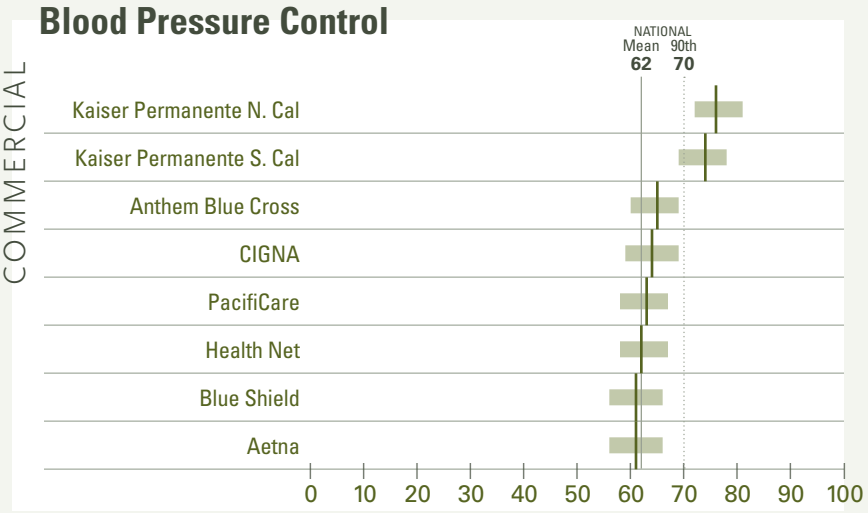
HIGH BLOOD PRESSURE

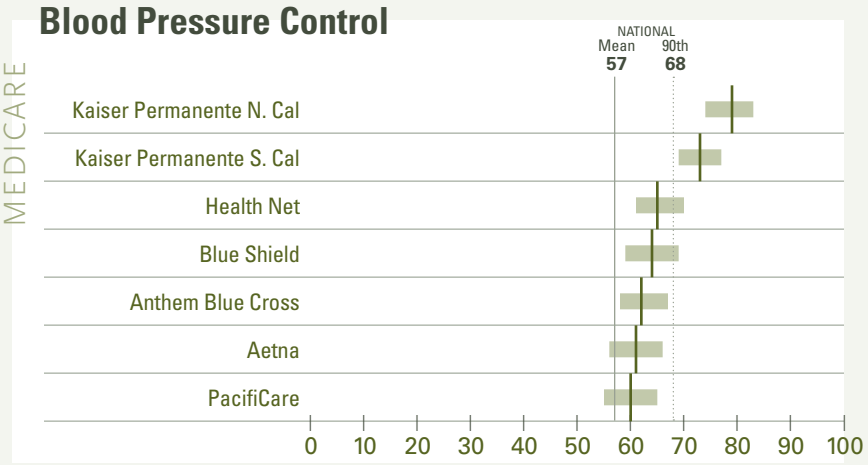
CONTROLLING HIGH BLOOD PRESSURE

The American Heart Association estimates that 72 million Americans have high blood pressure or nearly one in every three adults. Nearly one-third of these people don't know they have it. High blood pressure can lead to numerous life-threatening conditions including heart disease, stroke and kidney failure, the number one, number three and number nine causes of death in the U.S. Lowering the blood pressure, even in amounts as small as 5-6mm, has many benefits, including decreased overall risk of developing serious medical problems. In elderly patients where the incidence of congestive heart failure is common, aggressively treating hypertension can reduce coronary heart disease and deaths from stroke.

Hypertension is defined as blood pressure readings consistently higher than 140/90. This measure looks at whether blood pressure was controlled in adults aged 18-85 years of age who have diagnosed hypertension. Adequate control was defined as a blood pressure of lower than 140/90 mmHg. Hypertension can improve with changes in diet and lifestyle, including increased exercise and the appropriate use and monitoring of medications. With careful, individualized treatment, up to three-quarters of patients diagnosed with hypertension can achieve and maintain adequate blood pressure control. health plans can use educational programs and newsletters to increase provider and member awareness of the benefits of controlling high blood pressure.

Separate charts display results for commercial and Medicare members.





CHOLESTEROL MANAGEMENT *1 of 2*

CHOLESTEROL MANAGEMENT AFTER ACUTE CARDIOVASCULAR EVENT

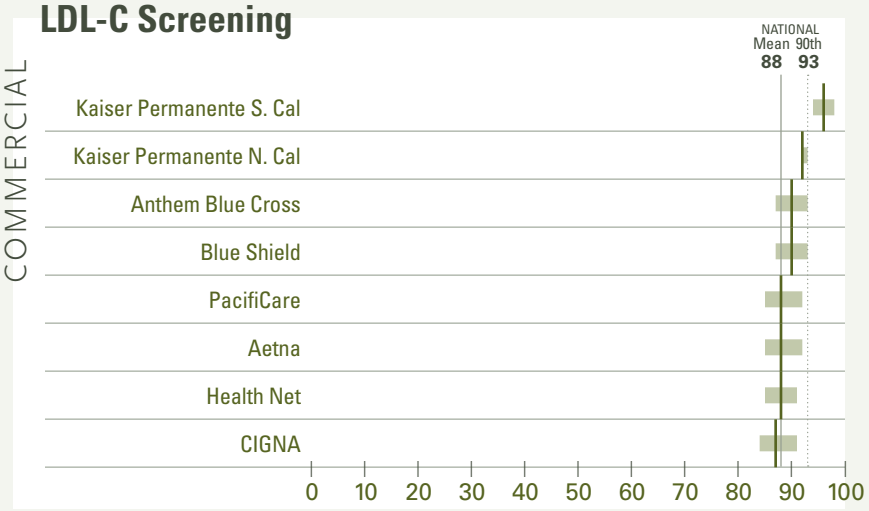
Cholesterol management is very important in the prevention and control of coronary artery disease, the leading cause of death in the United States. Approximately 452,300 deaths occur each year because of complications of this disease and many clinical studies have shown that high blood cholesterol levels are directly related to the development of coronary artery disease. Over 35% of adults over 18 have high cholesterol and less than half of persons who qualify for treatment are receiving it.

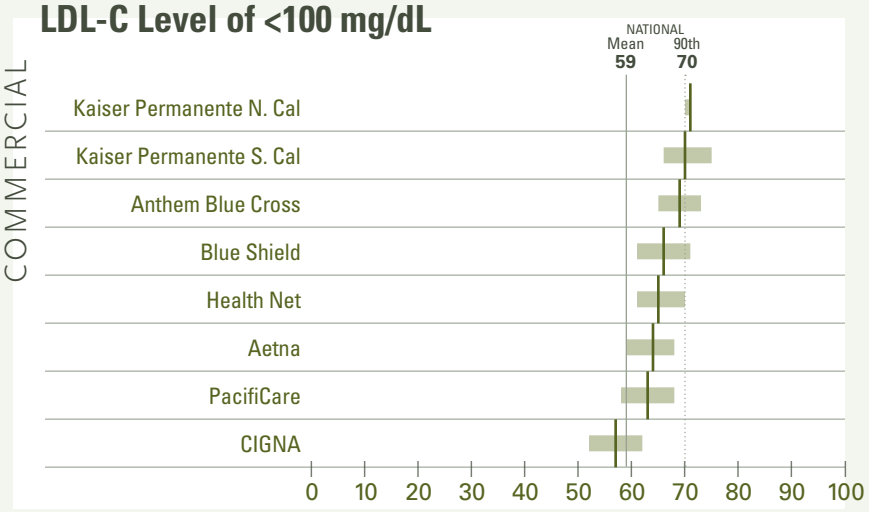
Elevated cholesterol levels can be lowered through a combination of lifestyle changes including a low-fat diet, increased physical activity and, when appropriate, treatment with cholesterol-lowering medications. Physicians routinely screen patients for high cholesterol. It is especially important for those who have already had a cardiac event such as a heart attack, bypass surgery, or coronary angioplasty to ask their doctors about treatment choices.

The first measure shown on this page reports the percentage of California adult HMO members discharged from the hospital following a heart attack, bypass surgery, or coronary angioplasty, who had evidence of an LDL screening during the year after their hospital discharge.

The second measure reflects the percentage of patients with known heart disease who have their cholesterol levels under control. Control for this measure means an LDL cholesterol level less than 100mg/dL. Controlling LDL cholesterol levels is very important in patients with existing heart disease and can help reduce the risk of a second heart attack by as much as 40 percent.

Separate charts display results for commercial and Medicare members.

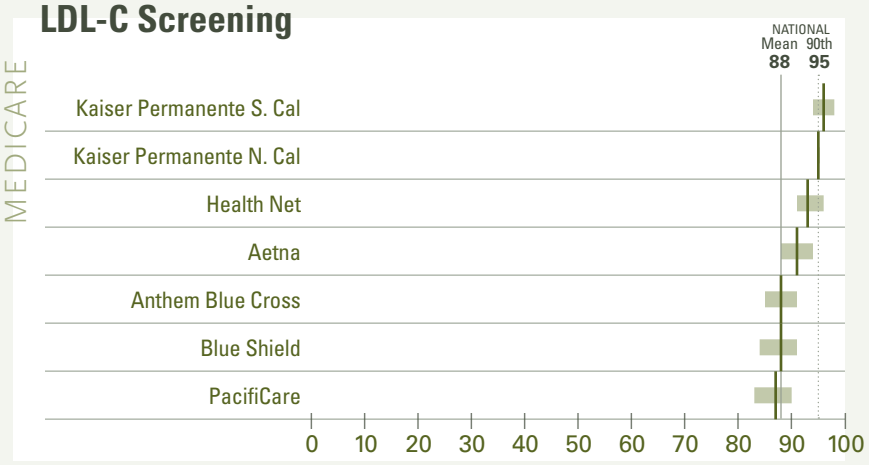




CHOLESTEROL MANAGEMENT *2 of 2*

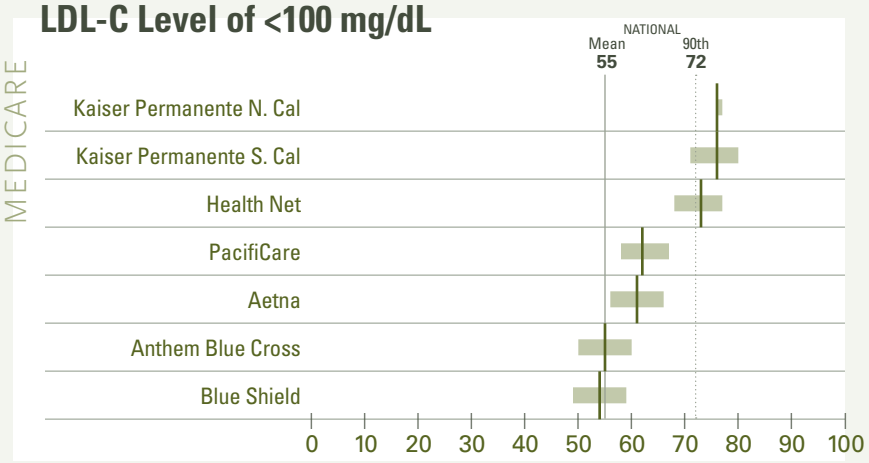
LDL-C Screening

MEDICARE



LDL-C Level of <100 mg/dL

MEDICARE



ANTIDEPRESSANT MEDICATION *1 of 2*

ANTIDEPRESSANT MEDICATION MANAGEMENT

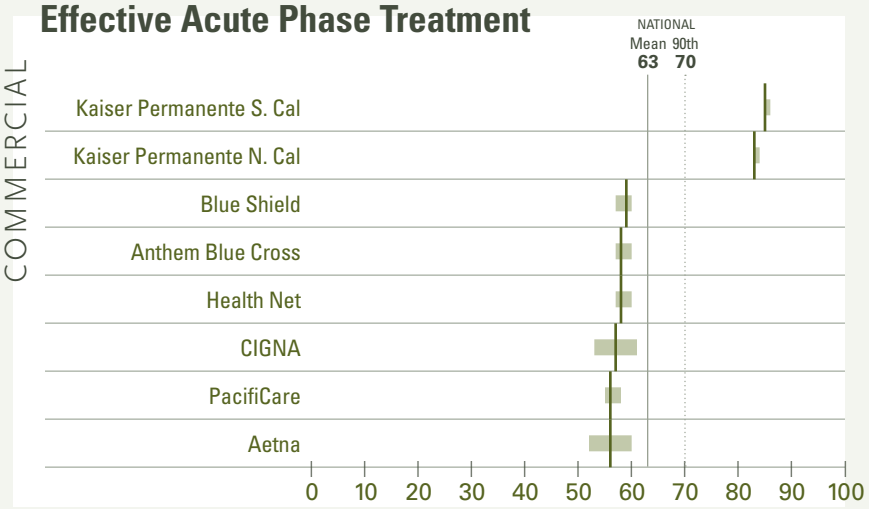
In any given one year period, 5.8% of the population or about 15 million American adults suffer from major depressive illness. If not properly treated with counseling and medications, patients can sometimes experience serious complications. Approximately 70% of patients who are diagnosed with severe depression respond favorably to antidepressant medications.

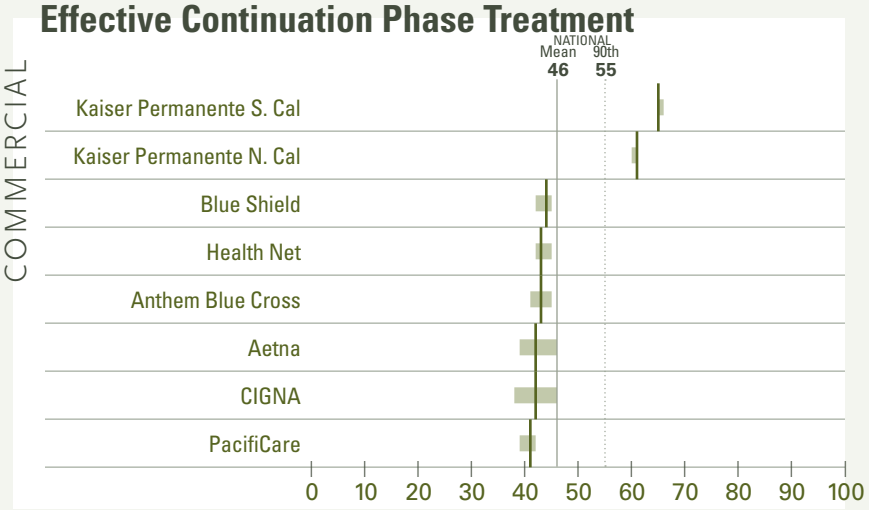
These charts display a two-part measure that looks at different facets of successful pharmacological management of depression. The two components of the measure estimate:

1. Effective Acute Phase: The percentage of eligible members who remained on antidepressant medication continuously for 12 weeks after the initial diagnosis;
2. Effective Continuation Phase: The percentage of eligible members who remained on antidepressant medication for at least six months after the initial diagnosis.

Nationally, only about half of all patients treated with antidepressant medications receive care for the recommended period of time. Better treatment rates suggest fewer patients are likely to experience a relapse of their depression symptoms. Health plans can improve clinical outcomes for their members by working in partnership with physicians to encourage appropriate treatment and improved medication management for patients with new episodes of depression.

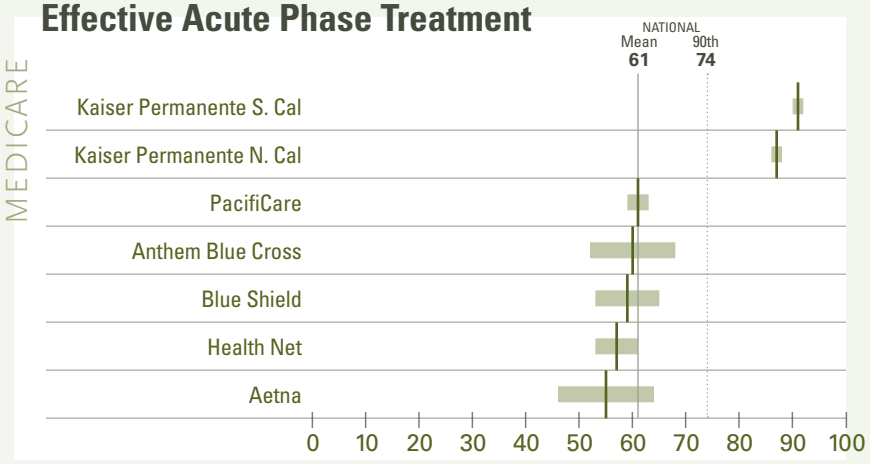
Separate charts display results for commercial and Medicare members.



