CALIFORNIA HEALTH CARE PERFORMANCE RESULTS

2007

REPORT ON

QUALITY

MANAGED CARE IN CALIFORNIA

ABOUT CCHRI

Measuring how well the managed 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 managed care members should receive. CCHRI also shares information about members' experience with their HMOs obtained from a statewide member survey of participating health 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, 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. Eight 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.

This report does not distinguish between physician groups' and health plans' roles in managing administrative and patient care responsibilities, which often overlap. This is especially true in California, where physician organizations perform many functions that in other parts of the country are directed by health plans.

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 2007 (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 managed care 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 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.

TABLE OF CONTENTS

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 listed below 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 managed care industry and, when used with the NCQA-approved Member Survey, helps identify health plan successes in providing preventive care and other medical services for managed care members. Results were collected in 2007 and reflect the percentage of sampled members who received the specific services during 2006, 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.

The information contained in this report pertains only to health maintenance organizations (HMOs). Comparable data about other insurance models, such as fee-for-service and preferred provider organizations, are not readily available because these systems are not designed to manage population-based preventive health care or collect data in the same ways as HMOs. Therefore, results listed are for commercial HMO members only.

CALIFORNIA HEALTH PLANS

	YOUNG FAMILIES							
	Prenatal and Postpartum Care		Childhood Immunizations		Adolescent Immunizations	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	Combo 2			Initiation Phase
Aetna	93	79	81[b]	49[b] ▼	59	33 ▼	78 ▼	21 ▼
Blue Cross	97 ▲	85 ▲	83[b]	52[b] ▼	65 ▲	32 ▼	80 ▼	27 ▼
Blue Shield	97 ▲	84	81	74 ▲	52[b] ▼	37 ▼	80 ▼	35
CIGNA	96 ▲	89 ▲	82[b]	54[b] ▼	59[b]	38 ▼	86 ▲	27 ▼
Health Net	95 ▲	85	84 ▲	75 ▲	64 ▲	43 ▼	82	20 ▼
Kaiser Permanente N. Cal	93 ▲	87 ▲	85 ▲	82 ▲	71[b] ▲	86 ▲	95 ▲	27 ▼
Kaiser Permanente S. Cal	87 ▼	79	86 ▲	82 ▲	74[b] ▲	80 ▲	92 ▲	28 ▼
PacifiCare	95 ▲	82	78	66	53[b]	37 ▼	81 ▼	20 ▼
2007 National Mean[a]	**91**	**80**	**80**	**66**	**58**	**73**	**83**	**33**
2007 National 75th Percentile[a]	**96**	**86**	**85**	**75**	**72**	**81**	**88**	**37**
2007 National 90th Percentile[a]	**98**	**89**	**88**	**81**	**81**	**86**	**91**	**42**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2007

b – 2006 rates reported—rotation measure

CALIFORNIA HEALTH PLANS

	CHRONIC DISEASE								
	Use of Appropriate Medications for People with Asthma			Comprehensive Diabetes Care					
	Ages 5-9	Ages 10-17	Ages 18-56	HbA1c Testing	HbA1c Level ≤9.0%	Retinal Exam	LDL-C Screening	LDL-C Level of <100 mg/dL	Nephropathy Monitoring
Aetna	93	90	87 ▼	86	70	58	84	41	83
Blue Cross	96	91	90	86	70	60 ▲	85	42	78
Blue Shield	97	94 ▲	90	86	75 ▲	59	83	45	80
CIGNA	95	90	89	88	72	57	85	41	79
Health Net	97	91 ▼	91	92 ▲	78 ▲	61 ▲	87 ▲	49 ▲	83
Kaiser Permanente N. Cal	98 ▲	97 ▲	94 ▲	90 ▲	77 ▲	66 ▲	89 ▲	55 ▲	91 ▲
Kaiser Permanente S. Cal	96	93	95 ▲	86	72	76 ▲	86	51 ▲	93 ▲
PacifiCare	94 ▼	89 ▼	89 ▼	86	67	56	82	40	82
2007 National Mean[a]	**96**	**93**	**90**	**88**	**70**	**55**	**83**	**43**	**80**
2007 National 75th Percentile[a]	**98**	**95**	**92**	**91**	**77**	**63**	**86**	**47**	**84**
2007 National 90th Percentile[a]	**99**	**97**	**94**	**93**	**81**	**71**	**88**	**51**	**87**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2007

CALIFORNIA HEALTH PLANS

	CARDIOVASCULAR HEALTH				
	Beta Blocker After Heart Attack	Persistence of Beta Blocker	Controlling High Blood Pressure	Cholesterol Management Cardiovascular Conditions	
				LDL-C Screening	LDL-C Level of <100 mg/dL
Aetna	99[b]	60 ▼	61	91 ▲	61
Blue Cross	100 ▲	75	60	90	66 ▲
Blue Shield	97	71	59	90	63 ▲
CIGNA	99[b]	55 ▼	64	90	64 ▲
Health Net	99[b]	73	62	90	63 ▲
Kaiser Permanente N. Cal	99	84 ▲	73 ▲	92 ▲	66 ▲
Kaiser Permanente S. Cal	98	85 ▲	74 ▲	95 ▲	63 ▲
PacifiCare	100[b] ▲	69	54 ▼	88	57
2007 National Mean[a]	**98**	**73**	**60**	**88**	**57**
2007 National 75th Percentile[a]	**100**	**78**	**65**	**90**	**63**
2007 National 90th Percentile[a]	**100**	**83**	**68**	**92**	**66**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2007

b – 2006 rates reported—rotation measure

CALIFORNIA HEALTH PLANS

	PREVENTIVE HEALTH SCREENINGS					
	Cervical Cancer Screening	Breast Cancer Screening		Chlamydia Screening in Women		Colorectal Cancer Screening
		Total	Ages 52-69	Ages 16-20	Ages 21-25	
Aetna	80	61 ▼	65 ▼	35	41 ▲	48[b] ▼
Blue Cross	83	67 ▼	70 ▼	30 ▼	34 ▼	50 ▼
Blue Shield	84	67 ▼	72	34 ▼	39 ▲	53
CIGNA	84	66 ▼	69 ▼	40 ▲	47 ▲	55[b]
Health Net	86 ▲	68 ▼	71 ▼	37 ▲	42 ▲	58[b]
Kaiser Permanente N. Cal	82 ▲	77 ▲	83 ▲	61 ▲	66 ▲	50 ▼
Kaiser Permanente S. Cal	82 ▲	76 ▲	85 ▲	66 ▲	69 ▲	51
PacifiCare	84	66 ▼	70 ▼	36	43 ▲	51
2007 National Mean[a]	**81**	**69**	**72**	**36**	**38**	**55**
2007 National 75th Percentile[a]	**84**	**73**	**76**	**41**	**45**	**60**
2007 National 90th Percentile[a]	**87**	**77**	**80**	**47**	**50**	**65**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2007

b – 2006 rates reported—rotation measure

CALIFORNIA HEALTH PLANS

	MENTAL HEALTH					OTHER			
	Antidepressant Medication Management			Follow-up After Hospitalization for Mental Illness					
	Optimal Practitioner Contacts	Effective Acute Phase Treatment	Effective Continuation Phase Treatment	Within 30 Days of Hospital Discharge	Within 7 Days of Hospital Discharge	Inappropriate Antibiotic Treatment Acute Bronchitis[c]	Anti-Rheumatic Drug Therapy	Low Back Pain Imaging	Annual Monitoring Persistent Medications Total
Aetna	22	56 ▼	43	74	58	76 ▼	86	80 ▲	66 ▼
Blue Cross	26 ▲	60	45	75	54	60 ▲	67 ▼	86 ▲	60 ▼
Blue Shield	19 ▼	57 ▼	44	70 ▼	50 ▼	78 ▼	85	78 ▲	68 ▼
CIGNA	21	56 ▼	43	74	60	73	79 ▼	77 ▲	71 ▼
Health Net	21	57 ▼	42 ▼	78	58	75 ▼	83 ▼	80 ▲	70 ▼
Kaiser Permanente N. Cal	19 ▼	82 ▲	59 ▲	84 ▲	70 ▲	66 ▲	91 ▲	78 ▲	70 ▼
Kaiser Permanente S. Cal	30 ▲	86 ▲	67 ▲	80 ▲	67 ▲	31 ▲	84 ▼	82 ▲	70 ▼
PacifiCare	21	57 ▼	40 ▼	83 ▲	71 ▲	77 ▼	82 ▼	77 ▲	70 ▼
2007 National Mean[a]	**20**	**61**	**45**	**76**	**57**	**71**	**85**	**74**	**74**
2007 National 75th Percentile[a]	**24**	**65**	**50**	**82**	**65**	**69**	**89**	**79**	**79**
2007 National 90th Percentile[a]	**31**	**70**	**53**	**88**	**73**	**61**	**92**	**81**	**81**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2007

c – Lower number reflects better performance

SERVICE MEASURES *1 of 1*

CALIFORNIA HEALTH PLANS	MEMBER SERVICE	
	Call Abandonment[c]	Call Answer Timeliness
Aetna	3 ▼	79 ▲
Blue Cross	NR	NR
Blue Shield	2 ▲	70 ▼
CIGNA	2 ▲	69 ▼
Health Net	5 ▼	74 ▼
Kaiser Permanente N. Cal	2 ▲	78 ▲
Kaiser Permanente S. Cal	1 ▲	82 ▲
PacifiCare	3 ▲	75 ▼
2007 National Mean[a]	**3**	**75**
2007 National 75th Percentile[a]	**2**	**79**
2007 National 90th Percentile[a]	**1**	**85**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2007

c – Lower number reflects better performance

NR – Not reported

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) and administered by the California Cooperative Healthcare Reporting Initiative (CCHRI). 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 2007 but reflects information about medical care and services provided to members during 2006.

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 choosing a personal physician, obtaining a referral to a specialist and delays in receiving health care).

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). The results listed are for commercial HMO members only and do not include information for Medicare beneficiaries covered under a managed care plan.

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	EXPERIENCE WITH PLAN		MEMBER EXPERIENCE WITH PROVIDERS				
	Health Plan Overall	Getting Needed Care[b]	Health Care Overall	Personal Doctor Overall	Specialist Overall	How Well Doctors Communicate	Getting Care Quickly[b]
Aetna	48	74	61	67	74	88	73
Blue Cross	57	75	65	73	73	88	75
Blue Shield	69	79	71	76	72	87	80
CIGNA	57	78	68	76	78	91	82
Health Net	64	80	68	78	75	90	77
Kaiser Permanente N. Cal	67	80	69	76	77	89	83
Kaiser Permanente S. Cal	65	77	68	79	77	92	75
PacifiCare	66	84	73	81	78	91	82
Western Health Advantage	68	82	71	75	75	88	80
CCHRI Average[a]	**62**	**79**	**68**	**76**	**76**	**89**	**79**

NOTES

a – This average includes all plans reporting data through CCHRI.

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

c – Due to changes made to the survey in 2007, NCQA recommends that this composite not be publicly reported.

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 2006; only those that did are listed in the chart below.

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

	CHRONIC DISEASE					
	Comprehensive Diabetes Care					
	HbA1c Testing	HbA1c Level ≤9%	Retinal Exam	LDL-C Screening	LDL-C Level of <100 mg/dL	Nephropathy Monitoring
Aetna	88	81 ▲	72 ▲	85	46	86
Blue Cross	89	83 ▲	73 ▲	86	42	84
Blue Shield	87	80 ▲	73 ▲	84	49	87
Health Net	91 ▲	82 ▲	73 ▲	90 ▲	57 ▲	89 ▲
Kaiser Permanente N. Cal	95 ▲	89 ▲	80 ▲	95 ▲	68 ▲	95 ▲
Kaiser Permanente S. Cal	95 ▲	90 ▲	85 ▲	95 ▲	62 ▲	97 ▲
PacifiCare	92 ▲	82 ▲	70 ▲	88 ▲	51 ▲	90 ▲
2007 National Mean[a]	**87**	**72**	**61**	**85**	**47**	**85**
2007 National 75th Percentile[a]	**92**	**83**	**73**	**91**	**54**	**89**
2007 National 90th Percentile[a]	**95**	**88**	**81**	**93**	**60**	**93**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2007

HEALTH PLANS WITH MEDICARE CONTRACTS

	CARDIOVASCULAR HEALTH					PREVENTIVE HEALTH SCREENINGS			
	Beta Blocker After Heart Attack	Persistence of Beta Blocker	Controlling High Blood Pressure	Cholesterol Management Cardiovascular Conditions		Breast Cancer Screening		Colorectal Cancer Screening	Osteoporosis Management in Women
				LDL-C Screening	LDL-C Level of <100 mg/dL	Total	Ages 52-69		
Aetna	97	72	57	86	54	65 ▼	65 ▼	50	14 ▼
Blue Cross	99 ▲	78	59	88	52	62 ▼	63 ▼	42 ▼	28 ▲
Blue Shield	99 ▲	77 ▲	61	87	50 ▼	67 ▼	68 ▼	55	11 ▼
Health Net	98 ▲	71	59	91	67 ▲	74 ▲	75 ▲	66 ▲	19 ▼
Kaiser Permanente N. Cal	98 ▲	85 ▲	81 ▲	94 ▲	71 ▲	87 ▲	88 ▲	50	30 ▲
Kaiser Permanente S. Cal	99 ▲	87 ▲	72 ▲	93 ▲	68 ▲	89 ▲	90 ▲	64 ▲	51 ▲
PacifiCare	99 ▲	75 ▲	62 ▲	89	59	69	70	57	19 ▼
2007 National Mean[a]	**94**	**69**	**56**	**89**	**56**	**69**	**70**	**53**	**22**
2007 National 75th Percentile[a]	**99**	**76**	**62**	**92**	**65**	**76**	**76**	**63**	**25**
2007 National 90th Percentile[a]	**100**	**85**	**66**	**94**	**70**	**81**	**82**	**70**	**30**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2007

HEALTH PLANS WITH MEDICARE CONTRACTS

	MENTAL HEALTH					OTHER			
	Antidepressant Medication Management			Follow-up After Hospitalization for Mental Illness		Anti-Rheumatic Drug Therapy	Annual Monitoring Persistent Medications	Drugs to be Avoided in the Elderly[c]	
	Optimal Practitioner Contacts	Effective Acute Phase Treatment	Effective Continuation Phase Treatment	Within 30 Days of Hospital Discharge	Within 7 Days of Hospital Discharge			One Prescription	Two or more Prescriptions
Aetna	9	45 ▼	37	12 ▼	9 ▼	85 ▲	76 ▼	26 ▼	6
Blue Cross	11	55	17 ▼	49	34	67	75 ▼	18 ▲	6 ▲
Blue Shield	15	58	45	29 ▼	17 ▼	66	80 ▼	26 ▼	6 ▼
Health Net	13	61	46	57	34	72 ▲	81 ▼	22 ▲	5 ▲
Kaiser Permanente N. Cal	12	86 ▲	64 ▲	77 ▲	60 ▲	81 ▲	82 ▼	22 ▲	5 ▲
Kaiser Permanente S. Cal	17 ▲	91 ▲	74 ▲	73 ▲	60 ▲	80 ▲	83 ▼	19 ▲	4 ▲
PacifiCare	9 ▼	60 ▲	46	38 ▼	20 ▼	74 ▲	83	26 ▼	6 ▼
2007 National Mean[a]	**11**	**58**	**45**	**56**	**37**	**68**	**83**	**23**	**6**
2007 National 75th Percentile[a]	**14**	**63**	**51**	**70**	**50**	**78**	**90**	**17**	**3**
2007 National 90th Percentile[a]	**19**	**70**	**59**	**81**	**63**	**82**	**91**	**13**	**2**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2007

c – Lower number reflects better performance

MEDICARE SERVICE MEASURES *1 of 1*

HEALTH PLANS WITH MEDICARE CONTRACTS	MEMBER SERVICE	
	Call Abandonment[c]	Call Answer Timeliness
Aetna	3 ▲	79 ▲
Blue Cross	11 ▼	54 ▼
Blue Shield	6 ▲	58 ▼
Health Net	10 ▼	70 ▲
Kaiser Permanente N. Cal	2 ▲	78 ▲
Kaiser Permanente S. Cal	1 ▲	82 ▲
PacifiCare	10 ▼	65 ▼
2007 National Mean[a]	**7**	**69**
2007 National 75th Percentile[a]	**3**	**79**
2007 National 90th Percentile[a]	**2**	**92**