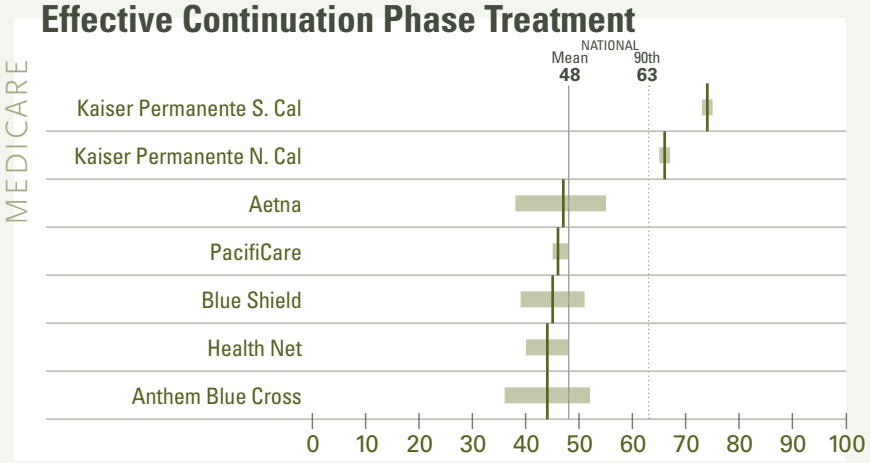


ANTIDEPRESSANT MEDICATION *2 of 2*

Effective Acute Phase Treatment



Effective Continuation Phase Treatment



MENTAL ILLNESS *1 of 2*

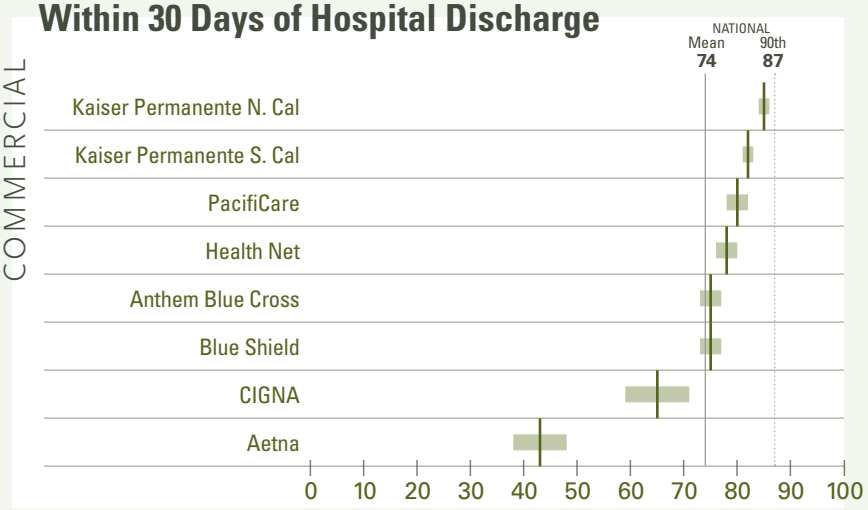
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

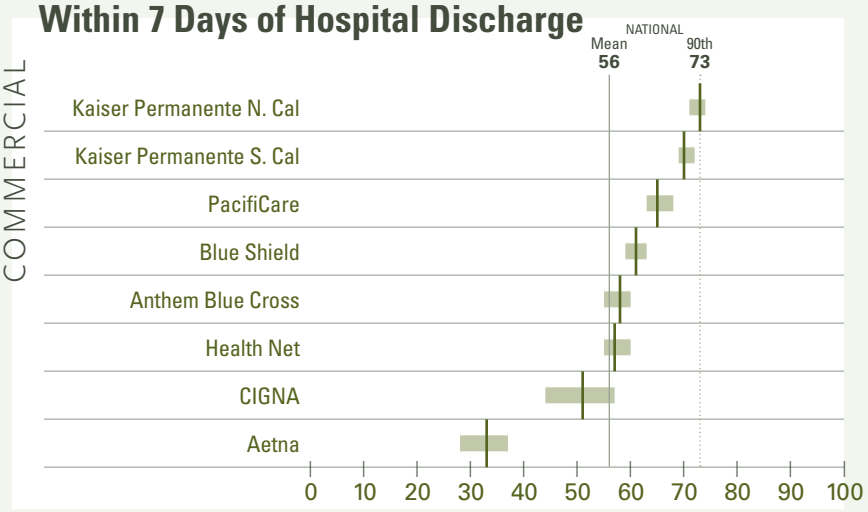
Mental illnesses such as depression, schizophrenia, and anxiety are real health conditions that, if untreated, can be as disabling and serious as cancer and heart disease. Fortunately, advances in mental health research and the availability of newer, more effective medication have broadened the treatment options for mental health problems and improved the overall level of mental health care.

Hospitalization is sometimes the most appropriate treatment for serious mental illness. When patients are discharged from the hospital, ongoing medical care and emotional support is essential to continued recovery. Patients who receive regular follow-up therapy with a mental health provider usually experience a smoother transition back to their regular routines at home and work. They also have lower rates of relapse and re-hospitalization.

This HEDIS indicator measures the percentage of HMO members ages 6 years and older who were seen on an outpatient basis by a mental health provider within seven days and within 30 days after being discharged for an inpatient mental health stay. HMOs can encourage appropriate follow-up treatment by educating members and physicians regarding the benefits of continued therapy and support in the immediate post-hospitalization period and about the various treatment options available to them.

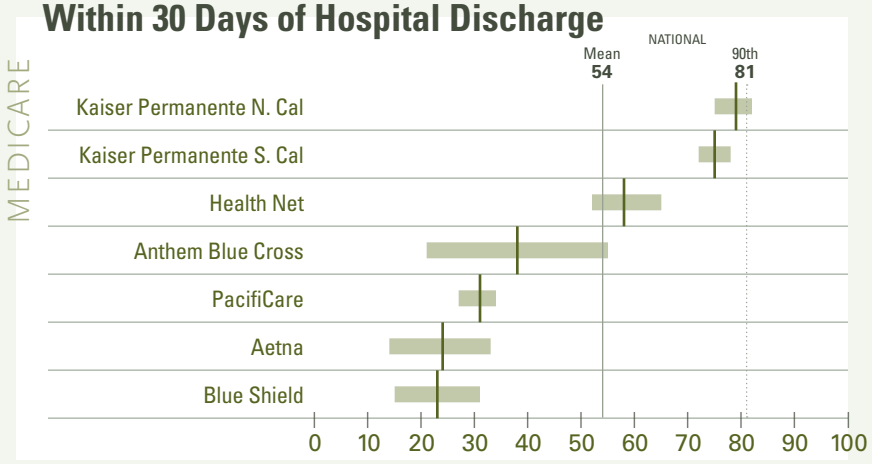
Separate charts display results for commercial and Medicare members.



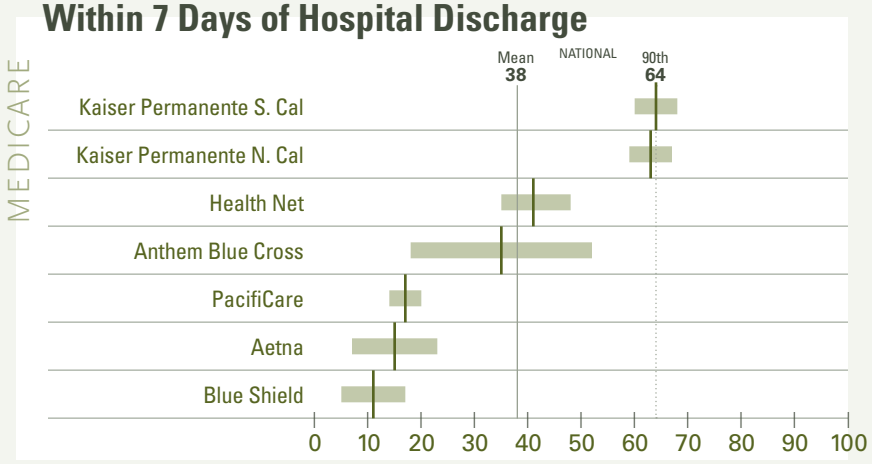


MENTAL ILLNESS *2 of 2*

Within 30 Days of Hospital Discharge



Within 7 Days of Hospital Discharge



ALCOHOL & DRUG TREATMENT *1 of 2*

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG (AOD) TREATMENT

The 2007 National Survey on Drug Use and Health (NSDUH), estimated that 22.3 million persons (9.0 percent of the population aged 12 or older) were classified with substance dependence or abuse in the past year. Of these, 3.2 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.7 million were dependent on or abused illicit drugs but not alcohol, and 15.5 million were dependent on or abused alcohol but not illicit drugs.

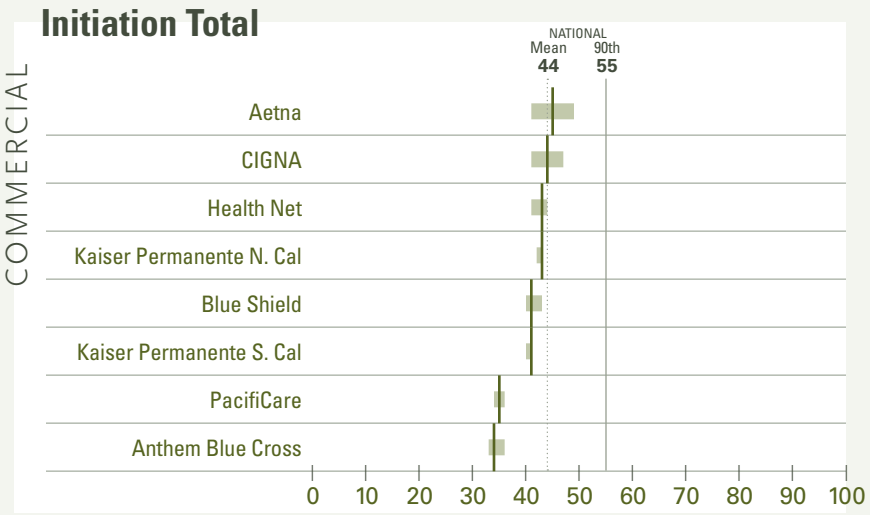
The Substance Abuse and Mental Health Services Administration's (SAMHSA) 2006 National Survey on Drug Use & Health indicated that more than a fourth of the persons under the legal age for drinking actually drank in the past month; that is, there were 10.8 million current underage drinkers. Younger female underage drinkers were more likely than older ones to have had their most recent drink in a car or other vehicle. For example, female underage drinkers aged 16 were eight times more likely to have had their last drank in a car than those aged 20 (12.8% vs. 1.6%).

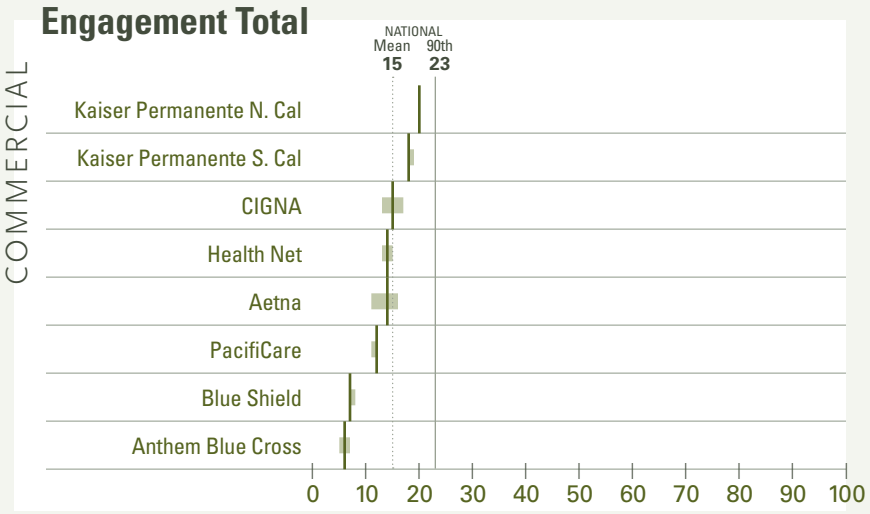
According to AHRQ's National Quality Measures Clearing House, "there are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance abuse places a huge burden on the health care system."

The initiation of alcohol and other drug (AOD) dependence treatment measure looks at the percentage of adolescent and adult members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.

The engagement of alcohol and other drug (AOD) treatment measure looks at the percentage of adolescent and adult members who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

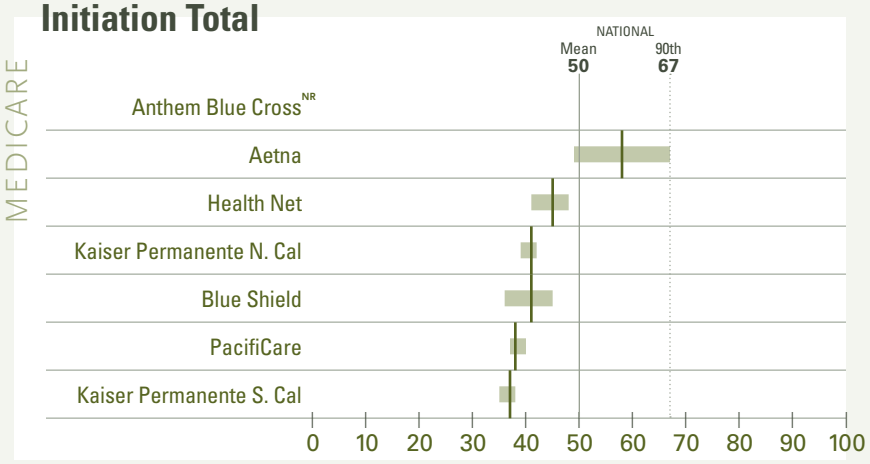
Separate charts display results for commercial and Medicare members.



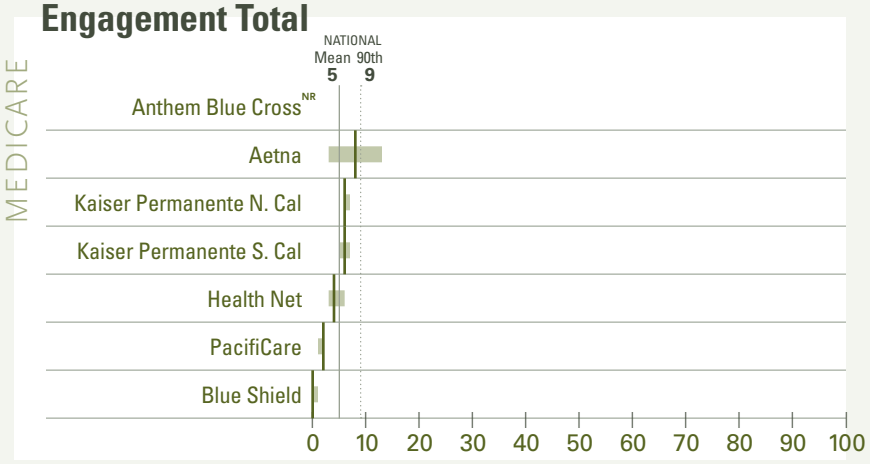


ALCOHOL & DRUG TREATMENT *2 of 2*

Initiation Total



Engagement Total



NOTES

NR - Rate not reported by plan.

ACUTE BRONCHITIS

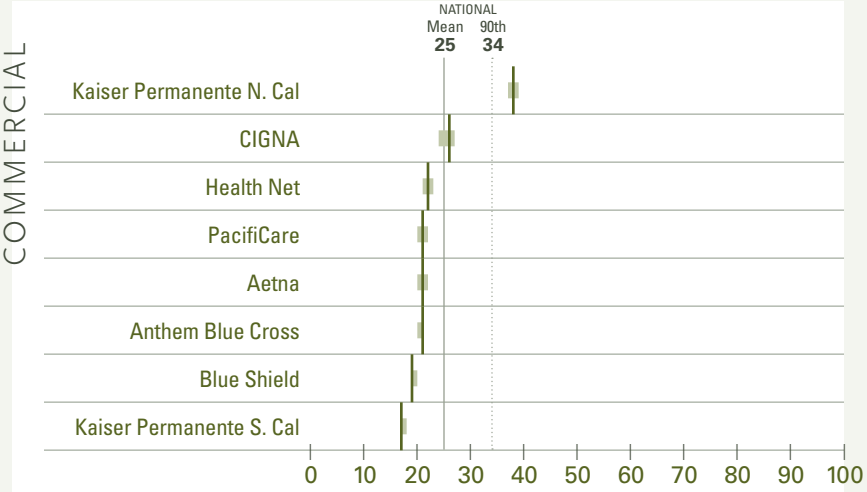
INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS

In the United States, about 5% of adults self-report an episode of acute bronchitis each year, and up to 90% of these persons seek medical attention. In 1997, adults in the United States made more than 10 million office visits for bronchitis. As a result, acute bronchitis consistently ranks among the 10 conditions that account for most ambulatory office visits to U.S. physicians. Antibiotics are most often inappropriately prescribed in adults with acute bronchitis.

Antibiotics are not indicated in clinical guidelines for the treatment of adults with acute bronchitis who do not have a comorbidity or other infection for which antibiotics may be appropriate.