▲ Significantly Above National Mean

▼ Significantly Below National Mean

NOTES

a – Source: National Committee for Quality Assurance (NCQA) Quality Compass 2007

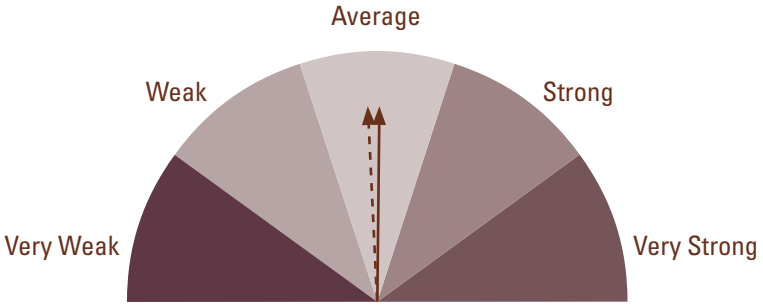
c – Lower number reflects better performance

OPPORTUNITIES FOR IMPROVEMENT IN CALIFORNIA

BACKGROUND

The Agency for Healthcare Research and Quality's National Healthcare Quality Report[1] for 2006 determined that while health care quality is improving nationally the rate of improvement is modest. California's results from the report demonstrate this trend:

Overall Health Care Quality Performance of California Compared to All States



Performance Meter: All Measures

Most Recent Year

Baseline Year

(Baseline year may vary across measures)

In this report, measures of health care quality address the extent to which physicians and hospitals deliver evidence-based care for specific services as well as the outcomes of the care provided. The measures are organized around four dimensions of quality—effectiveness, patient safety, timeliness, and patient centeredness—and cover three stages of care—staying healthy, getting better, and living with illness or disability.

The CCHRI 2007 all-plan averages for HEDIS clinical measures also reflect very modest improvement from the prior year, with a majority of the measures showing a change of less than 2%. Patient experience with their medical groups shows a similar modest improvement, while their ratings of health plans actually dropped.

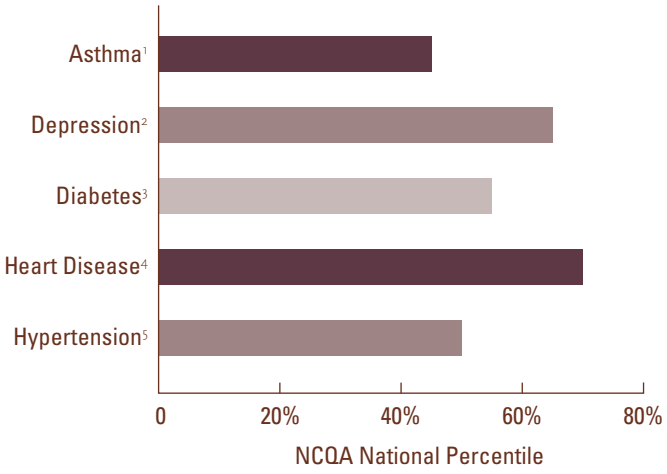
NOTES

1 – http://statesnapshots.ahrq.gov

OPPORTUNITIES FOR IMPROVEMENT IN CALIFORNIA

When we compare the CCHRI 2007 all-plan averages for key measures to national health plan performance rates, we get the following:

CCHRI 2007 All-Plan Average vs. National Health Plan Performance Rates[a]



Taking asthma as an example, CCHRI plans performance on the measure for use of appropriate medications for people with asthma is near the 40th percentile nationally, demonstrating that as a state we are performing below the median. The pace of improvement must be accelerated if we are to move ahead of the rest of the country.

NOTES

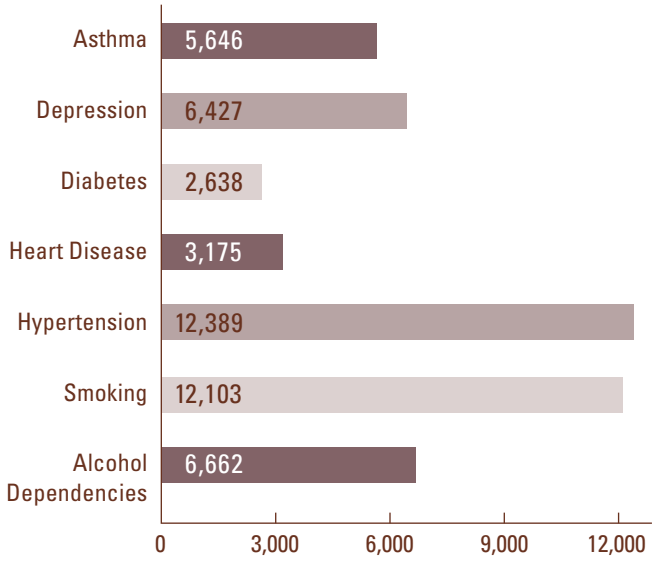
a – Source: CCHRI Report Card and NCQA Quality Compass
b – Source: www.ncqacalculator.com
1 – Use of appropriate medications for people with asthma ages 18 – 56
2 – Optimal practitioner contacts
3 – HbA1c level <=9%
4 – LDL-C level of < 100 mg/dL
5 – Controling high blood pressure
6 – www.ncqacalculator.com

WHY DOES THIS MATTER?

Using NCQA's Quality Dividend Calculator[6], one can quantify the impact that goes beyond individual health status; health care quality affects the productivity and absenteeism of the work force as well. When employees get higher quality care, they stay healthier, absenteeism drops, and productivity improves. The calculator estimates the absenteeism, lost productivity and related expenses that result from a specific set of chronic conditions: asthma, depression, diabetes, heart disease, and others. The model which is specific to employer type, shows how health plans can affect employees' absenteeism and productivity, based on their performance in managing employee health.

For example, for a fictional California financial services company with 70,000 employees and $15 billion in revenue, NCQA estimates that the following number of employees will suffer from various chronic conditions:

Expected Number of Emplyees with Selected Chronic Conditions[b]



In comparing a NCQA nationally accredited average plan with one that is in the top 10% for this fictional financial institution, the calculator estimates the overall impact of the higher performing health plan as the following:

- Days gained from lower absenteeism and higher productivity equals 26,694 fewer work days off per year with the nationally accredited top 10% plan

OPPORTUNITIES FOR IMPROVEMENT IN CALIFORNIA

- This translates into cost savings from less absenteeism/ presenteeism of $7,540,051 per year
- And sick day wages savings of $7,081,669 per year.

Therefore, were this fictional employer to switch from an average to a high performing plan, it would save approximately $15 million per year. When translated to the total number of employees in California, it's clear we are paying a very significant dollar cost for being "average", not to mention the impact on employees' health.

WHAT CAN WE DO?

Part of the answer requires that we gain greater insight into the drivers of quality improvement, such as, how much does a health plan affect a score versus a physician organization. In 2007 CCHRI undertook special studies that would inform the stakeholders where to focus their improvement efforts.

SPECIAL STUDIES – WHERE SHOULD IMPROVEMENT EFFORTS BE FOCUSED?

The California managed health care system is fairly unique due to its reliance on delegated physician groups along with the fact that there is major overlap among health plan provider networks. One significant feature of this shared delivery system is that the contribution to quality of plans versus groups is often blurred. Two studies were conducted in 2007 to assess if plans have an effect on measure results independent of groups:

1. "The Relative Effects of Plans and Providers on HEDIS Quality Measures" conducted by Laurence Baker, Stanford and David Hopkins, PBGH
2. "Analysis of the Relative Contributions of Health Plans and Provider Organizations to the 2007 Patient Assessment Survey (PAS) Scores" conducted by Beate Danielson and Cheryl Damberg.

In response to the question "do plans influence measured HEDIS rates independent of the groups they contract with?" the conclusions were that plans do make a contribution to explaining variation independent of groups, but that the share of variation explained by groups is significantly larger than that explained by plans. When evaluating the Patient Assessment Survey (PAS) data to identify key drivers of performance scores, however, no statistically significant or practically significant effect of health plans was found on patient experience with care.

The results of these studies combined with analysis of IHA Pay for Performance results demonstrating great variation in measure results across physician organizations clearly indicate that focusing improvement efforts on the poorer performing groups who have large member populations will have the most significant impact on improving performance and care for California. There is also a need for further study to better understand the drivers of variation; for example, does the diversity within the California population contribute to this variation? Does our delegated model have some unintended consequences in terms of creating confusion and, sometimes, access barriers for patients?

IMPROVING DATA FOR PERFORMANCE MEASUREMENT

Another priority area for focus is the data available for performance measurement and improvement—there is a need to clarify if our performance scores are a reflection of actual performance or if there are data flow issues that impact the results. Improving the flow and types of data being shared between groups and plans through bi-directional monthly data exchanges will ensure that plans and groups have as complete a set of information as possible not only for performance measurement but also for coordinated quality improvement activities.

In addition, using a standard encounter rate definition to measure data flows between groups and plans will enable plans to track improvement in data quality and completeness in a systematic way.

COLLABORATION IS KEY

California is well grounded in collaboration. Purchasers, health plans and physician organizations working together to improve health care performance is the founding principle of CCHRI. While CCHRI's focus is on efficient performance measurement and reporting, there are other collaboratives that are dedicated to improving the quality of healthcare in California. The California Quality Collaborative (CQC) works with physicians and physician organizations to improve quality, while the Pay-for-Performance program provides financial incentives and rewards for physician organizations that demonstrate good quality performance. The model for improvement of a key measure is well developed: first identify a measure to be improved; second, include it in the IHA P4P set for reward; third, have provider organizations include it in their internal bonus programs and fourth give the physicians tools for improvement. Of course improvement of systems of care should be the top priority as it will lead to improvement in most if not all the areas being measured.

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:

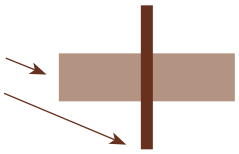
- The use of preventive services and routine screening tests, such as immunizations and mammograms, that help patients stay healthy;
- The utilization of the most up-to-date medical treatment and medication for the treatment of sudden illnesses such as heart attacks, that help patients get better;
- 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 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.

PRENATAL & POSTPARTUM

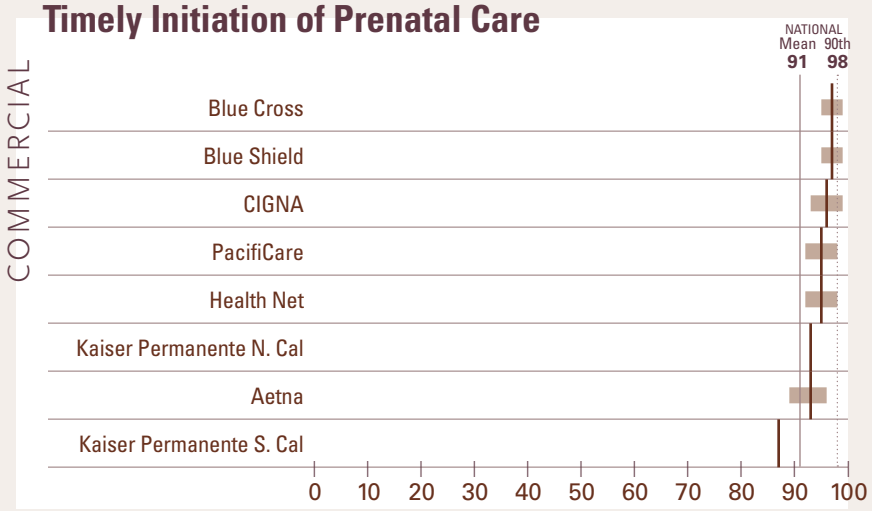
PRENATAL & POSTPARTUM CARE

Each year, there are 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.

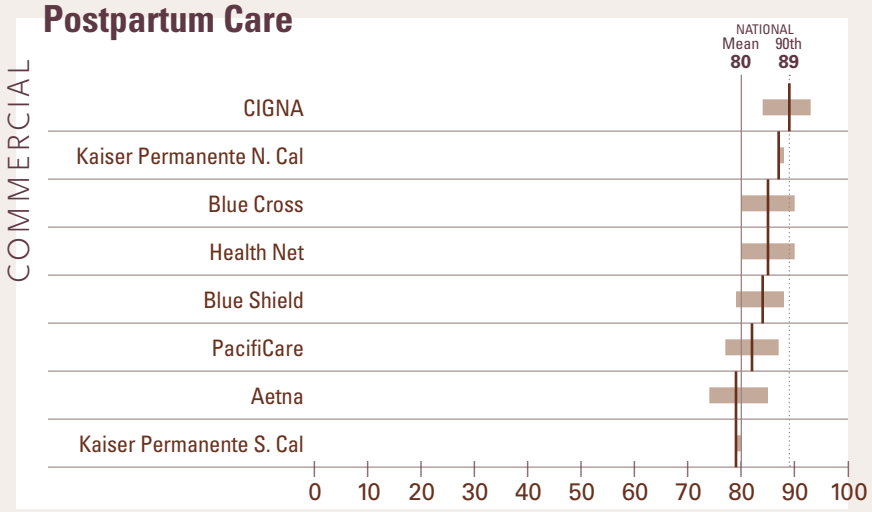
Likewise, it is very important for a new mother to have a postpartum visit with her health care provider within three to eight weeks after delivery. Since the period immediately following birth is a time of many physical and emotional adjustments, practitioners can be helpful in recognizing and discussing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

The charts on this page reflect the care women received in 2005 and 2006 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

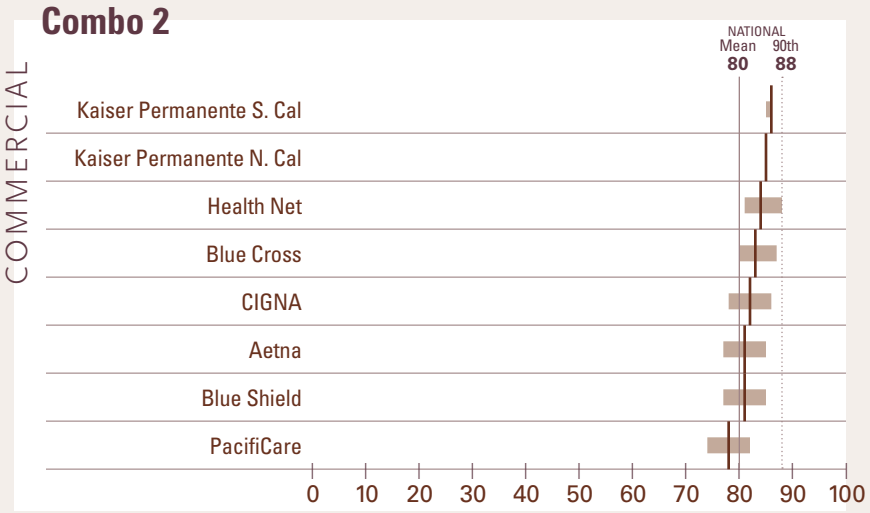
Immunizations are one of the safest and most effective ways to protect children from serious diseases.

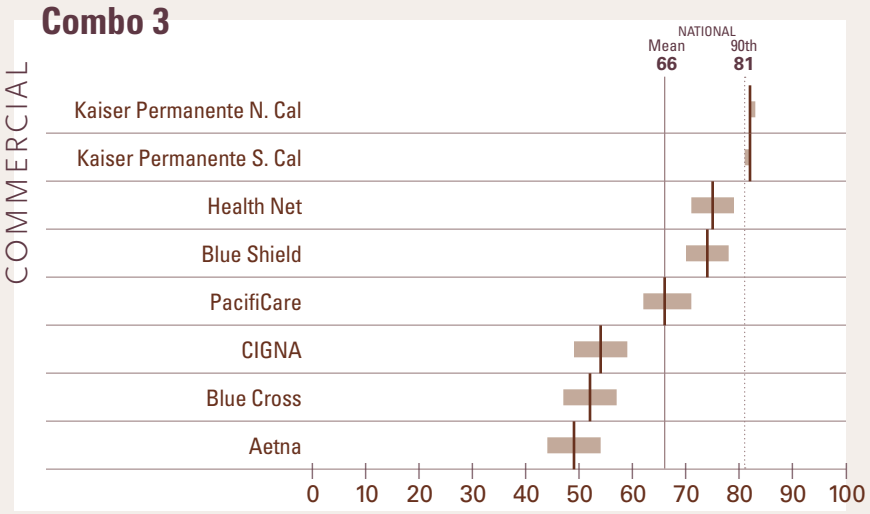
The chart for Combo 2 shows the performance of California health plans in providing all of the following immunizations.

- Four DTP (diphtheria-tetanus-pertussis)
- Three OPV/IPV (oral or inactivated poliovirus) immunizations
- One dose of MMR (measles-mumps-rubella)
- Two Hemophilus influenza type b conjugate vaccine
- 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.