Inappropriate antibiotic treatment of adults with acute bronchitis is of clinical concern, especially since misuse and overuse of antibiotics lead to antibiotic drug resistance. Despite the fact that the majority of acute bronchitis cases have a non-bacterial cause (greater than 90%), antibiotics are prescribed 65 percent to 80 percent of the time.

This measure is used to assess the percentage of healthy adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.



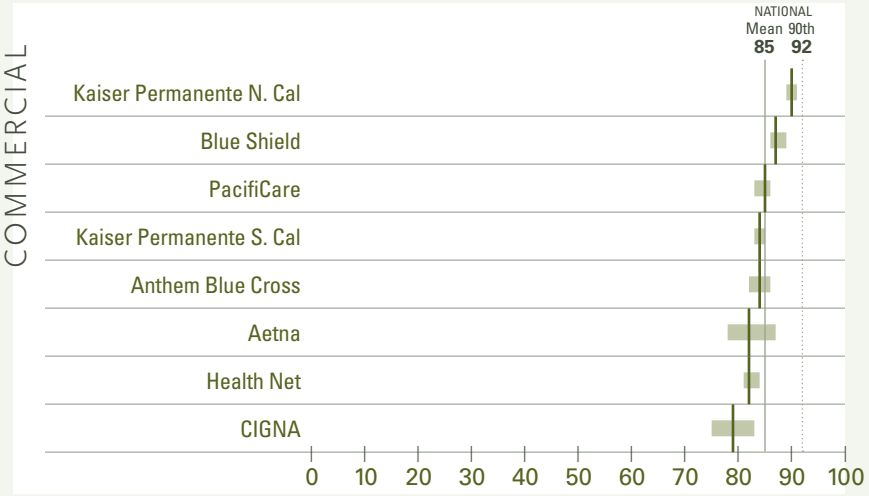
ANTI-RHEUMATIC DRUG THERAPY

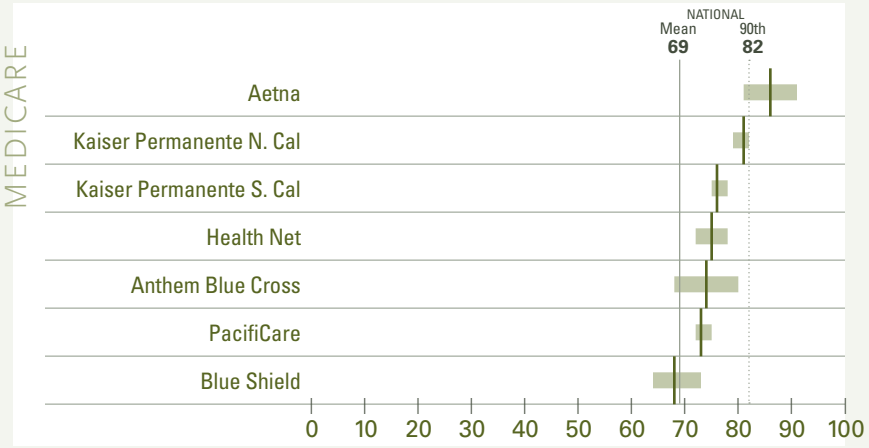
DISEASE MODIFYING ANTI-RHEUMATIC DRUG THERAPY

Rheumatoid arthritis is a chronic autoimmune disorder often characterized by progressive joint destruction and multisystem involvement. It affects approximately 2.5 million Americans, and women disproportionately. There is no cure; consequently, the goal of treatment is to slow the progression of disease and thereby delay or prevent joint destruction, relieve pain and maintain functional capacity.

This measure assesses whether patients diagnosed with rheumatoid arthritis (RA) have been prescribed a disease modifying anti-rheumatic drug (DMARD). DMARDs modify the disease course of rheumatoid arthritis through reduction of the progression of bony erosions, lessening of inflammation and long-term structural damage. The utilization of DMARDs is also expected to provide improvement in functional status.

Separate charts display results for commercial and Medicare members.





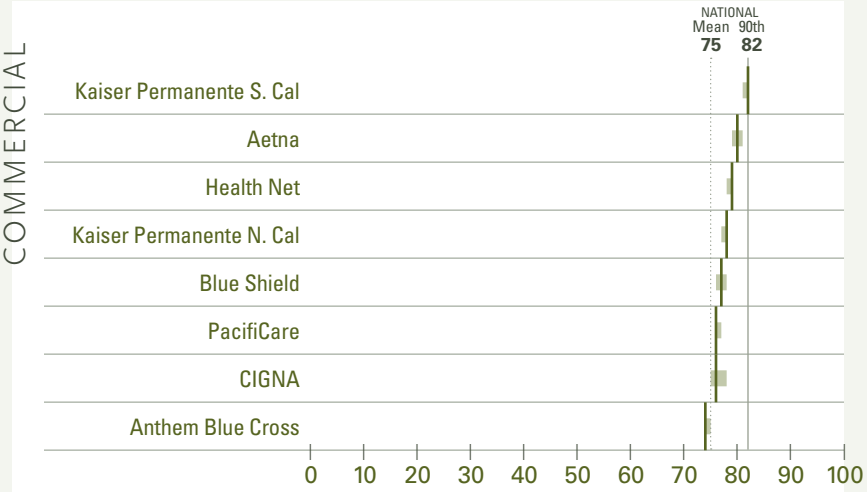
LOW BACK PAIN IMAGING

USE OF IMAGING STUDIES FOR LOW BACK PAIN

In the United States, at least 80 percent of adults have at least one episode of low back pain during their lifetimes. Low back pain and degenerative joint disease account for almost 5% of all adult physician visits, and the direct medical costs related to low back pain exceed $25 billion annually. Fortunately, in as many as 90 percent of patients, acute low back pain resolves within six weeks regardless of treatment methods.

The approach to evaluation of low back pain varies considerably among physicians, current evidence suggests that many of the tests performed are unnecessary and overuse of imaging studies ranged from 20% among primary care physicians to 70% among orthopedists.

This HEDIS measure assesses whether imaging studies such as X-rays, MRIs, CT scans, are overused in evaluating patients with acute back pain. A higher score indicates the appropriate treatment of low back pain i.e. an imaging study did not occur when it was not necessary.



PERSISTENT MEDICATIONS

ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

Patient safety is highly important, especially for patients at increased risk of adverse drug events from long-term medication use. Persistent use of these drugs warrants monitoring and follow-up by the prescribing physician to assess for side-effects and adjust drug dosage/therapeutic decisions accordingly. The drugs included in this measure also have potentially more harmful effects in the elderly.

The costs of annual monitoring are offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications. The total costs of drug-related problems due to misuse of drugs in the ambulatory setting has been estimated to exceed $76 billion annually.

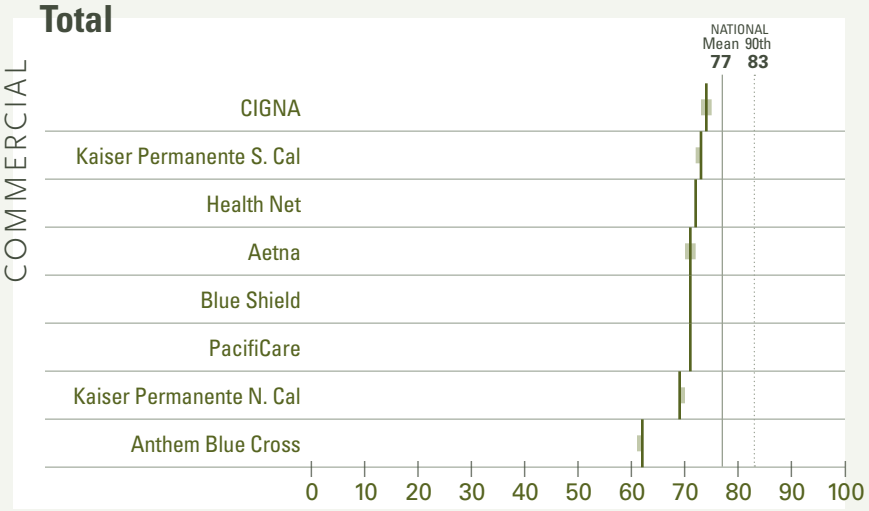
Appropriate monitoring of drug therapy remains a significant issue to guide therapeutic decision making and provides largely unmet opportunities for improvement in care for patients on persistent medications.

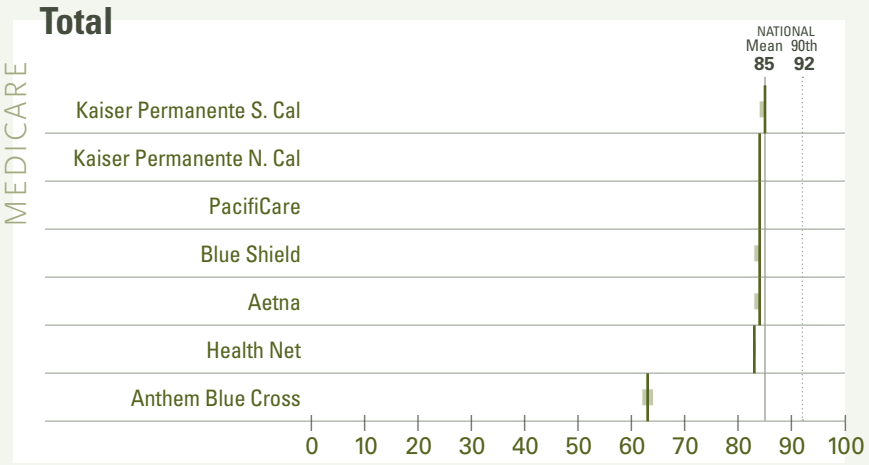
This measure is used to assess the percentage of health plan members 18 years of age and older who received at least a 180-days supply of ambulatory medication therapy for the following medications:

- Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)
- Digoxin
- Diuretics
- Anticonvulsants

The result reported is the total rate for the four medications.

Separate charts display results for commercial and Medicare members.





DRUGS AND THE ELDERLY

USE OF HIGH-RISK MEDICATIONS IN THE ELDERLY

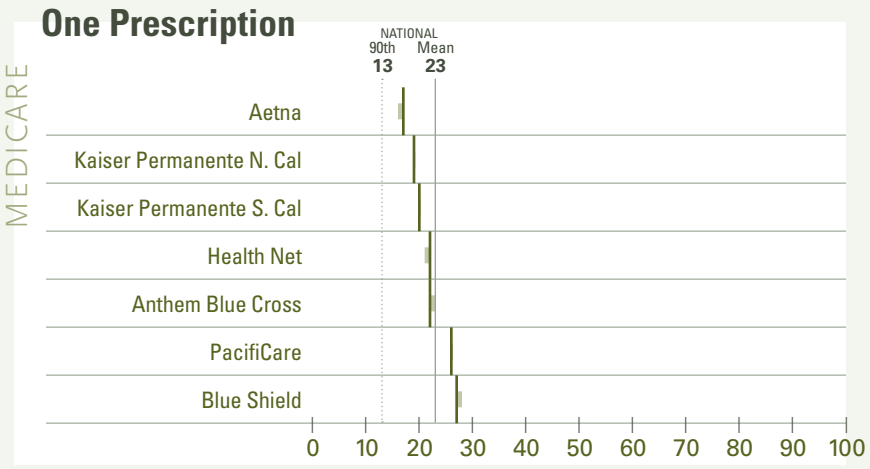
With an increasing focus on patient safety, NCQA introduced new HEDIS patient safety measures assessing the safe use of medications in the Medicare population, in 2006. Certain medications are associated with increased risk of harm from drug side-effects and drug toxicity and pose a concern for patient safety. There is clinical consensus that these drugs pose increased risks in the elderly. Studies link prescription drug use by the elderly with adverse drug events that contribute to hospitalization, increased length of hospital stay, increased duration of illness, nursing home placement and falls and fractures that are further associated with physical, functional and social decline in the elderly.

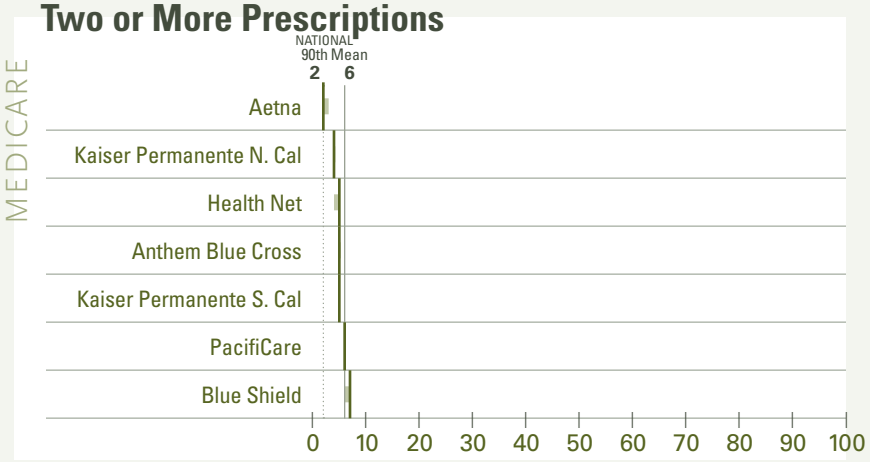
Reducing prescriptions of high-risk drugs in the elderly represents an opportunity to reduce the costs associated with the harm from medications (i.e., hospitalizations from drug toxicity) and encourage clinicians to consider safer, alternative medications. Reducing unnecessary prescribing will also help to reduce cost, given that the elderly population represent one third of all prescription drug expenditures in the U.S. but comprises only 13 percent of the population.

Use of high-risk medications in the elderly (DAE), assesses whether patients 65 and older have filled prescriptions for drugs (such as barbiturates) that have been determined to be harmful to elderly patients. These drugs have been deemed harmful regardless of drug dose, frequency, or patient's underlying health status and are based widely used consensus criteria for medication use in older adults. This measure reports two rates:

- The percentage of Medicare members 65 years of age and older who received at least one high-risk medication.
- The percentage of Medicare members 65 years of age and older who received at least two different high-risk medications.

For this measure a lower number is better. As a result, the order for displaying the mean and 90th percentile have been reversed.



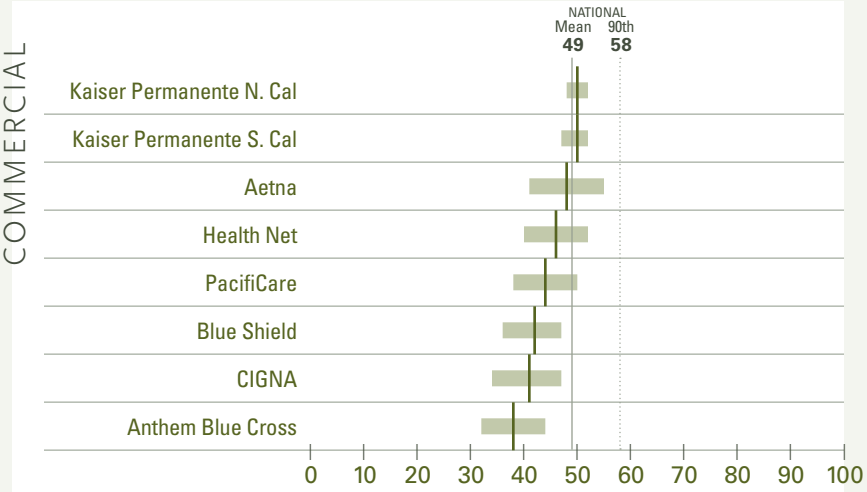


FLU SHOT

FLU SHOT FOR ADULTS

Influenza, also know as the flu, is a contagious disease that is caused by the influenza virus. Millions of people in the U.S.—about 5% to 20% of U.S. residents—will get influenza each year. Most people who get influenza will recover in one or two weeks, but some people will develop life-threatening complications as a result of the flu. An average of about 36,000 people each year in the U.S. dies from influenza, and more than 200,000 have to be admitted to the hospital as a result of influenza. Some people with certain health conditions are at high risk for serious flu complications such as bacterial pneumonia, dehydration and worsening of chronic medical conditions such as asthma or diabetes. Nearly one-third of people 50-64 years of age in the U.S. have one or more medical conditions that place them at increased risk for serious flu complications.

This HEDIS measure is collected using survey methodology and estimates the percentage of members 50-64 who received an influenza vaccination during 2007. The single best way to prevent the flu is to get a flu vaccination each fall. People who are at high risk of having serious flu complications or people who live with or care for those at high risk for serious complications should get vaccinated each year.



DRUG INTERACTIONS

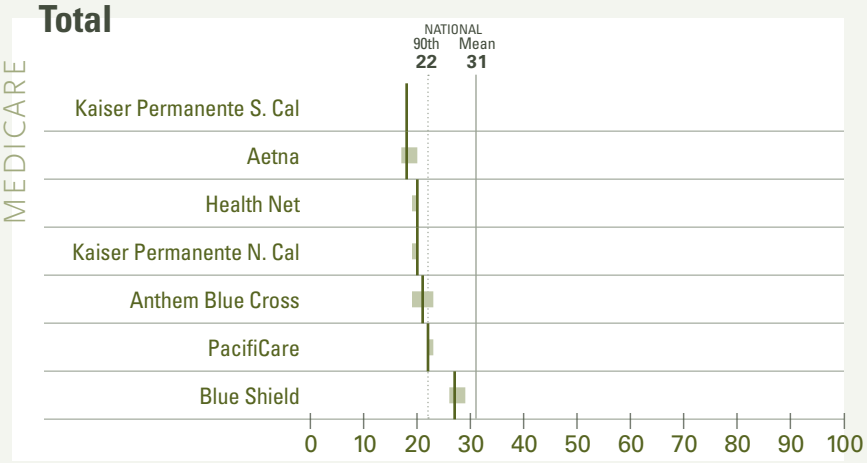
POTENTIALLY HARMFUL DRUG-DISEASE INTERACTIONS IN THE ELDERLY

Drug therapy is an essential component of medical treatment for older patients, but medications are also responsible for many adverse events in this group. According to AHRQ almost 90 percent of people 65 years of age or older take at least one medication, significantly more than any other age group. Many older adults take multiple medications for treatment of several conditions, which increases the chance of adverse drug reactions, drug-drug interactions and drug-disease interactions. Adverse drug events have been linked to preventable problems in elderly patients, such as depression, constipation, falls, immobility, confusion and hip fractures.

This measure reports the percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for contraindicated medications, concurrent with or after the diagnosis. The total rate is reported and reflects the following:

- A history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents
- Dementia and a prescription for tricyclic antidepressants or anticholinergic agents
- Chronic renal failure and prescription for nonaspirin NSAIDs or Cox-2 Selective NSAIDs

For this measure a lower number is better. As a result, the order for displaying the mean and 90th percentile have been reversed.



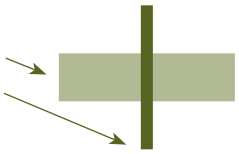
MEASURES OF ACCESS/AVAILABILITY OF CARE

The service performance results displayed on the following pages use HEDIS Access/Availability of Care measures to gauge performance in key areas of customer service. High levels of service and member satisfaction are closely related, and are used by health care purchasers and consumers in selecting a plan.

Data for these HEDIS measures are obtained from California health plans, using NCQA specified processes and guidelines that assure the accuracy and comparability of the results.

1. Health plans supply data on member services call center volumes during hours of operation.
2. Health plans then supply data on how the call was handled.
3. An independent research firm contracted with CCHRI evaluates and analyzes the data from all the participating health plans.

HOW TO READ THESE GRAPHS



The horizontal bars show scores for each California health plan. The vertical bar is the best estimate of the plan's true score based on a sample or sub-set, of health plan members. When the horizontal bars for two plans do not overlap, this means the health plan scores are significantly different from each other. The length of the horizontal bar is related to the size of the health plan sample. A smaller sample results in a longer horizontal bar because the exact score is less certain. The score is more accurate if the sample is larger and the bar is smaller. Plans with longer horizontal bars do not necessarily have better scores than plans with shorter bars.

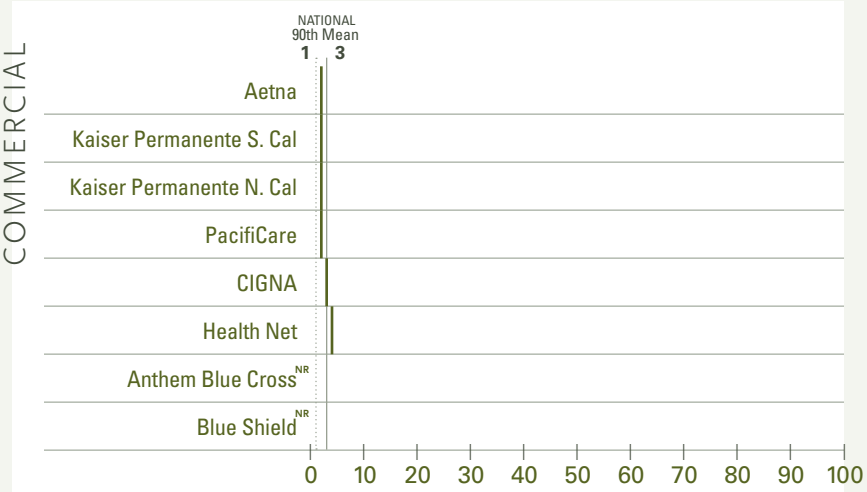
CALL ABANDONMENT

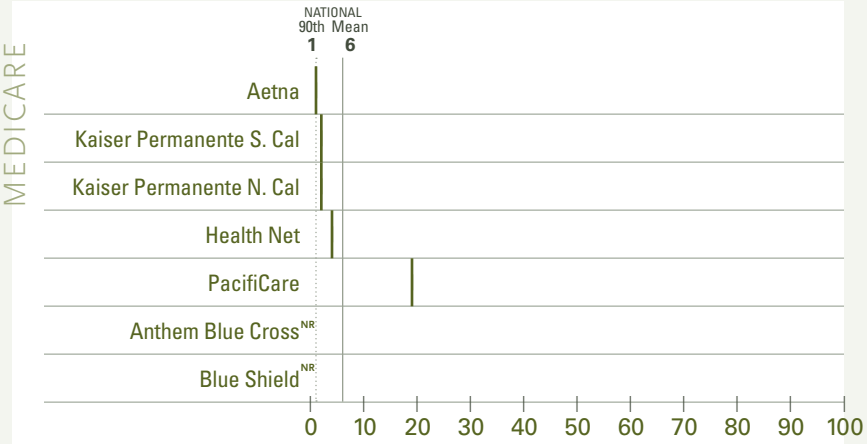
CALL ABANDONMENT

The Call Abandonment measure determines the rate of calls to the health plan call center (during operating hours) that were abandoned (i.e., the caller decided to hang up) before being answered by a live person.

For this measure a lower number is better. As a result, the order for displaying the mean and 90th percentile have been reversed.

Separate charts display results for commercial and Medicare members.





NOTES

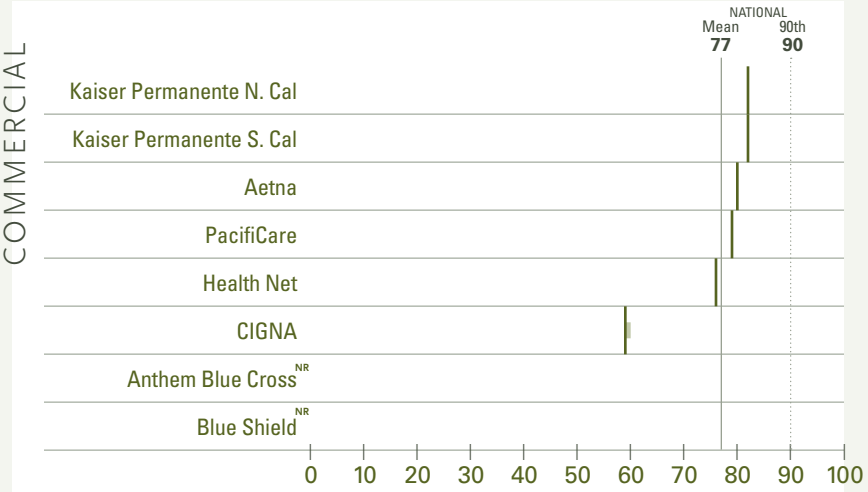
NR - Not reported.

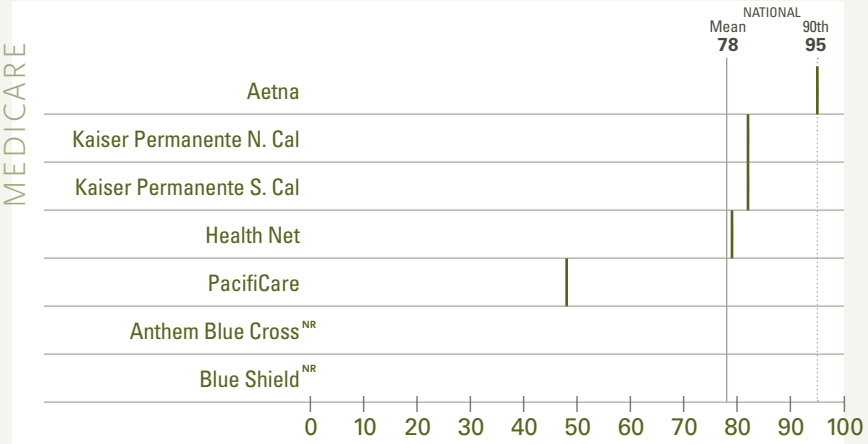
CALL ANSWER TIMELINESS

CALL ANSWER TIMELINESS

The Call Answer Timeliness measure addresses the performance of health plan call centers, calculating the percentages of calls answered by a live voice within 15 and 30 seconds.

Separate charts display results for commercial and Medicare members.





NOTES

NR - Not reported.

MEMBER SURVEY INTRODUCTION

ABOUT THE MEMBER SURVEYS

Another important part of the HEDIS measurement set is a standardized member survey used by health plans to evaluate patients' experience and satisfaction with their plan. Information obtained from these surveys helps plans improve the quality of their services. Consumers use the comparative results to learn more about CCHRI health plans.

An independent research firm, using a uniform process that produces accurate and comparable results about specific plans, administered the NCQA-approved member survey for CCHRI. The survey was mailed to a randomly selected subset of members from each health plan and follow-up telephone calls were conducted for those members who didn't respond to the initial questionnaire.

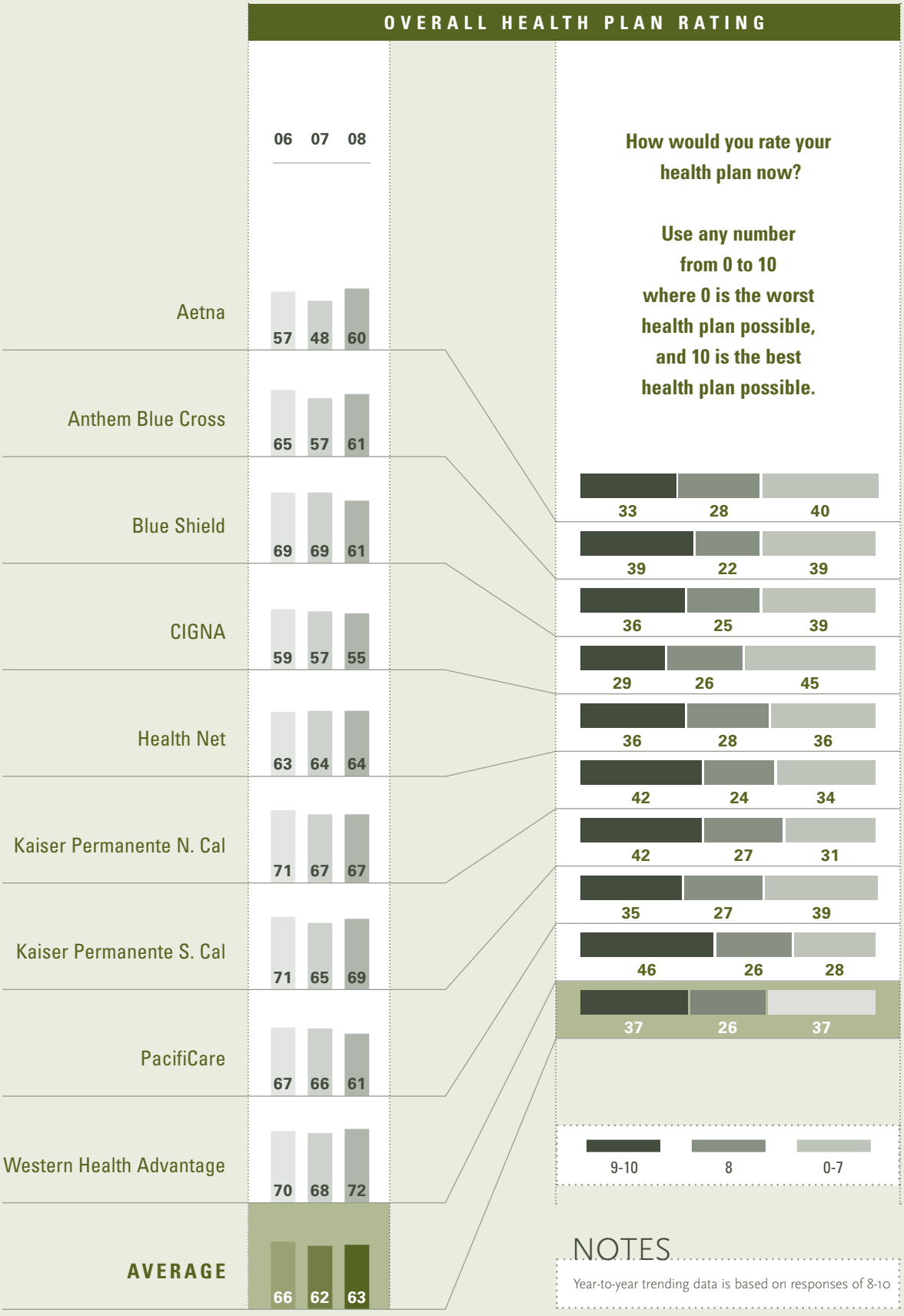
Beginning in 2007 NCQA made significant changes to the member survey that affect comparisons to prior years. Footnotes are provided throughout this section indicating the relevant changes.

In early 2008, approximately 24,000 members received questionnaires asking them to evaluate their experiences with their health plan during 2007. The research firm tabulated and reported the results based on answers from members who replied to the survey. Findings shown in this report include responses to individual questions as well as combined responses from several similar questions that are summarized into composite categories.

It is possible that members who participated in this survey are more satisfied or less satisfied than members who did not receive questionnaires or participate in the survey.