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





ADOLESCENT IMMUNIZATIONS

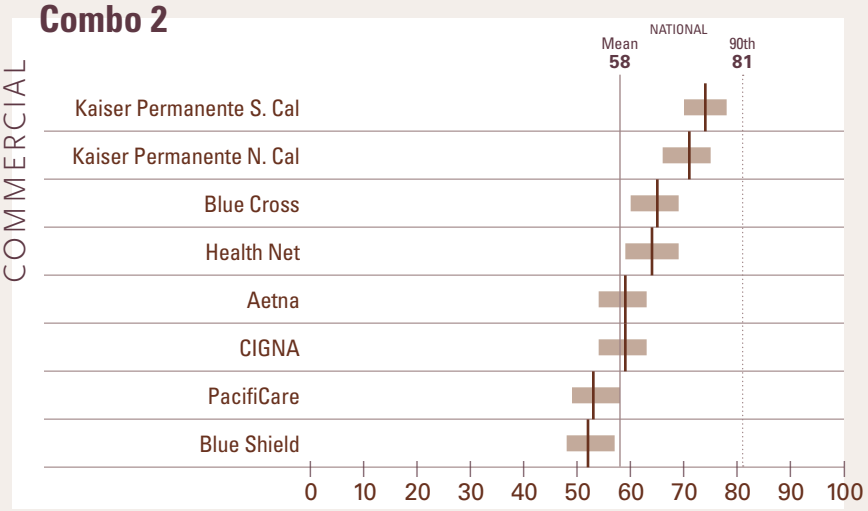
ADOLESCENT IMMUNIZATION STATUS

Vaccine-preventable diseases such as Hepatitis B, measles, mumps and rubella continue to affect adolescents. Between the ages of four and 13, children need several vaccinations to prevent these common diseases than can cause serious problems. The Varicella Vaccine (VZV, chickenpox) is also recommended for children in this age group.

The chart on this page shows the performance of California health plans in providing the following immunizations by the thirteenth birthday.

- Second dose of MMR between ages four and thirteen
- Three HepB (hepatitis B)
- Varicella Vaccine (VZV, chicken pox)

HMOs encourage doctors and parents to assess whether adolescents need the MMR and hepatitis vaccines during a visit and, if the doctor or nurse believes it is appropriate, to give the vaccination and any follow-up information. Parents can help keep school-age children healthy by recording the dates and types of shots their children receive. It is helpful to give each new health care provider an up-to-date copy of the immunization record.



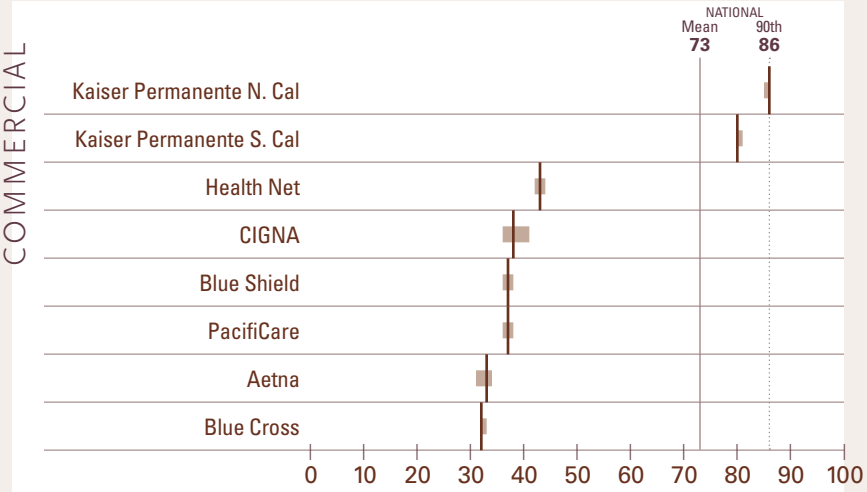
CHILDREN WITH PHARYNGITIS

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.

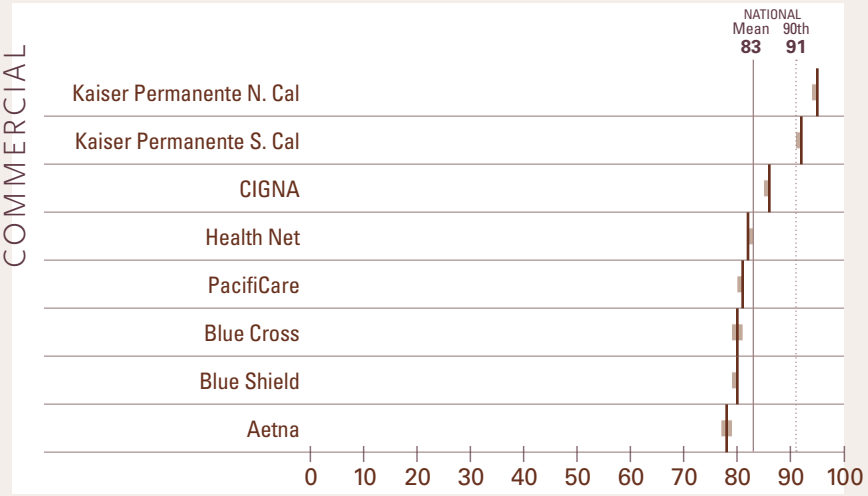


CHILDREN WITH URI

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.



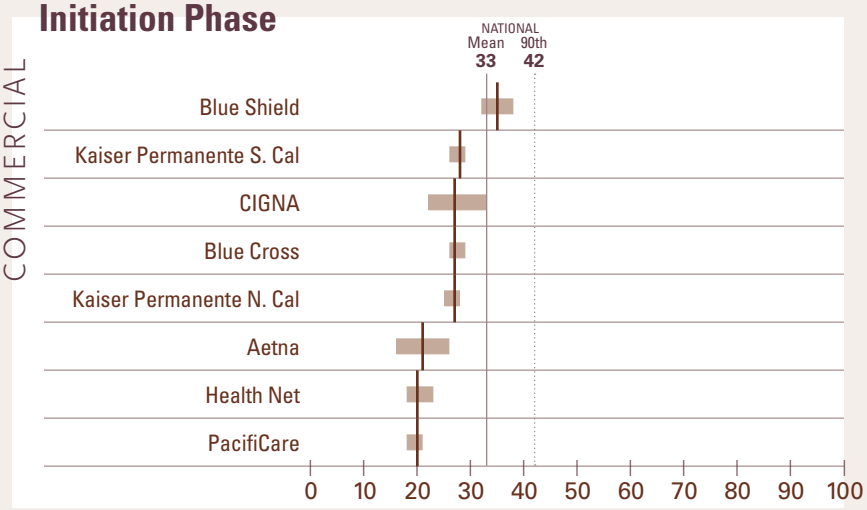
FOLLOW-UP CARE - ADHD

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.



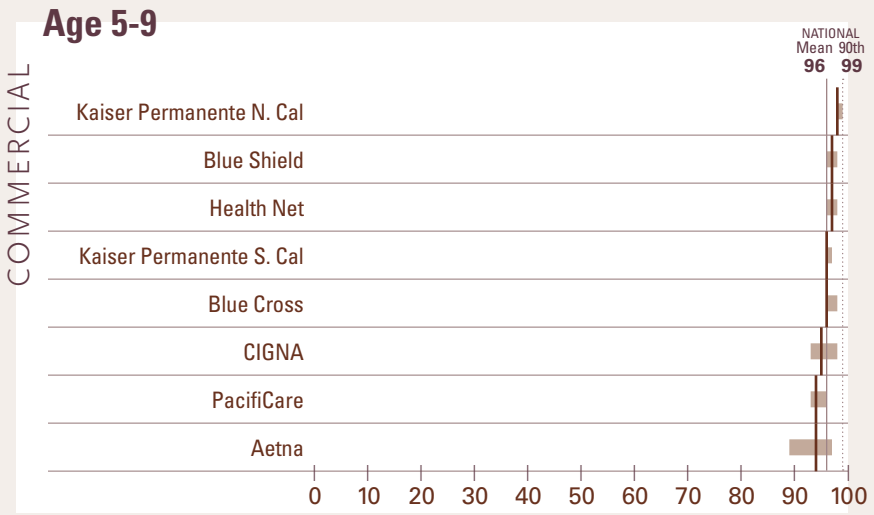
ASTHMA

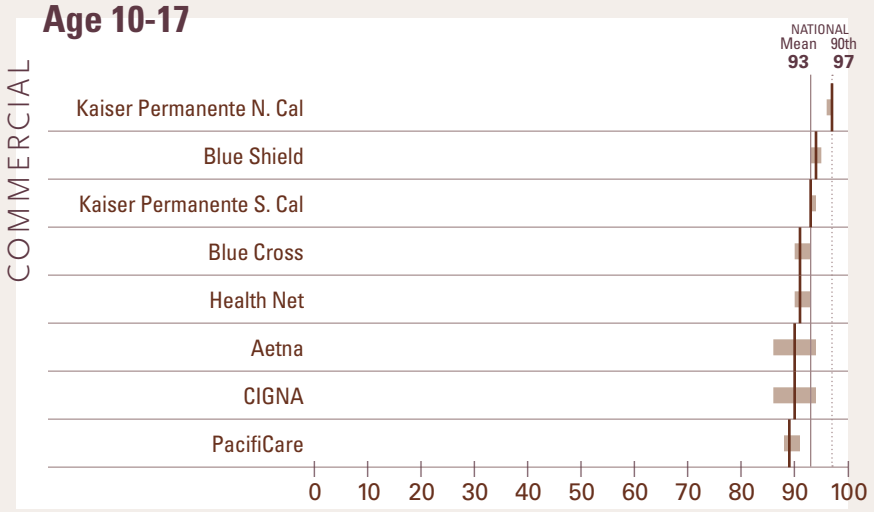
USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