MEMBER SURVEY

HEALTH PLAN *1 of 3*

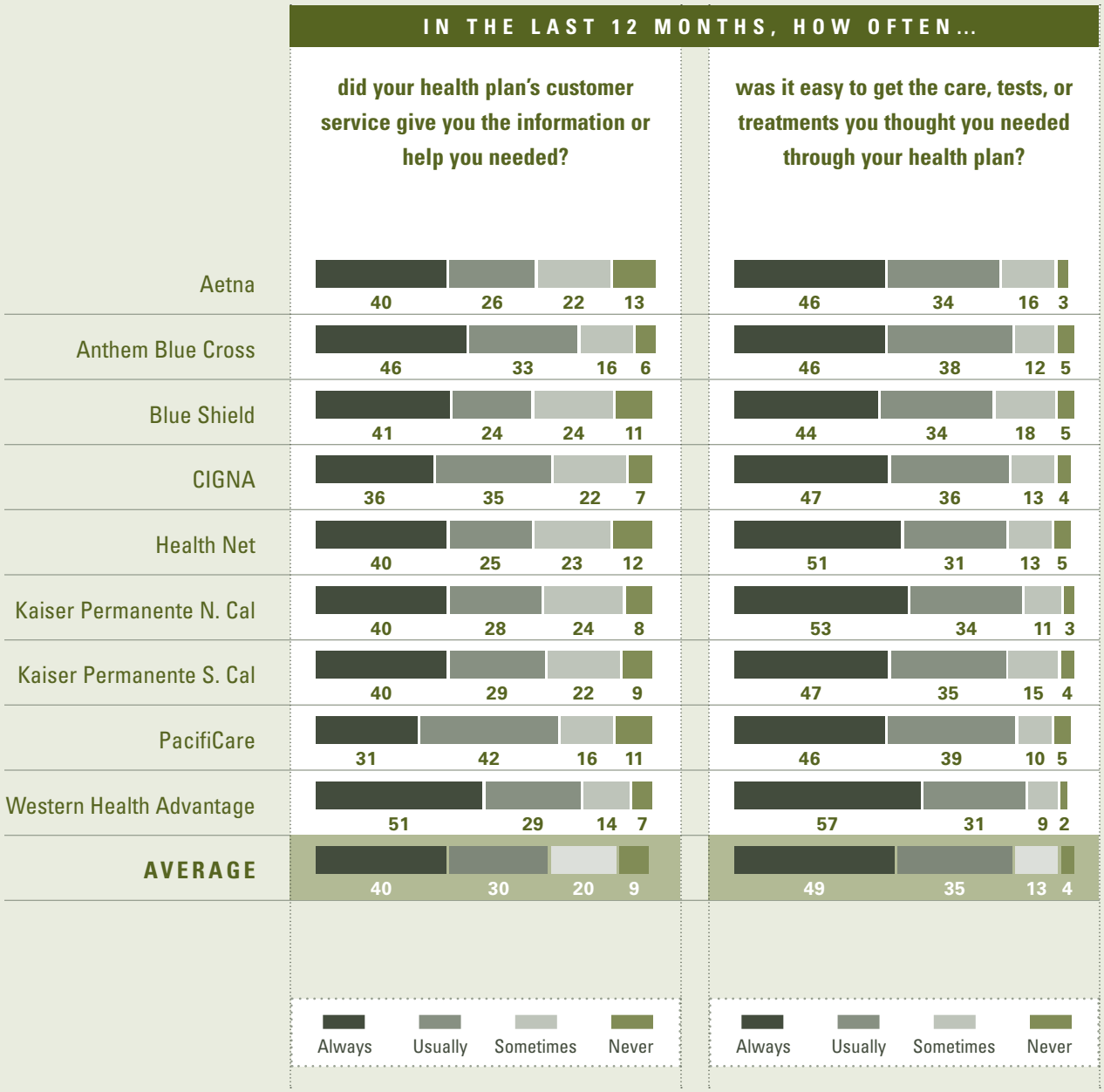


NOTES

Year-to-year trending data is based on responses of 8-10

MEMBER SURVEY

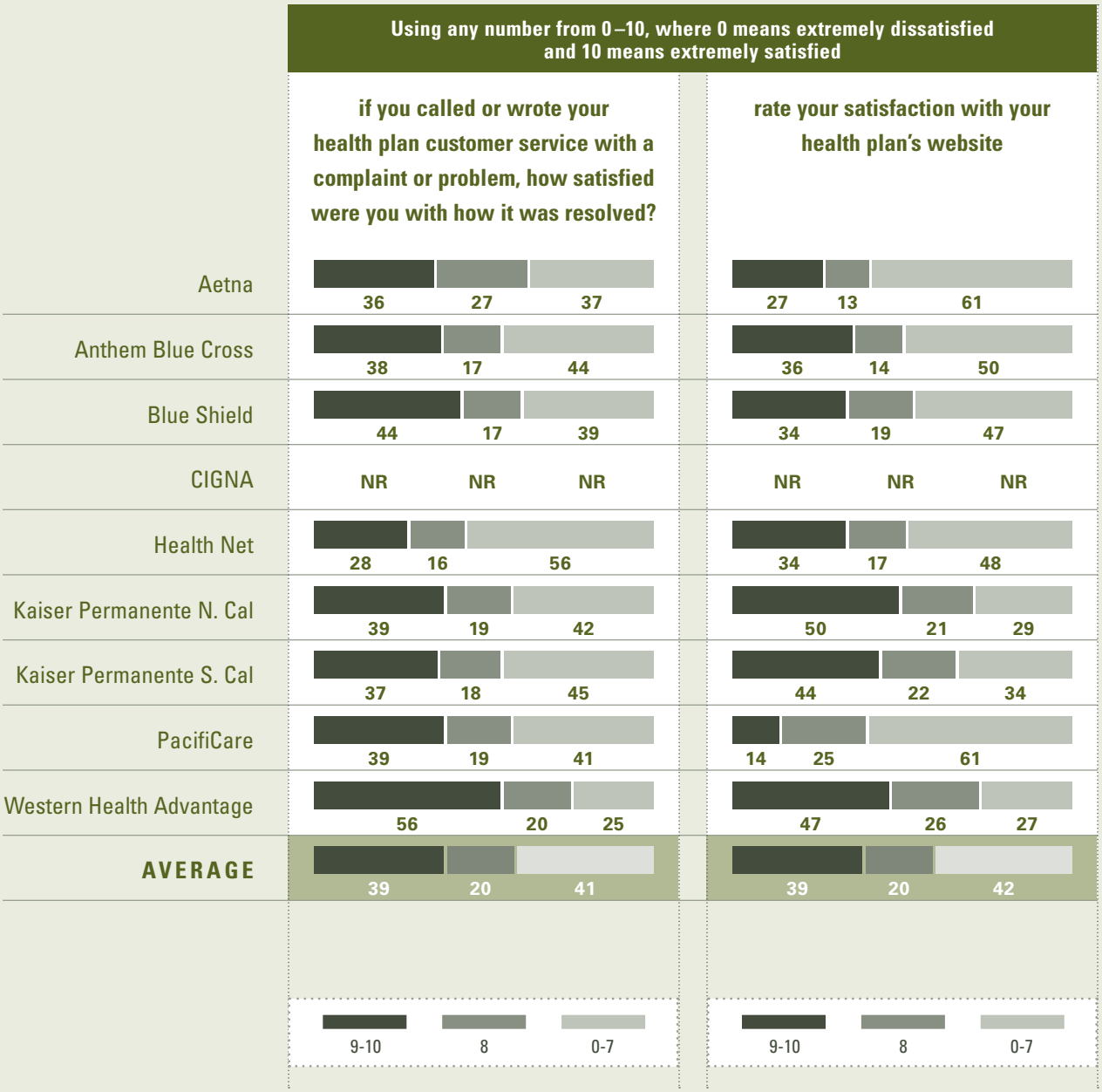
HEALTH PLAN *2 of 3*



MEMBER SURVEY

HEALTH PLAN *3 of 3*

Using any number from 0–10, where 0 means extremely dissatisfied and 10 means extremely satisfied



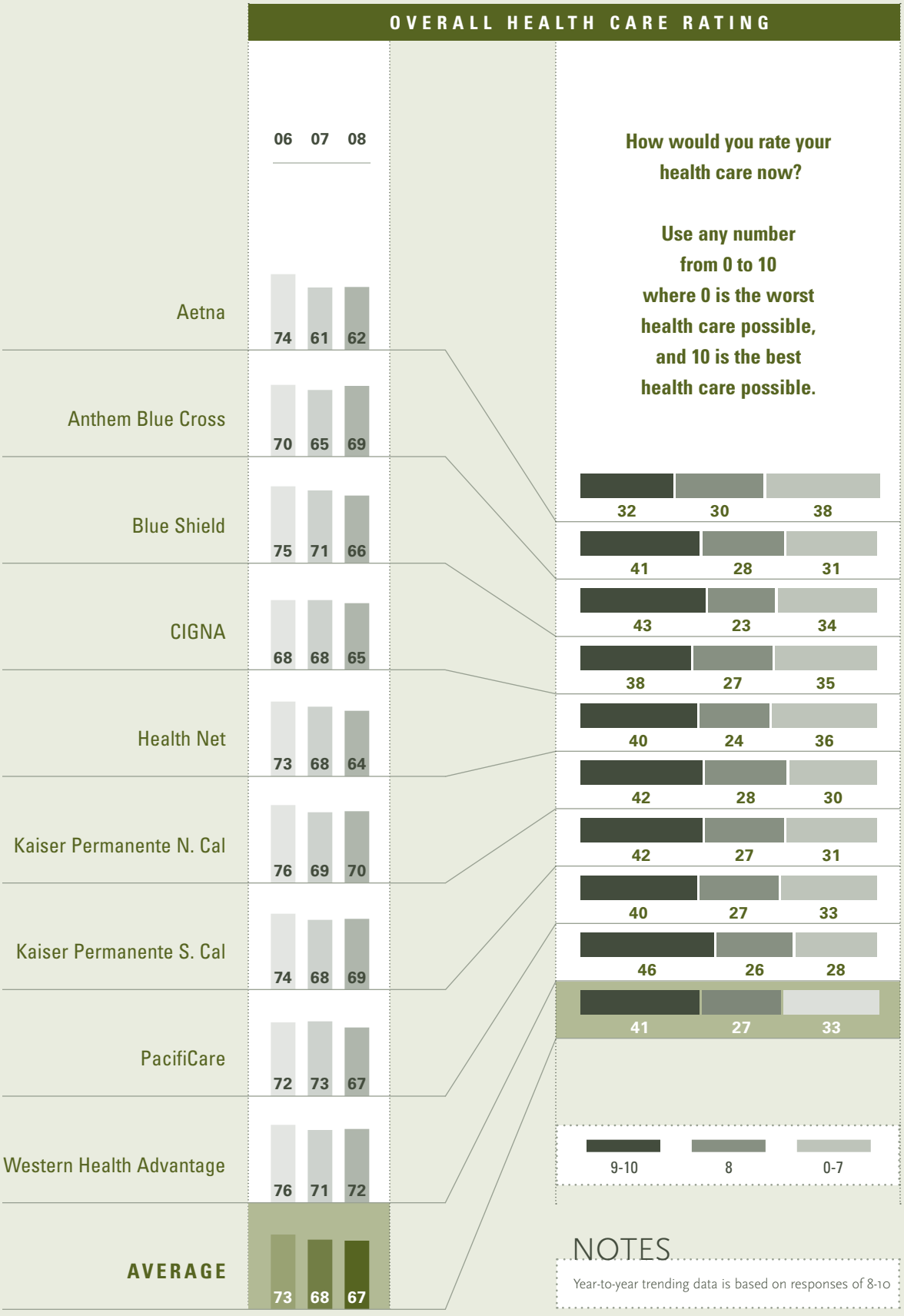
NOTES

NR - Results not available

HEALTH CARE *1 of 6*

MEMBER SURVEY

OVERALL HEALTH CARE RATING



NOTES

Year-to-year trending data is based on responses of 8-10

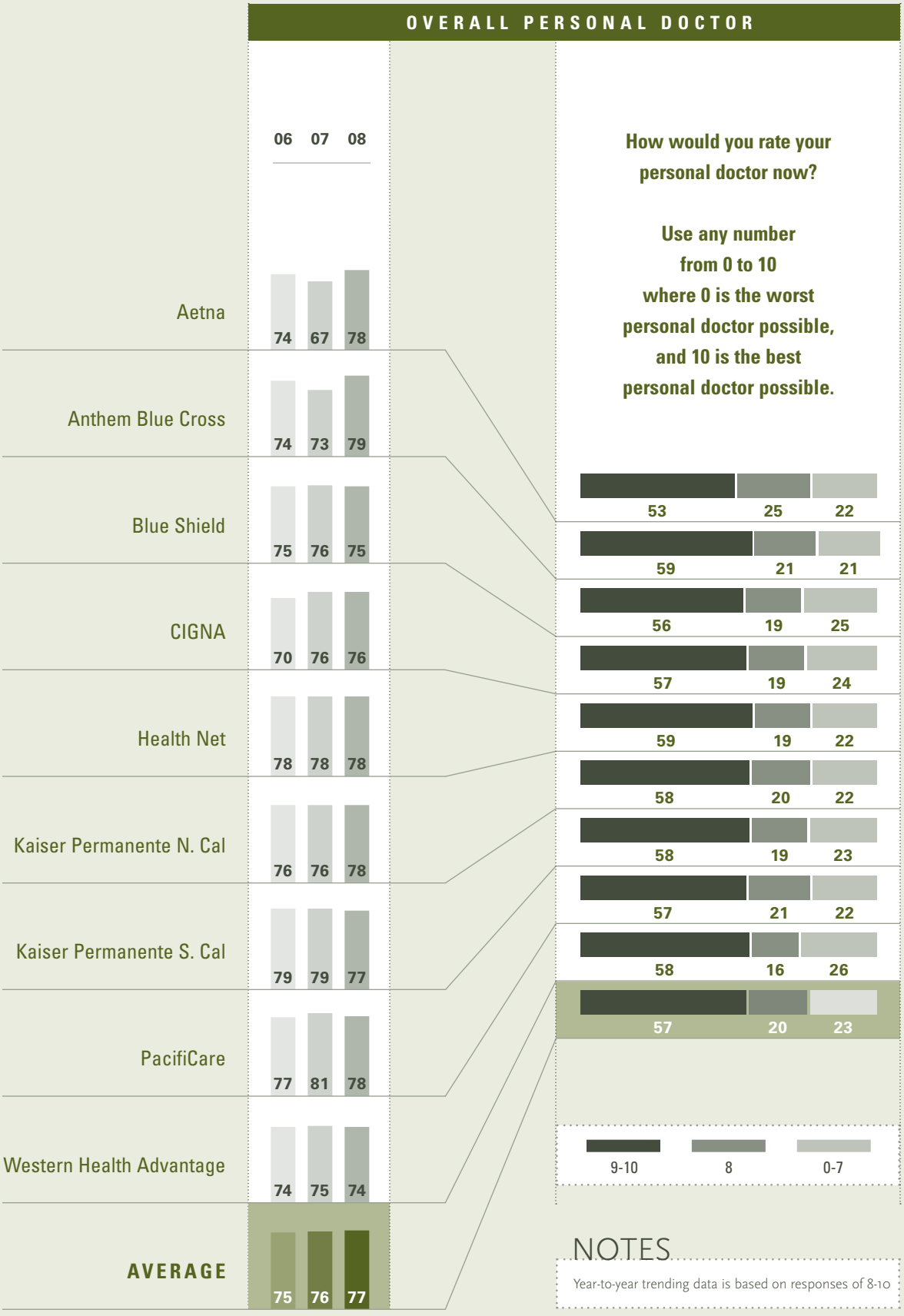
HEALTH CARE *2 of 6*

MEMBER SURVEY

OVERALL PERSONAL DOCTOR

How would you rate your personal doctor now?

Use any number from 0 to 10 where 0 is the worst personal doctor possible, and 10 is the best personal doctor possible.

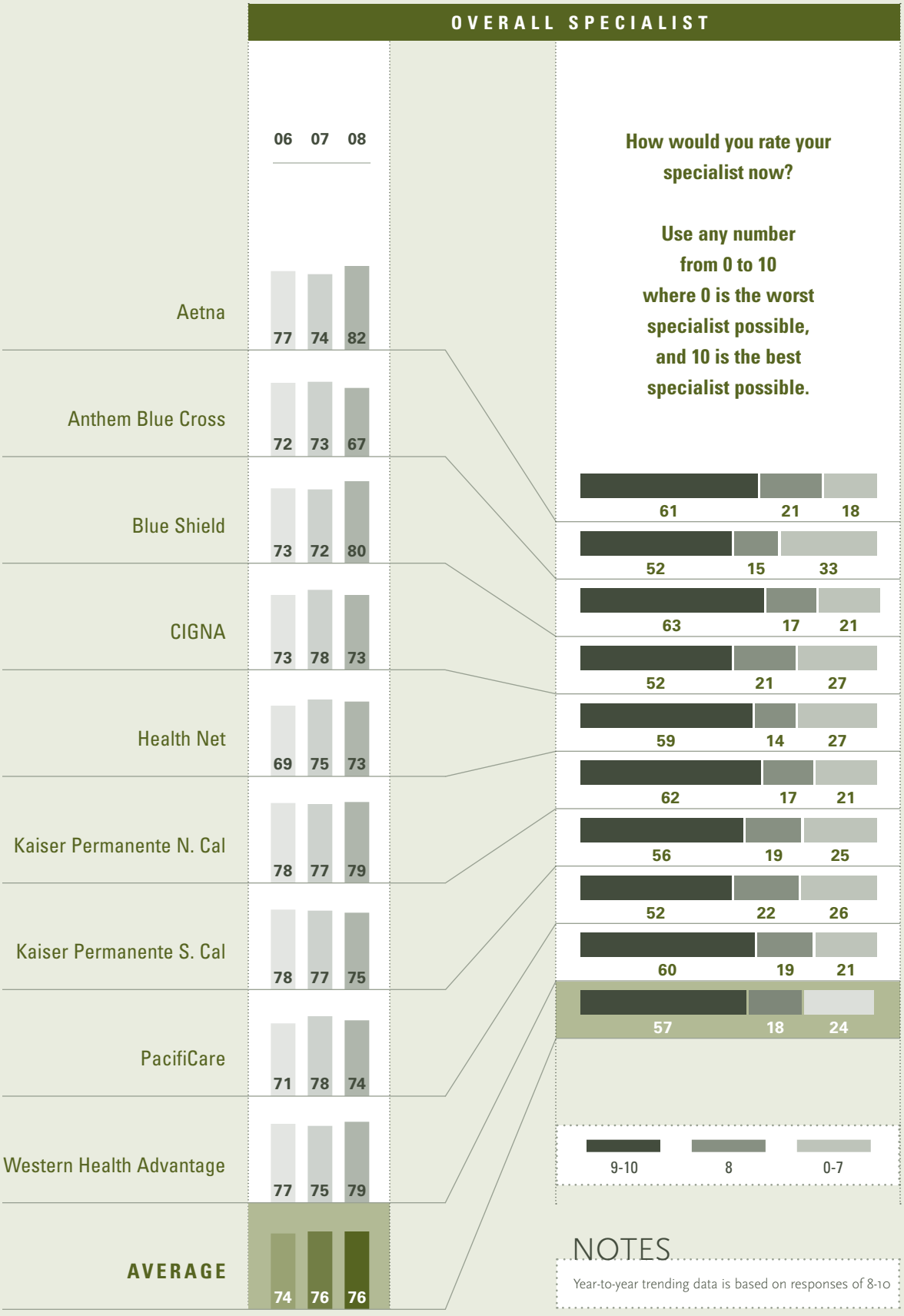


NOTES

Year-to-year trending data is based on responses of 8-10

HEALTH CARE *3 of 6*

MEMBER SURVEY

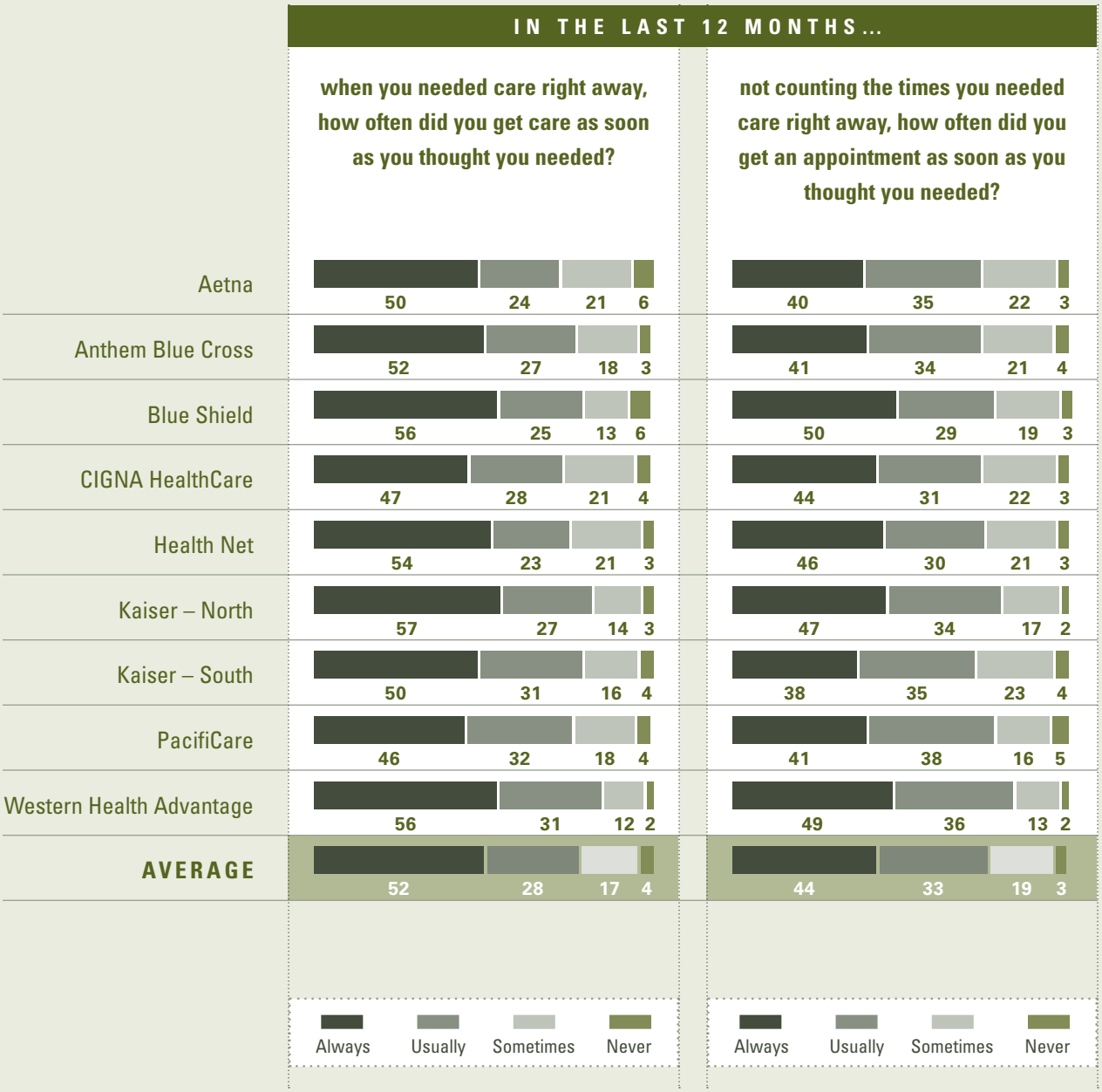


NOTES

Year-to-year trending data is based on responses of 8-10

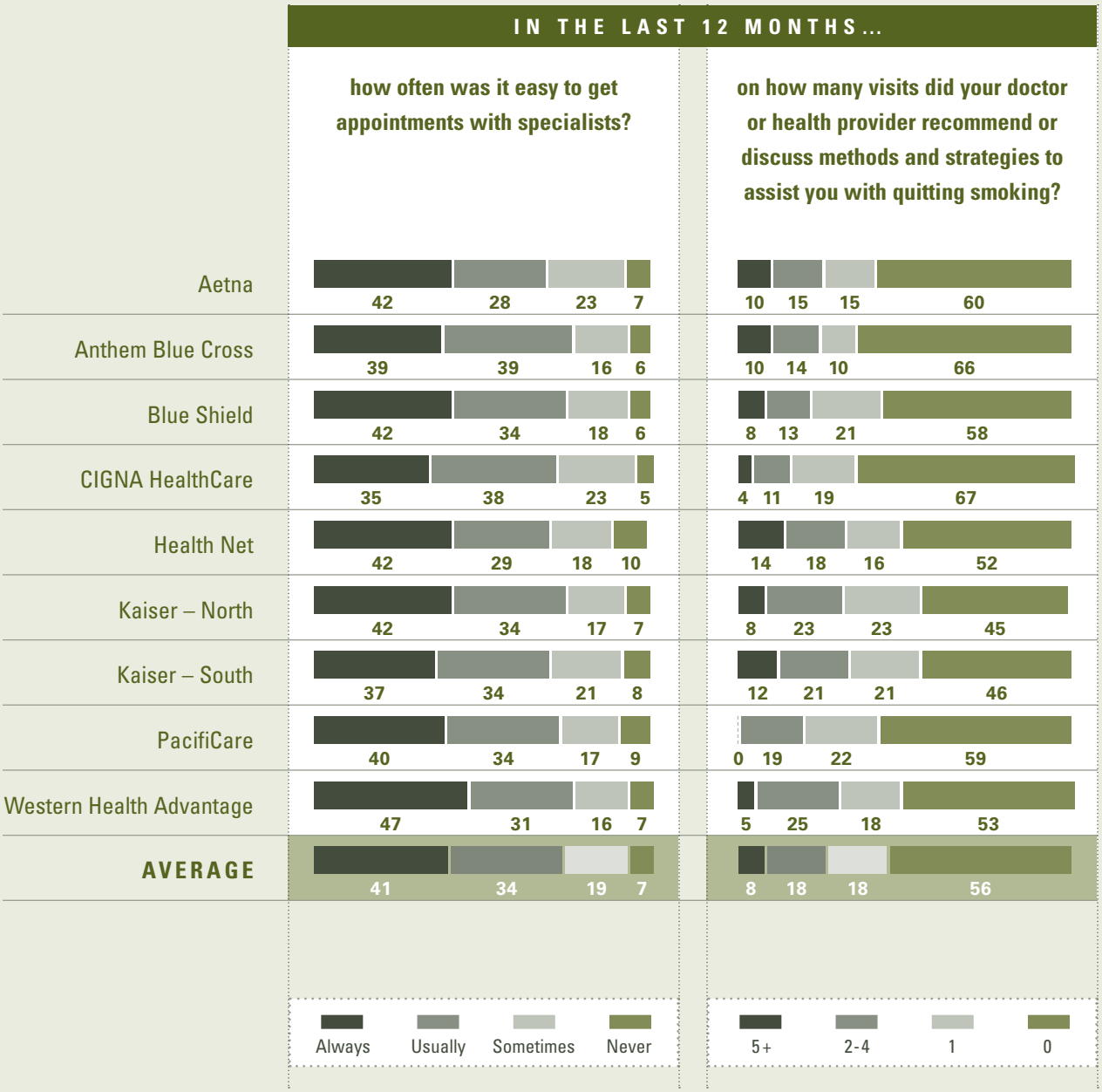
HEALTH CARE *4 of 6*

MEMBER SURVEY



HEALTH CARE *5 of 6*

MEMBER SURVEY



HEALTH CARE *6 of 6*

MEMBER SURVEY

TREND DATA INTRODUCTION

MEASURES OF EFFECTIVENESS OF CARE

Looking at results obtained over a period of several years can help evaluate whether plans are improving the way they provide care in certain clinical areas.

This chart compares health plan performance for clinical measures in the commercial population. Depending on the availability of comparable data, results are trended over two or three years. NCQA continuously improves the way performance measures are collected, and occasionally adds new measures, making it difficult to compare ratings for more than three years for specific measures.

Many year-to-year changes are small and may not be meaningful. Changes that are statistically significant are noted with a red or green arrow crossing this year's and last year's rates. In addition, longer-term meaningful changes are noted where the arrow crosses all three years of trend data and compares this year's results to the 2006 results. Changes not noted with an arrow are not meaningful and may be due to random chance.

HOW TO READ THESE GRAPHS

Not all data are required to be collected yearly. Therefore, the hollow bars in the graphs on the following pages indicate that the health plan elected to honor the NCQA rotation strategy for that measurement year and therefore the most recently available data reported by the health plan may be from the prior measurement year.

NOTES

NR – Not reported.

TREND DATA COMMERCIAL *1 of 8*

TREND DATA COMMERCIAL *2 of 8*

TREND DATA COMMERCIAL *3 of 8*

TREND DATA COMMERCIAL *4 of 8*

TREND DATA COMMERCIAL *5 of 8*

TREND DATA COMMERCIAL *6 of 8*

TREND DATA COMMERCIAL *7 of 8*

TREND DATA COMMERCIAL *8 of 8*

TREND DATA MEDICARE *1 of 5*

MEASURES OF EFFECTIVENESS OF CARE

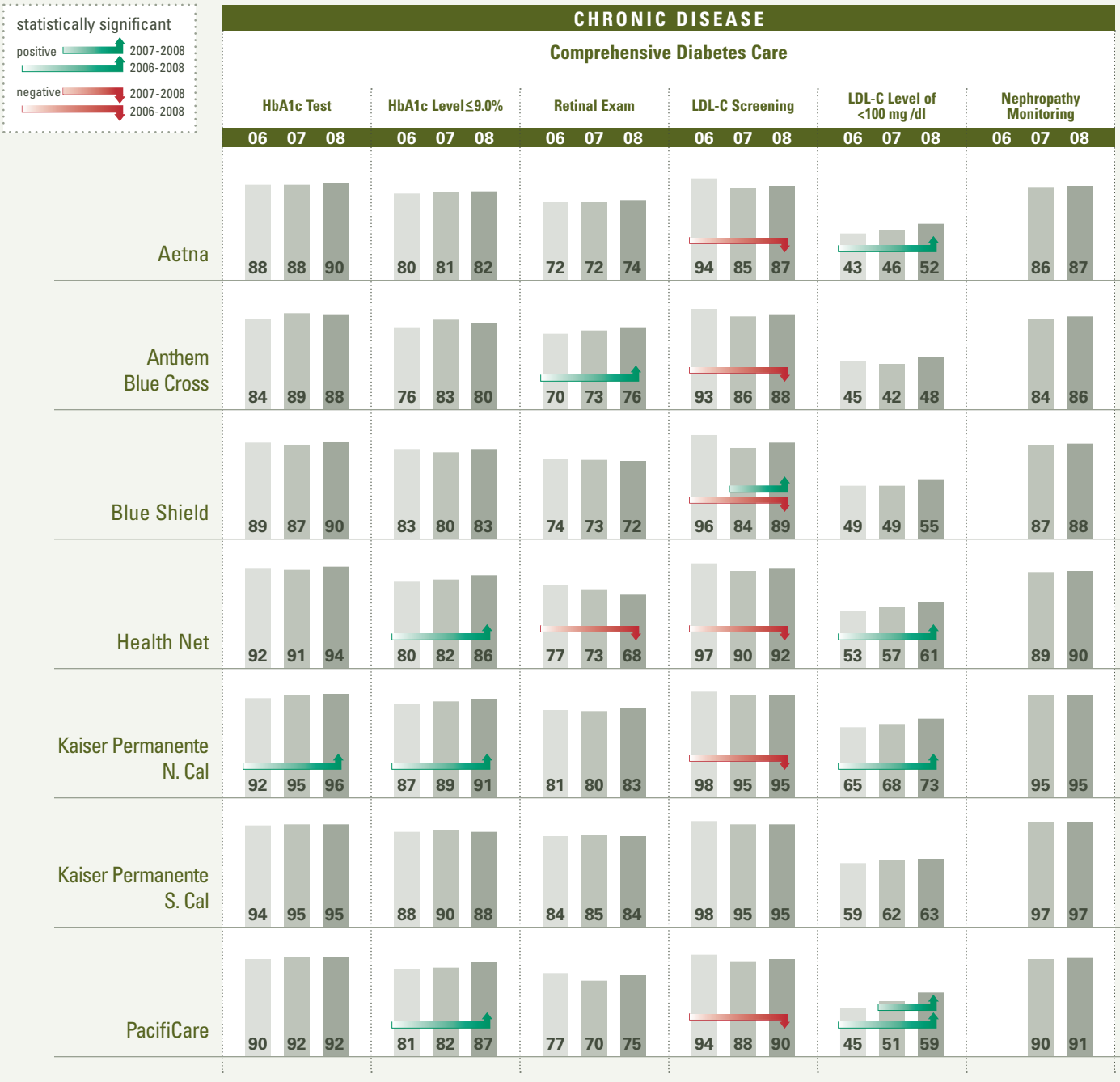
Looking at performance results obtained over a period of several years can help evaluate whether plans are improving the way they provide care in certain clinical areas.

The trend charts on the next few pages compare health plan performance for clinical and service measures for the Medicare population.

Several of the measures contain more than one rate. Depending on the availability of comparable data, results are trended over two or three years. NCQA continuously improves the way performance measures are collected, and occasionally adds new measures, making it difficult to compare ratings for more than three years for specific measures.

Many year-to-year changes are small and may not be meaningful. Changes that are statistically significant are noted with a red or green arrow crossing this year's and last year's rates. In addition, longer-term meaningful changes are noted where the arrow crosses all three years of trend data and compares this year's results to the 2006 and/or 2007 results. Changes not noted with an arrow are not meaningful and may be due to random chance.

TREND DATA MEDICARE *2 of 5*



TREND DATA MEDICARE *3 of 5*

TREND DATA MEDICARE *4 of 5*

TREND DATA MEDICARE *5 of 5*

ABOUT THE SURVEYS

Other sections of this Report help consumers understand the role of health plans in assuring that patients receive good medical care. However, it is also important for consumers to know whether medical groups or IPAs provide good access to medical treatment, how well physicians communicate with patients, and whether physicians are coordinating a patient's care.

For the seventh year in a row, CCHRI administered a patient experience survey at the physician group-level. The 2008 Patient Assessment Survey (PAS) is derived from the clinician-group CAHPS survey, which has been endorsed by the National Quality Forum as the national standard survey for assessing patient experience with care.

This Report summarizes the findings of the 2008 PAS. The results presented in the following tables show overall ratings of care and composite measures of performance. Composite measures are created by combining information from questions that measure similar aspects of care. For example, the doctor-patient interaction composite included questions on whether the doctor listened carefully, explained things clearly, and treated the patient with respect. For information about patient responses to individual questions that comprise the composite measures, please go to www.cchri.org where the full report is available.

CCHRI was able to implement the 2008 PAS because of the financial support and assistance from participating physician groups and the following health plans:

Aetna Health of California
Anthem Blue Cross
Blue Shield of California
CIGNA
Health Net of California
Kaiser Permanente Northern California
Kaiser Permanente Southern California
Pacificare, a UnitedHealthcare Company
Western Health Advantage

PATIENT ASSESSMENT SURVEY

The 2008 Patient Assessment Survey (PAS) evaluated patients' experience with the care they received from 148 distinct medical groups and IPAs in Northern and Southern California (this represents 186 reporting units). These physician groups ranged in size from 2,500 to 2.8 million members. The results were calculated from 62,122 individual patients who responded to the survey, for an overall response rate of 36.6%. Participating physician groups agree to publicly report the results from the survey, and the results are used to determine payouts for the statewide Integrated Healthcare Association's pay-for-performance program that 7 of the 9 plans are participating in.

HMO and POS adult patients enrolled in the 148 medical groups and IPAs participating in the survey were asked to evaluate the following aspects of their care experience:

- Overall ratings of their Primary Care Physician (PCP), specialist, and all care revceived from providers
- Interactions between the patient and physician (i.e., communication)
- Access to primary and specialty care for urgent and nonturgent situations
- Interactions with the office staff
- Counseling on preventive care topics, such as diet, nutrition and exercise.

Nine hundred adults (ages 18 and older) who had a minimum of one visit in the prior year (2007) were randomly selected (450 with PCP encounters and 450 with specialist encounters) from each physician group to participate in the survey. The PAS survey was mailed and made available for completion via the internet, with phone-follow-up interviews for those that did not respond via the internet or mailed copies of the survey.

AFTER HOURS ACCESS SURVEY

In order to supplement important access information obtained from the Patient Assessment Survey, CCHRI also conducted an after-hours telephone survey of physicians' offices. This Provider Telephone Access Survey focused on the same primary care physicians associated with the medical groups and IPAs participating in the PAS. An impartial research firm used a CCHRI-developed telephone interview survey to assess whether office recordings and answering services offer appropriate information to after-hours callers experiencing a medical emergency or urgent care need.