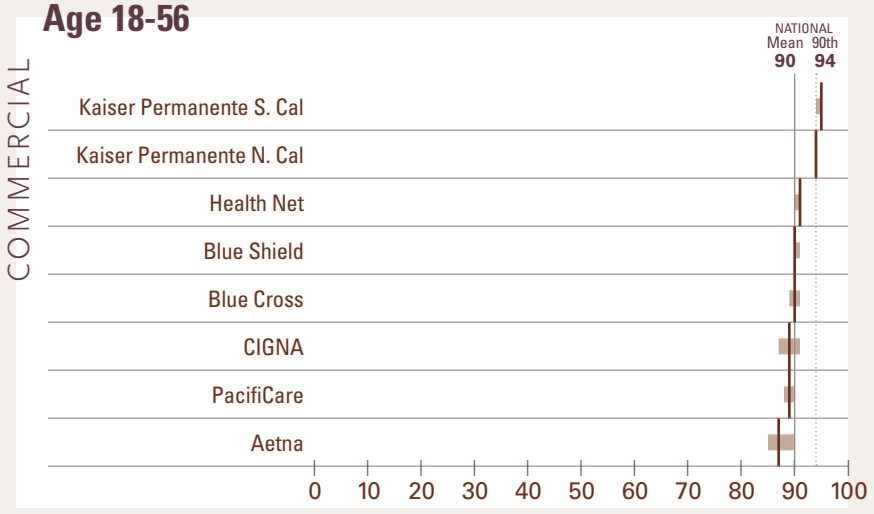
Asthma is a chronic lung disease and a rapidly growing public health problem. It is the most common chronic respiratory disease in children and can result in life-threatening episodes of illness for both adults and children. Asthma is the leading cause of school absenteeism from a chronic childhood condition. 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 breakthrough 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 HMO 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 measures were obtained in those age groups. This measure reports the percentage of members diagnosed with asthma who received appropriate medication management during 2006.







DIABETES *1 of 5*

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

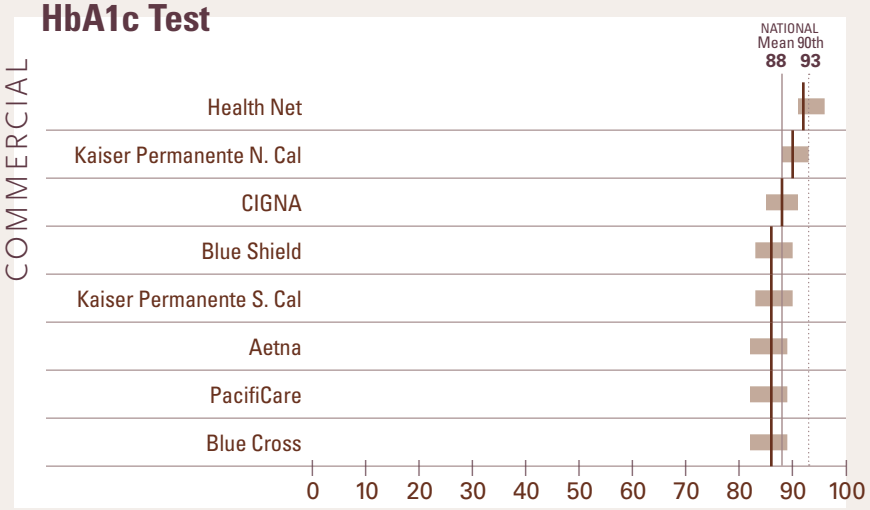
High levels of sugar in the blood are one common finding in patients with diabetes. Frequent testing for glycated hemoglobin, also known as hemoglobin A1c (HbA1c), measures a patient's average blood sugar level for the 2-3 month period before the test.

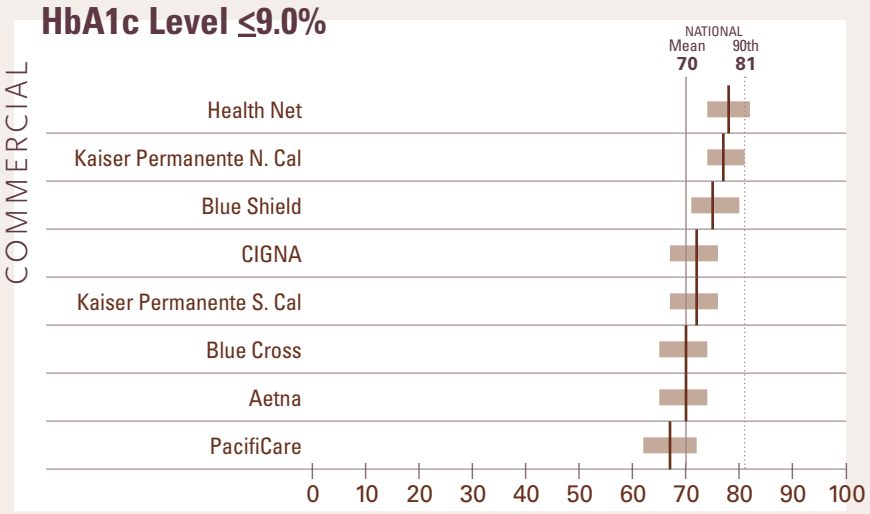
People with poorly controlled diabetes as shown by high blood sugar levels are more likely to develop high blood pressure, high cholesterol and fat levels, heart disease, eye and nerve problems, and kidney problems.

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

The first table displayed on this page measures the percentage of patients with diabetes who received at least one screening test for HbA1c during 2006. 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.

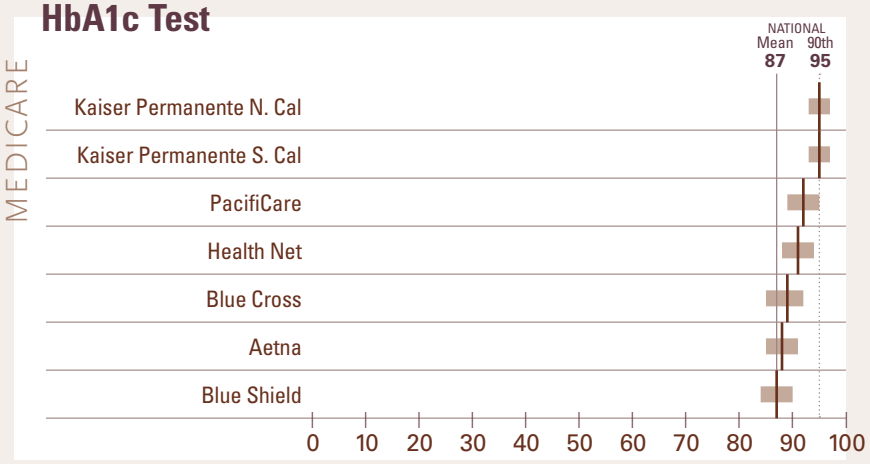
Separate charts display results for commercial and Medicare members.