CCHRI asked participating medical groups and IPAs to assist with the provider survey by supplying contact information and telephone numbers for their primary care physicians. Fifty PCP offices were randomly selected from each provider organization. Results obtained from these phone calls are included, side-by-side, in the same tables that contain results for the access to care questions from the Patient Assessment Survey.

Results for the after-hours phone calls are shown as percentage scores. Calculations were made based on the total number of interviews completed and the total number of appropriate responses.

HOW TO READ THESE GRAPHS

Responses included in a composite measure are combined to obtain a single mean score and items are weighted equally. Scores are computed as a mean value, based on a 100 point scale. Most questions are based on a six-item response choice set; however, the overall rating items used a 0-10 rating scale. Each physician group's score has been case-mix adjusted to account for differences across groups in the mix of their patient populations (i.e., age, sex, race/ethnicity-language spoken, specialty type, language survey was completed in, response mode, specialty type of physician, mental health status, functional health status, body mass index, and presence of chronic conditions).

Each group's mean score is compared to the overall statewide mean score and statistically significant results above or below the statewide average are displayed by arrows. ▲▼

When reviewing the results, please compare each group's score to the statewide average and not to the scores of other individual groups.

NOTES

✱ – Reliability threshold not met.

ϕ – Physician group declined to participate in After Hours Survey.

NORTHERN CALIFORNIA *1 of 4*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY				
	Rating of Overall Health Care	Rating of Personal Doctor	Rating of Specialist	Coordination of Care	Doctor-Patient Interactions
Affinity Medical Group	86 ▲	86	88	75	90
AllCare IPA	85	85	85	76	88
Alta Bates Medical Group	84	87	88	76	90
Bay Valley Medical Group	84	86	88	76	88
Brown & Toland Medical Group	84	86	88 ▲	74	88
Camino Medical Group	87 ▲	92 ▲	90 ▲	84 ▲	93 ▲
Central Valley Medical Group	87 ▲	89	89 ▲	79 ▲	91 ▲
Chinese Community Health Care Assoc.	83	86	*	71 ▼	84 ▼
Golden State Physicians Medical Group	80 ▼	81 ▼	82 ▼	70 ▼	85 ▼
Hill Physicians Medical Grp - East Bay	86	88	84	80 ▲	90
Hill Physicians Medical Grp - Sacramento	84	85	87	73	89
Hill Physicians Medical Grp - San Francisco	87 ▲	89	89 ▲	77	91 ▲
Hill Physicians Medical Grp - San Joaquin	86	84	86	74	88
Hill Physicians Medical Grp - Solano	86	86	88	75	89
Hill Physicians Medical Grp (Rollup)	85 ▲	86	86	75	89 ▲
Humboldt-Del Norte IPA	85	87	89 ▲	80 ▲	91 ▲
John Muir Physician Network	87 ▲	89	89 ▲	79 ▲	91 ▲
Kaiser Permanente - Central Valley	83	86	88	77	88
Kaiser Permanente - Diablo	84	86	88	78	88
Kaiser Permanente - Fresno	85	89	86	80 ▲	90
Kaiser Permanente - Greater Southern Alameda	85	87	89 ▲	81 ▲	90
Kaiser Permanente - Napa Solano	85	88	90 ▲	80 ▲	90 ▲
Kaiser Permanente - North Valley	84	86	85	78	88
Kaiser Permanente - Oakland/Richmond	84	88	87	78	89
Kaiser Permanente - Redwood City	85	87	87	80 ▲	90
Kaiser Permanente - San Francisco	85	89	88	81 ▲	90
Kaiser Permanente - San Rafael	83	86	87	80 ▲	89
Kaiser Permanente - Santa Clara	85	88	91 ▲	80 ▲	90 ▲
Kaiser Permanente - Santa Rosa	85	89	88	81 ▲	90
Kaiser Permanente - Santa Teresa	86 ▲	88	90 ▲	79 ▲	90
Kaiser Permanente - South Sacramento	83	87	89 ▲	79 ▲	90
Kaiser Permanente - South San Francisco	83	84 ▼	88	79 ▲	89
Kaiser Permanente (Rollup)	84	87	88 ▲	79 ▲	89 ▲
Key Medical Group, Inc.	83	85	86	77	89
Marin IPA	86 ▲	90 ▲	88	80 ▲	91 ▲
Medcore Medical Group/Omni IPA	87 ▲	87	87	73	90
Mercy Medical Group	85	88	88 ▲	78	91 ▲
Mills-Peninsula Medical Group	85	89	86	76	90
NorthBay Healthcare	84	89	85	72 ▼	89
Palo Alto Medical Foundation	88 ▲	91 ▲	85	83 ▲	91 ▲
Physicians Integrated Medical Group, Inc	83	85	88	74	89
Physicians Medical Group of San Jose	85	84	*	74	87
CALIFORNIA STATEWIDE AVERAGE	**84**	**87**	**85**	**75**	**88**

NORTHERN CALIFORNIA *2 of 4*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY				
	Rating of Overall Health Care	Rating of Personal Doctor	Rating of Specialist	Coordination of Care	Doctor-Patient Interactions
Physicians Medical Group Of Santa Cruz	83	85	86	78	88
San Jose Medical Group	85	87	85	77	88
Santa Clara County IPA	84	85	85	75	88
Santa Cruz Medical Foundation	84	89 ▲	86	79 ▲	91 ▲
Sante Community Physicians IPA	83	86	79 ▼	72 ▼	84 ▼
Sierra Nevada Medical Associates	84	86	87	79 ▲	90 ▲
Solano Regional Medical Group	85	88	86	79 ▲	88
Sonoma County Primary Care IPA	86 ▲	88	84	81 ▲	90 ▲
Sutter Delta Medical Group	87 ▲	88	90 ▲	79 ▲	92 ▲
Sutter Gould Medical Foundation	86 ▲	90 ▲	86	78	90
Sutter Independent Physicians	85	82 ▼	88 ▲	75	87
Sutter Medical Group	87 ▲	88	89 ▲	79 ▲	90
Sutter Medical Group of the Redwoods	88 ▲	90 ▲	87	82 ▲	91 ▲
Sutter West Medical Group	87 ▲	92 ▲	89 ▲	81 ▲	91 ▲
UC Davis Health System	85	90 ▲	87	77	90
Woodland Clinic Medical Group	87 ▲	90 ▲	88	82 ▲	91 ▲
CALIFORNIA STATEWIDE AVERAGE	**84**	**87**	**85**	**75**	**88**

NORTHERN CALIFORNIA *3 of 4*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY		AFTER HOURS
	Office Staff Interactions	Patient Access	Emergency Instructions
Affinity Medical Group	86	78 ▲	84
AllCare IPA	85	74	76 ▼
Alta Bates Medical Group	85	76	ϕ
Bay Valley Medical Group	85	77	88 ▲
Brown & Toland Medical Group	84	78 ▲	100 ▲
Camino Medical Group	89 ▲	79 ▲	100
Central Valley Medical Group	86	77 ▲	92 ▲
Chinese Community Health Care Assoc.	84	74	98 ▲
Golden State Physicians Medical Group	82	75	98
Hill Physicians Medical Grp - East Bay	88 ▲	79 ▲	90
Hill Physicians Medical Grp - Sacramento	85	77 ▲	90
Hill Physicians Medical Grp - San Francisco	88 ▲	80 ▲	90
Hill Physicians Medical Grp - San Joaquin	86	77 ▲	90
Hill Physicians Medical Grp - Solano	86	75	90
Hill Physicians Medical Grp (Rollup)	87 ▲	78 ▲	90
Humboldt-Del Norte IPA	88 ▲	79 ▲	94
John Muir Physician Network	86	78 ▲	94 ▲
Kaiser Permanente - Central Valley	87 ▲	79 ▲	100 ▲
Kaiser Permanente - Diablo	85	76	100 ▲
Kaiser Permanente - Fresno	86	78 ▲	100 ▲
Kaiser Permanente - Greater Southern Alameda	85	78 ▲	100 ▲
Kaiser Permanente - Napa Solano	85	77 ▲	100 ▲
Kaiser Permanente - North Valley	85	77 ▲	100 ▲
Kaiser Permanente - Oakland/Richmond	84	77 ▲	100 ▲
Kaiser Permanente - Redwood City	87 ▲	79 ▲	100 ▲
Kaiser Permanente - San Francisco	85	79 ▲	100 ▲
Kaiser Permanente - San Rafael	85	79 ▲	100 ▲
Kaiser Permanente - Santa Clara	85	79 ▲	100 ▲
Kaiser Permanente - Santa Rosa	85	77 ▲	100 ▲
Kaiser Permanente - Santa Teresa	85	78 ▲	100 ▲
Kaiser Permanente - South Sacramento	85	77 ▲	100 ▲
Kaiser Permanente - South San Francisco	86	77	100 ▲
Kaiser Permanente (Rollup)	85 ▲	78 ▲	100 ▲
Key Medical Group, Inc.	85	75	98
Marin IPA	90 ▲	80 ▲	90
Medcore Medical Group/Omni IPA	85	77	ϕ
Mercy Medical Group	84	75	83
Mills-Peninsula Medical Group	85	79 ▲	93 ▼
NorthBay Healthcare	85	75	64 ▲
Palo Alto Medical Foundation	89 ▲	80 ▲	98
Physicians Integrated Medical Group, Inc	85	75	94 ▲
Physicians Medical Group of San Jose	85	77	98
CALIFORNIA STATEWIDE AVERAGE	**84**	**74**	**94**

NORTHERN CALIFORNIA *4 of 4*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY		AFTER HOURS
	Office Staff Interactions	Patient Access	Emergency Instructions
Physicians Medical Group Of Santa Cruz	84	75	90
San Jose Medical Group	85	75	ϕ
Santa Clara County IPA	86	77 ▲	94
Santa Cruz Medical Foundation	84	72 ▼	85
Sante Community Physicians IPA	83	73	94
Sierra Nevada Medical Associates	88 ▲	80 ▲	84
Solano Regional Medical Group	86	74	100 ▲
Sonoma County Primary Care IPA	90 ▲	83 ▲	100 ▲
Sutter Delta Medical Group	90 ▲	81 ▲	92
Sutter Gould Medical Foundation	87 ▲	77 ▲	100 ▲
Sutter Independent Physicians	87 ▲	78 ▲	92
Sutter Medical Group	87 ▲	80 ▲	88
Sutter Medical Group of the Redwoods	86	80 ▲	88
Sutter West Medical Group	88 ▲	79 ▲	100 ▲
UC Davis Health System	83	75	88
Woodland Clinic Medical Group	87 ▲	79 ▲	100 ▲
CALIFORNIA STATEWIDE AVERAGE	**84**	**74**	**94**

SOUTHERN CALIFORNIA *1 of 8*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY				
	Rating of Overall Health Care	Rating of Personal Doctor	Rating of Specialist	Coordination of Care	Doctor-Patient Interactions
Affiliated Doctors of Orange County	83	86	83	73	86 ▼
Alamitos IPA	83	84 ▼	86	72	85 ▼
All Care Medical Group	84	87	*	69 ▼	85 ▼
Alliance Physicians	79 ▼	82 ▼	81 ▼	66 ▼	83 ▼
Alliance Physicians Medical Groups	83	86	85	73	88
Allied Physicians of California	82	83 ▼	83	71 ▼	85 ▼
AltaMed Health Services	81 ▼	90	*	72	87
AMVI Medical Group	80 ▼	*	*	70 ▼	83 ▼
Anaheim Memorial IPA	83	86	83	71 ▼	86 ▼
Antelope Valley/Pegasus Medical Group	79 ▼	74 ▼	87	71 ▼	84 ▼
AppleCare Medical Group - Downey	83	87	84	72	87
AppleCare Medical Group - St. Francis	80 ▼	83 ▼	* ▼	69 ▼	84 ▼
Axminster Medical Group, Inc.	82	85	83	70 ▼	85 ▼
Bakersfield Family Medical Center	81 ▼	85	82 ▼	72	86 ▼
Bay Area Community Medical Group	84	88	80 ▼	75	85 ▼
Beaver Medical Group	86 ▲	89	86	77	89
Bright Medical Associates	85	87	88	76	89
Bristol Park Medical Group	86 ▲	92 ▲	83	79 ▲	90
Cedars-Sinai Health Associates	84	88	83	76	88
Cedars-Sinai Medical Group	86 ▲	88	88	80 ▲	90
Centinela Valley IPA	80 ▼	* ▼	86	67 ▼	86
Centre For Health Care Medical Associate	84	88	84	77	88
Choice Medical Group	77 ▼	81 ▼	82 ▼	64 ▼	83 ▼
Citrus Valley Physicians Group	78 ▼	* ▼	* ▼	62 ▼	80 ▼
Community Medical Grp of the West Valley	81 ▼	84	80 ▼	68 ▼	84 ▼
Desert Oasis Healthcare	80 ▼	86	81 ▼	73	86 ▼
Eastland Medical Group IPA	81 ▼	84	82 ▼	71 ▼	84 ▼
Edinger Medical Group	87 ▲	93 ▲	85	78	90 ▲
Empire Physicians Medical Group	78 ▼	*	78 ▼	64 ▼	83 ▼
Encompass Family Physicians MG	83	85	*	78	88
Facey Medical Group	82	84 ▼	84	68 ▼	85 ▼
Family Care Specialists Medical Group	83	*	*	72	90
Family Practice MG of San Bernardino	87 ▲	86	89 ▲	78	90
Gateway Medical Group, Inc.	82	88	80 ▼	72 ▼	86
GEMCare	83	89	79 ▼	75	86
Genesis Healthcare	85	90 ▲	81 ▼	74	89
Glendale Physicians Alliance	81 ▼	85	81 ▼	66 ▼	84 ▼
Good Samaritan Medical Practice Association	84	86	*	71	89
Greater Covina Medical Group	82	87	83	75	88
CALIFORNIA STATEWIDE AVERAGE	**84**	**87**	**85**	**75**	**88**

SOUTHERN CALIFORNIA *2 of 8*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY				
	Rating of Overall Health Care	Rating of Personal Doctor	Rating of Specialist	Coordination of Care	Doctor-Patient Interactions
Greater Newport Physicians Medical Group	87 ▲	88	85	78	90
Greater Tri-Cities IPA	80 ▼	80 ▼	85	72	85 ▼
HealthCare Partners IPA	82	85	84	75	86
HealthCare Partners Medical Group	86	89	88	78 ▲	89
High Desert Medical Group	79 ▼	84 ▼	79 ▼	69 ▼	83 ▼
High Desert Medical Group (Rollup)	77 ▼	81 ▼	78 ▼	67 ▼	82 ▼
High Desert MG - California Desert IPA	76 ▼	77 ▼	76 ▼	64 ▼	80 ▼
High Desert MG - Heritage Victor Valley	76 ▼	78 ▼	78 ▼	65 ▼	81 ▼
High Desert Primary Care Medical Group	81 ▼	87	83	70 ▼	86
Imperial County Physicians Medical Group	83	87	*	70 ▼	89
Inland HealthCare Group	84	84	86	67 ▼	87
Lakeside Medical Group, Inc.	81 ▼	87	84	73	88
Lakewood Health Plan Inc.	84	86	81 ▼	71 ▼	84 ▼
Loma Linda University Health Care	85	89	87	74	88
Memorial HealthCare (Rollup)	85	89 ▲	85	78 ▲	89
Memorial HealthCare IPA - Long Beach	85	89	85	78	89
Mercy Physicians Medical Group, Inc.	86 ▲	86	87	79 ▲	89
MidCoast Care Inc.	84	86	88	75	89
Mid-County Physicians Medical Group	84	87	85	80 ▲	89
Mission Hospital Affiliated Physicians	83	80 ▼	88	75	87
Monarch HealthCare	83	88	81 ▼	75	87
Multi-Cultural Primary Care Medical Group	81 ▼	85	80 ▼	70 ▼	85 ▼
Noble AMA IPA	83	84	*	74	87
Northridge Medical Group	82	84 ▼	82 ▼	69 ▼	86 ▼
Nuestra Familia Medical Group, Inc.	81 ▼	82 ▼	* ▼	67 ▼	84 ▼
Ojai Valley Community Medical Group	85	90 ▲	84	80 ▲	89
OmniCare Medical Group	82	85	*	74	88
Orange Coast Memorial IPA	87 ▲	91 ▲	88	79 ▲	91 ▲
Pacific Independent Physician Assoc.	82 ▼	86	86	76	88
Phys. Assoc. of Gr. San Gabriel Valley	83	87	83	70 ▼	87
Physicians' Healthways IPA	80 ▼	82 ▼	*	70 ▼	84 ▼
Pinnacle Medical Group	83	83 ▼	*	76	86 ▼
Pioneer Medical Group, Inc	87 ▲	86	89 ▲	77	90
Premier Physician Network	81 ▼	83 ▼	82 ▼	70 ▼	85 ▼
Presbyterian Health Physicians	84	86	85	72	87
Primary Care Associated Medical Group	85	87	87	78	87
PrimeCare Medical Network	82 ▼	85	80 ▼	71 ▼	85 ▼
ProMed Health Network of Pomona Valley	85	88	84	73	87
Prospect Healthsource Medical Group, Inc	81 ▼	87	*	69 ▼	87
Prospect Medical Group	82 ▼	86	79 ▼	70 ▼	84 ▼
Prospect Northwest Orange County MG	82	84	82 ▼	68 ▼	85 ▼
Prospect Professional Care Medical Group	82	87	82	71 ▼	87
CALIFORNIA STATEWIDE AVERAGE	**84**	**87**	**85**	**75**	**88**

SOUTHERN CALIFORNIA *3 of 8*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY				
	Rating of Overall Health Care	Rating of Personal Doctor	Rating of Specialist	Coordination of Care	Doctor-Patient Interactions
Redlands Yucaipa Medical Group	82	83 ▼	83	72	85 ▼
Regal Medical Group	83	86	84	69 ▼	87
Riverside Medical Clinic	83	87	87	75	89
Riverside Physician Network	84	90 ▲	78 ▼	72	86
S. Cal Permanente Medical Group (Rollup)	85 ▲	89 ▲	88 ▲	75	90 ▲
S. Cal Permanente Medical Group Baldwin Park	84	89	87	73	90
S. Cal Permanente Medical Group Bellflower	86	91 ▲	90 ▲	77	93 ▲
S. Cal Permanente Medical Group Fontana	85	89	89	77	92 ▲
S. Cal Permanente Medical Group Kern County	83	82 ▼	85	71 ▼	86
S. Cal Permanente Medical Group Los Angeles	87 ▲	87	90 ▲	78	93 ▲
S. Cal Permanente Medical Group Orange County	85	90 ▲	86	73	90
S. Cal Permanente Medical Group Panorama	83	87	85	68 ▼	86
S. Cal Permanente Medical Group Riverside	86	89	89 ▲	78	90 ▲
S. Cal Permanente Medical Group San Diego	82	89	87	73	90
S. Cal Permanente Medical Group South Bay/Harbor City	87 ▲	88	92 ▲	78	91 ▲
S. Cal Permanente Medical Group West Los Angeles	84	91 ▲	87	75	90
S. Cal Permanente Medical Group Woodland Hills	86	88	89 ▲	77	91 ▲
San Bernardino Medical Group	87 ▲	92 ▲	89 ▲	80 ▲	92 ▲
San Diego Physicians Medical Group	84	84 ▼	84	74	87
San Luis Obispo Select IPA	81 ▼	83 ▼	84	74	86 ▼
Sansum Clinic	84	89	84	79 ▲	89
Santa Barbara Select IPA	86 ▲	87	89 ▲	81 ▲	90 ▲
Scripps Clinic Medical Group	87 ▲	89	91 ▲	80 ▲	92 ▲
Scripps Clinic Penn Elm Medical Group	88 ▲	92 ▲	90 ▲	79 ▲	93 ▲
Scripps Mercy Medical Group	87 ▲	91 ▲	87	82 ▲	91 ▲
SeaView IPA	82	84 ▼	87	73	87
Sharp Community Med Grp - Chula Vista	85	88	86	71 ▼	89
Sharp Community Med Grp - Coronado	86 ▲	88	87	76	89
Sharp Community Med Grp - Graybill	84	91 ▲	84	82 ▲	90
Sharp Community Med Grp - Grossmont	85	88	84	77	88
Sharp Community Med Grp - Inland North	85	88	86	80 ▲	90
Sharp Community Med Grp - Metro San Diego	84	86	84	78	87
Sharp Community Med Grp (Rollup)	85 ▲	88	85	77 ▲	88
Sharp Mission Park Medical Group	85	90 ▲	85	79 ▲	89
Sharp Rees-Stealy Medical Centers	88 ▲	91 ▲	90 ▲	80 ▲	92 ▲
Sierra Medical Group	79 ▼	86	80 ▼	64 ▼	85 ▼
St. Joseph Heritage Medical Group	86 ▲	88	87	75	90
St. Joseph Hospital Affil. Physicians	85	88	88	76	90
St. Jude Heritage Medical Group	87 ▲	91 ▲	87	80 ▲	90 ▲
St. Jude Hospital Affiliated Physicians	85	85	89 ▲	76	89
St. Mary IPA - Lakewood Health Plan	84	87	87	70 ▼	88
CALIFORNIA STATEWIDE AVERAGE	**84**	**87**	**85**	**75**	**88**

SOUTHERN CALIFORNIA *4 of 8*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY				
	Rating of Overall Health Care	Rating of Personal Doctor	Rating of Specialist	Coordination of Care	Doctor-Patient Interactions
St. Vincent IPA	83	86	84	72	88
Talbert Medical Group	84	87	87	77	90
The Industry Health Network	* ▲	*	*	76	88
Torrance Hospital IPA	85	87	83	74	87
UCLA Medical Group	85	90 ▲	85	76	91 ▲
UCSD Healthcare Network	85	91 ▲	85	76	89
United Family Care	79 ▼	86	* ▼	72	84 ▼
Universal Care Medical Group	80 ▼	80 ▼	*	70 ▼	83 ▼
Upland Medical Group	82	85	82	67 ▼	87
Valley Care IPA	87 ▲	91 ▲	84	80 ▲	90
Verdugo Hills Medical Group	84	89	84	76	88
West Covina Medical Clinic	76 ▼	82 ▼	79 ▼	60 ▼	82 ▼
CALIFORNIA STATEWIDE AVERAGE	84	87	85	75	88

SOUTHERN CALIFORNIA *5 of 8*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY		AFTER HOURS
	Office Staff Interactions	Patient Access	Emergency Instructions
Affiliated Doctors of Orange County	83	75	96
Alamitos IPA	85	76	98
All Care Medical Group	78 ▼	69 ▼	ϕ
Alliance Physicians	78 ▼	64 ▼	93
Alliance Physicians Medical Groups	82 ▼	73	98 ▲
Allied Physicians of California	81 ▼	71 ▼	ϕ
AltaMed Health Services	78 ▼	67 ▼	ϕ
AMVI Medical Group	78 ▼	71 ▼	96
Anaheim Memorial IPA	84	74	90
Antelope Valley/Pegasus Medical Group	82	75	ϕ
AppleCare Medical Group - Downey	85	71 ▼	94
AppleCare Medical Group - St. Francis	80 ▼	72	96
Axminster Medical Group, Inc.	80 ▼	68 ▼	100 ▲
Bakersfield Family Medical Center	85	73	96
Bay Area Community Medical Group	82 ▼	70 ▼	80 ▼
Beaver Medical Group	87 ▲	75	ϕ
Bright Medical Associates	85	71 ▼	100 ▲
Bristol Park Medical Group	85	77 ▲	100 ▲
Cedars-Sinai Health Associates	84	72	ϕ
Cedars-Sinai Medical Group	81 ▼	73	ϕ
Centinela Valley IPA	83	69 ▼	93
Centre For Health Care Medical Associate	86	75	100 ▲
Choice Medical Group	78 ▼	68 ▼	87
Citrus Valley Physicians Group	80 ▼	70 ▼	89
Community Medical Grp of the West Valley	78 ▼	69 ▼	100 ▲
Desert Oasis Healthcare	83	74	90
Eastland Medical Group IPA	81 ▼	70 ▼	96
Edinger Medical Group	85	76	100 ▲
Empire Physicians Medical Group	81 ▼	71 ▼	100 ▲
Encompass Family Physicians MG	87	77 ▲	ϕ
Facey Medical Group	80 ▼	66 ▼	100 ▲
Family Care Specialists Medical Group	81 ▼	68 ▼	94
Family Practice MG of San Bernardino	87 ▲	78 ▲	ϕ
Gateway Medical Group, Inc.	81 ▼	70 ▼	ϕ
GEMCare	84	72	ϕ
Genesis Healthcare	85	75	ϕ
Glendale Physicians Alliance	77 ▼	65 ▼	95
Good Samaritan Medical Practice Association	83	77 ▲	ϕ
Greater Covina Medical Group	86	76	ϕ
CALIFORNIA STATEWIDE AVERAGE	**84**	**74**	**94**

SOUTHERN CALIFORNIA *6 of 8*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY		AFTER HOURS
	Office Staff Interactions	Patient Access	Emergency Instructions
Greater Newport Physicians Medical Group	87 ▲	79 ▲	96
Greater Tri-Cities IPA	83	74	92
HealthCare Partners IPA	83	73	ϕ
HealthCare Partners Medical Group	85	75	ϕ
High Desert Medical Group	83	66 ▼	92
High Desert Medical Group (Rollup)	81 ▼	65 ▼	92
High Desert MG - California Desert IPA	80 ▼	65 ▼	92
High Desert MG - Heritage Victor Valley	79 ▼	64 ▼	92
High Desert Primary Care Medical Group	80 ▼	66 ▼	100 ▲
Imperial County Physicians Medical Group	82	68 ▼	48 ▼
Inland HealthCare Group	79 ▼	69 ▼	100 ▲
Lakeside Medical Group, Inc.	82	71 ▼	92
Lakewood Health Plan Inc.	84	73	100 ▲
Loma Linda University Health Care	81 ▼	65 ▼	100 ▲
Memorial HealthCare (Rollup)	84	74	90
Memorial HealthCare IPA - Long Beach	84	74	90
Mercy Physicians Medical Group, Inc.	88 ▲	79 ▲	94
MidCoast Care Inc.	84	77 ▲	93
Mid-County Physicians Medical Group	86	77	100 ▲
Mission Hospital Affiliated Physicians	86	77	93
Monarch HealthCare	85	77 ▲	84
Multi-Cultural Primary Care Medical Group	81 ▼	70 ▼	97
Noble AMA IPA	81 ▼	73	92
Northridge Medical Group	82	73	88
Nuestra Familia Medical Group, Inc.	80 ▼	71 ▼	ϕ
Ojai Valley Community Medical Group	88 ▲	79 ▲	93
OmniCare Medical Group	81 ▼	73	100 ▲
Orange Coast Memorial IPA	86	75	90
Pacific Independent Physician Assoc.	82 ▼	75	96
Phys. Assoc. of Gr. San Gabriel Valley	84	73	96
Physicians' Healthways IPA	79 ▼	71 ▼	ϕ
Pinnacle Medical Group	85	73	ϕ
Pioneer Medical Group, Inc	84	74	100 ▲
Premier Physician Network	82	75	90
Presbyterian Health Physicians	83	70 ▼	92
Primary Care Associated Medical Group	81 ▼	74	100 ▲
PrimeCare Medical Network	83	68 ▼	96
ProMed Health Network of Pomona Valley	80 ▼	70 ▼	100 ▲
Prospect Healthsource Medical Group, Inc	84	75	ϕ
Prospect Medical Group	84	73	ϕ
Prospect Northwest Orange County MG	81 ▼	74	ϕ
Prospect Professional Care Medical Group	83	73	ϕ
CALIFORNIA STATEWIDE AVERAGE	**84**	**74**	**94**

SOUTHERN CALIFORNIA *7 of 8*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY		AFTER HOURS
	Office Staff Interactions	Patient Access	Emergency Instructions
Redlands Yucaipa Medical Group	85	72 ▼	ϕ
Regal Medical Group	83	73	96
Riverside Medical Clinic	85	69 ▼	100 ▲
Riverside Physician Network	84	73	ϕ
S. Cal Permanente Medical Group (Rollup)	86 ▲	73 ▼	100 ▲
S. Cal Permanente Medical Group Baldwin Park	84	72 ▼	100 ▲
S. Cal Permanente Medical Group Bellflower	86	73	100 ▲
S. Cal Permanente Medical Group Fontana	88 ▲	74	100 ▲
S. Cal Permanente Medical Group Kern County	86	72	100 ▲
S. Cal Permanente Medical Group Los Angeles	85	71 ▼	100 ▲
S. Cal Permanente Medical Group Orange County	88 ▲	74	100 ▲
S. Cal Permanente Medical Group Panorama	85	69 ▼	100 ▲
S. Cal Permanente Medical Group Riverside	87 ▲	75	100 ▲
S. Cal Permanente Medical Group San Diego	87 ▲	73	100 ▲
S. Cal Permanente Medical Group South Bay/Harbor City	87 ▲	75	100 ▲
S. Cal Permanente Medical Group West Los Angeles	84	70 ▼	100 ▲
S. Cal Permanente Medical Group Woodland Hills	86	74	100 ▲
San Bernardino Medical Group	87 ▲	75	ϕ
San Diego Physicians Medical Group	87 ▲	79 ▲	92
San Luis Obispo Select IPA	85	76	88
Sansum Clinic	85	74	100 ▲
Santa Barbara Select IPA	90 ▲	83 ▲	86
Scripps Clinic Medical Group	88 ▲	79 ▲	100 ▲
Scripps Clinic Penn Elm Medical Group	86	77 ▲	100 ▲
Scripps Mercy Medical Group	87 ▲	79 ▲	100 ▲
SeaView IPA	83	75	86
Sharp Community Med Grp - Chula Vista	84	75	78 ▼
Sharp Community Med Grp - Coronado	86	76	78 ▼
Sharp Community Med Grp - Graybill	84	77	78 ▼
Sharp Community Med Grp - Grossmont	85	75	78 ▼
Sharp Community Med Grp - Inland North	87 ▲	79 ▲	78 ▼
Sharp Community Med Grp - Metro San Diego	85	77 ▲	78 ▼
Sharp Community Med Grp (Rollup)	85	76 ▲	78 ▼
Sharp Mission Park Medical Group	85	75	100 ▲
Sharp Rees-Stealy Medical Centers	90 ▲	76	91
Sierra Medical Group	77 ▼	66 ▼	ϕ
St. Joseph Heritage Medical Group	84	72 ▼	100 ▲
St. Joseph Hospital Affil. Physicians	82	75	ϕ
St. Jude Heritage Medical Group	84	73	95
St. Jude Hospital Affiliated Physicians	85	75	91
St. Mary IPA - Lakewood Health Plan	87	75	100 ▲
CALIFORNIA STATEWIDE AVERAGE	**84**	**74**	**94**

SOUTHERN CALIFORNIA *8 of 8*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY		AFTER HOURS
	Office Staff Interactions	Patient Access	Emergency Instructions
St. Vincent IPA	88 ▲	78 ▲	94
Talbert Medical Group	83	75	100 ▲
The Industry Health Network	84	77	ϕ
Torrance Hospital IPA	82 ▼	73	98 ▲
UCLA Medical Group	83	74	96
UCSD Healthcare Network	82 ▼	69 ▼	100 ▲
United Family Care	78 ▼	62 ▼	100 ▲
Universal Care Medical Group	81 ▼	70 ▼	ϕ
Upland Medical Group	85	71 ▼	98 ▲
Valley Care IPA	87 ▲	78 ▲	100 ▲
Verdugo Hills Medical Group	83	75	97
West Covina Medical Clinic	78 ▼	65 ▼	100 ▲
CALIFORNIA STATEWIDE AVERAGE	**84**	**74**	**94**

ACKNOWLEDGEMENTS

Each year CCHRI participants and supporting organizations distinguish themselves through their cooperation, teamwork, and the generous time they give to our projects.

CCHRI gratefully acknowledges the leadership and commitment shown by the following individuals and Committees:

LEAH SMITH, *Health Net, Chairperson, and the other members of the Health Plan HEDIS Data Collection Project Committee, for guiding CCHRI through another challenging and successful year;*

THE PATIENT ASSESSMENT SURVEY PROJECT COMMITTEE, *for refining and implementing the PAS survey of patient experience with medical groups and IPAs;*

THE MEMBER SURVEY PROJECT COMMITTEE, *for providing guidance and input to the CAHPS survey and reporting process;*

THE PROVIDER AFTER HOURS ACCESS SURVEY PROJECT COMMITTEE *for providing leadership and direction for refining and implementing the After Hours Survey;*

SHARON RICCIUTI, *PacifiCare, CCHRI Reporting Committee chairperson, and the other members of the Reporting Committee, for their focus and hard work in consistently offering constructive and objective recommendations about many complex and sensitive reporting decisions.*

CCHRI is also grateful for the important contributions made by the following organizations:

THOMSON REUTERS *for the important role they fill in supporting the Health Plan HEDIS Data Collection Project. In particular, we acknowledge the dedication and support provided by Marlise Goodwin and Mahil Senathirajah.*

CENTER FOR THE STUDY OF SERVICES (CSS) *for administering the Patient Assessment Survey and providing analytical and reporting support to the project. In particular we acknowledge the contributions of Jeff Burkeen.*

DSS RESEARCH, *for successfully fielding and reporting the CAHPS Member Survey Project.*

NATO, *for successfully fielding and reporting The Provider After Hours Access Survey.*

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