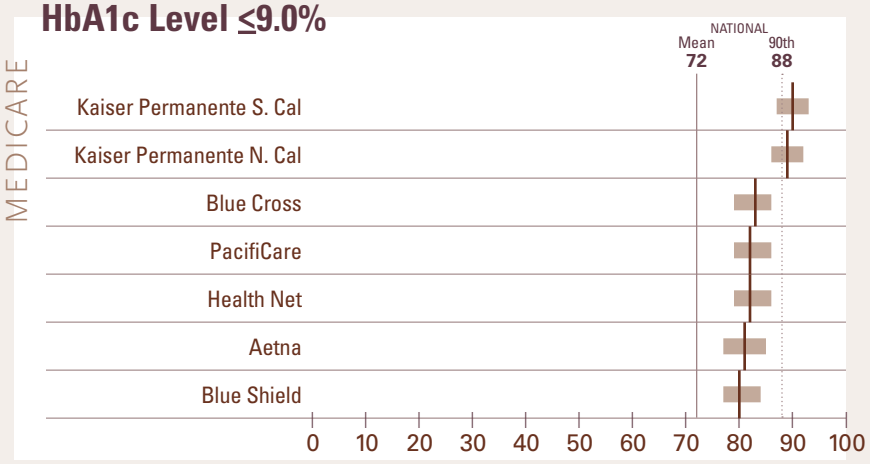


DIABETES *2 of 5*

HbA1c Test



HbA1c Level ≤9.0%



DIABETES *3 of 5*

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.

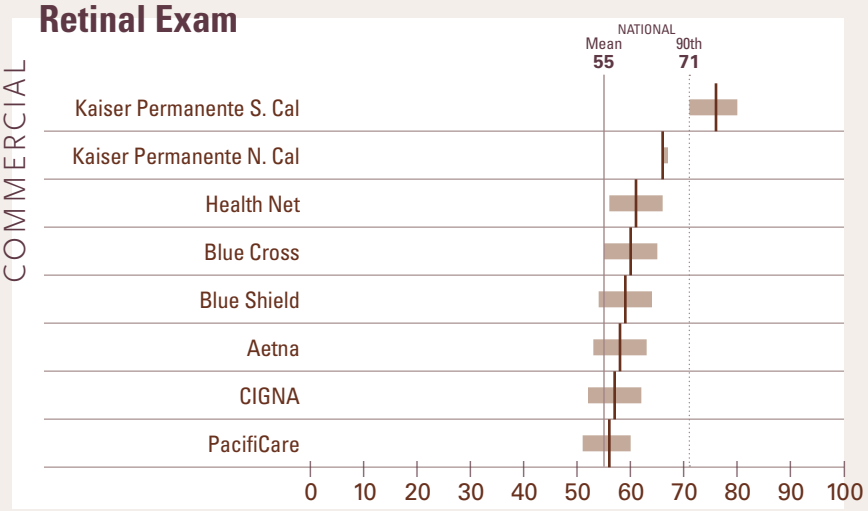
The HEDIS Comprehensive Diabetes Care measure reports how many people with diabetes had an examination by an eye care professional during 2006. For some patients, depending upon their over-all health status and how well their diabetes is controlled, an eye exam performed during 2005 was also counted 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.

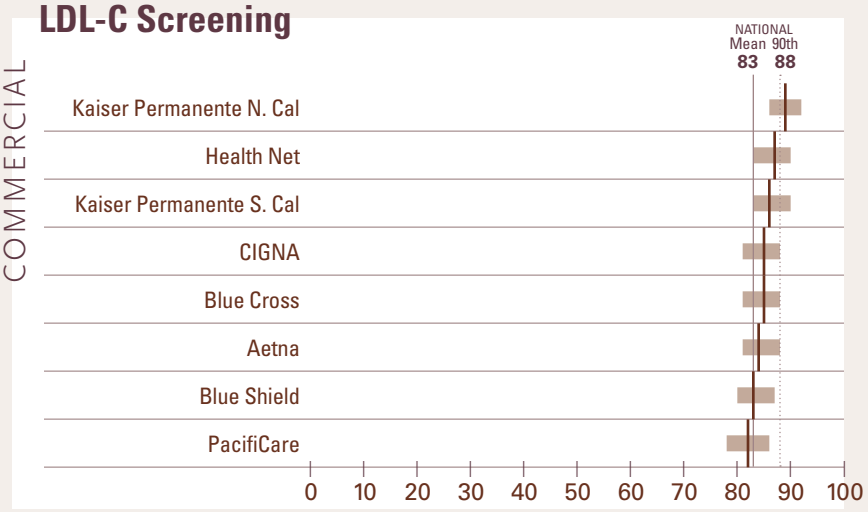
CHOLESTEROL MANAGEMENT
LDL Test

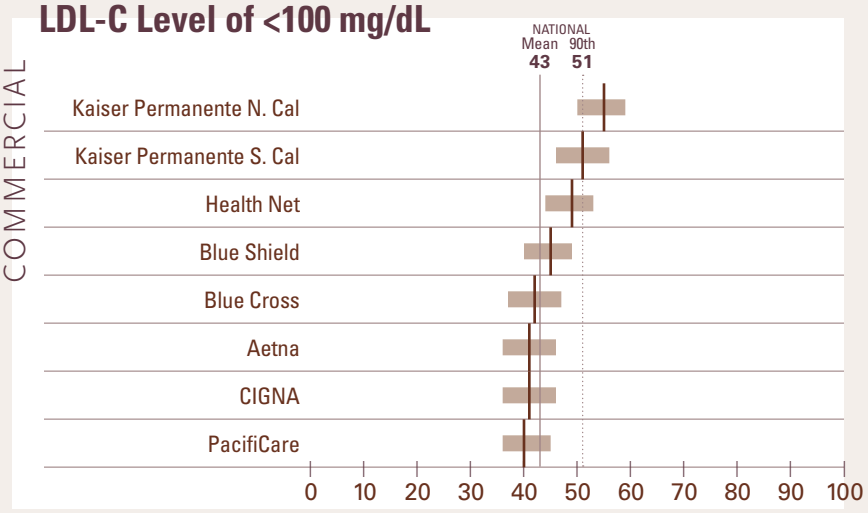
Heart disease strikes people with diabetes twice as often as people without diabetes and is one of the most common medical complications. Higher levels of cholesterol and fat in the blood greatly contribute to the increased incidence of coronary artery disease and heart disease.

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 130 and 100 mg/dl. The HEDIS Comprehensive Diabetes Care measure calculates the percentage of patients with diabetes who received an LDL cholesterol screening test during 2006 or 2005 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.

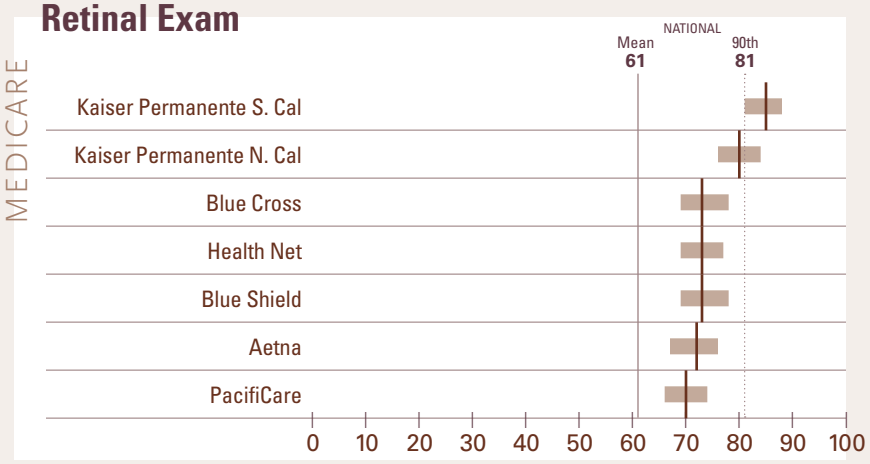




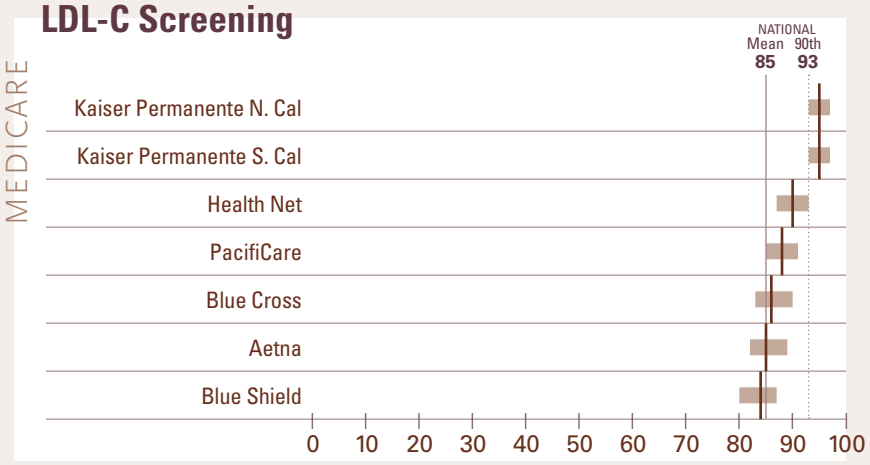


DIABETES *4 of 5*

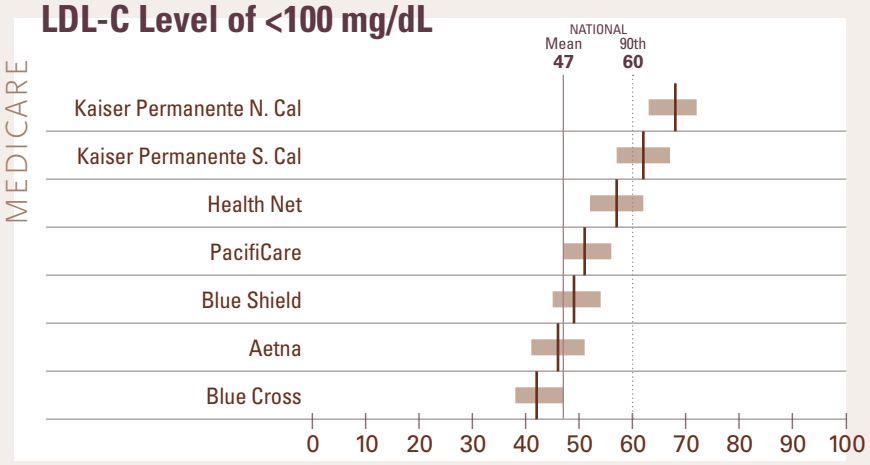
Retinal Exam



LDL-C Screening



LDL-C Level of <100 mg/dL



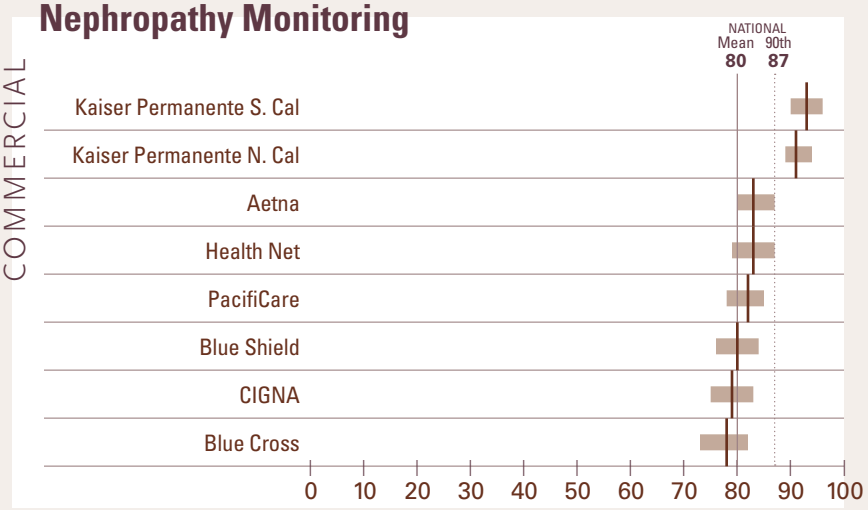
DIABETES *5 of 5*

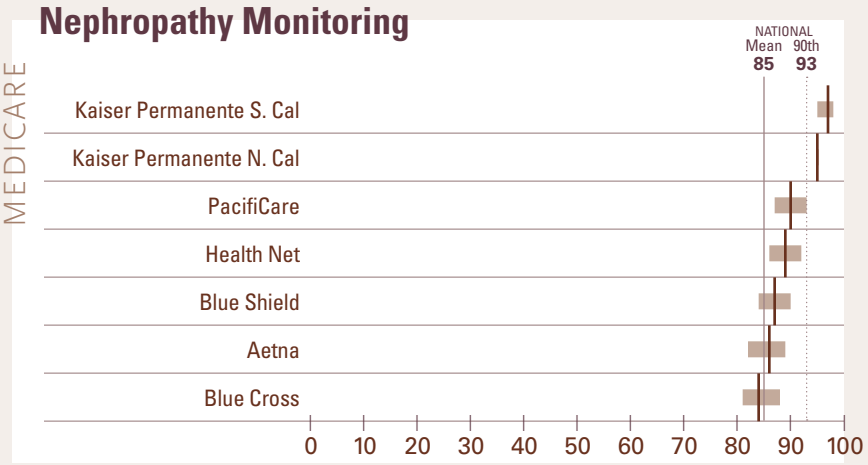
KIDNEY DISEASE MONITORING
Nephropathy Monitoring

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 HMO patients with diabetes who received a screening for microalbuminuria during 2006.

Separate charts display results for commercial and Medicare members.





BETA BLOCKER TREATMENT *1 of 2*

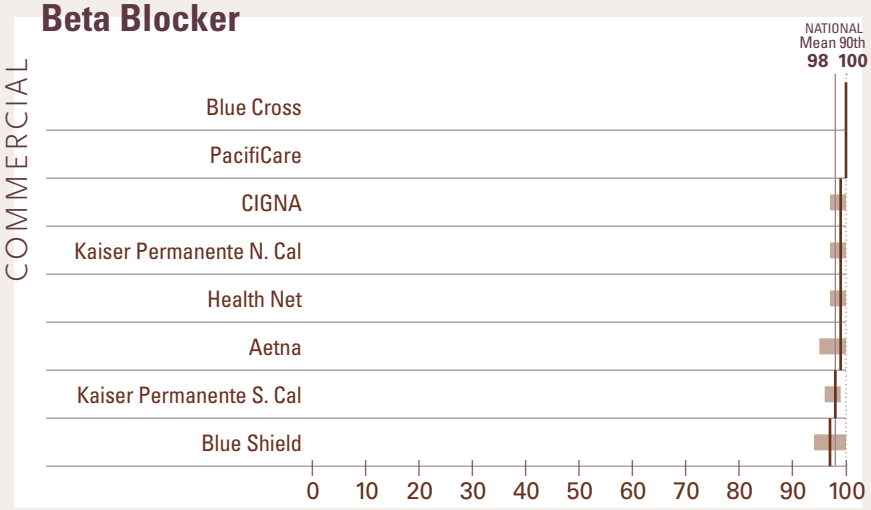
BETA BLOCKER TREATMENT AFTER HEART ATTACK

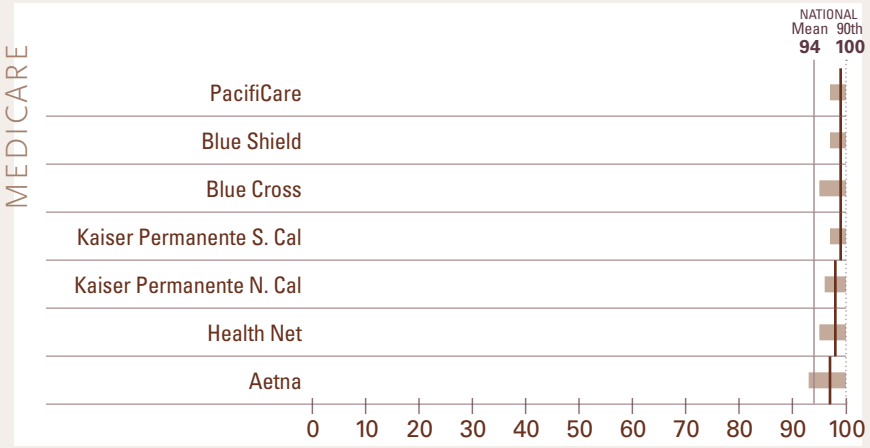
Heart attacks, also known as acute myocardial infarctions or AMI, occur in approximately 1.2 million Americans each year. Unfortunately, patients who have had a heart attack are at higher risk than the general public to have another one.

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.

This measure calculates the percentage of HMO members 35 years of age and older who were hospitalized and discharged from the hospital after surviving a heart attack and who received a prescription for a beta blocker. HMOs improve beta blocker treatment rates by encouraging physicians to evaluate clinical options, including the use of medications, for patients with heart disease and especially for those who have suffered a heart attack. Health plans also provide educational materials about the appropriate use of beta blockers to physicians and members.

Separate charts display results for commercial and Medicare members.





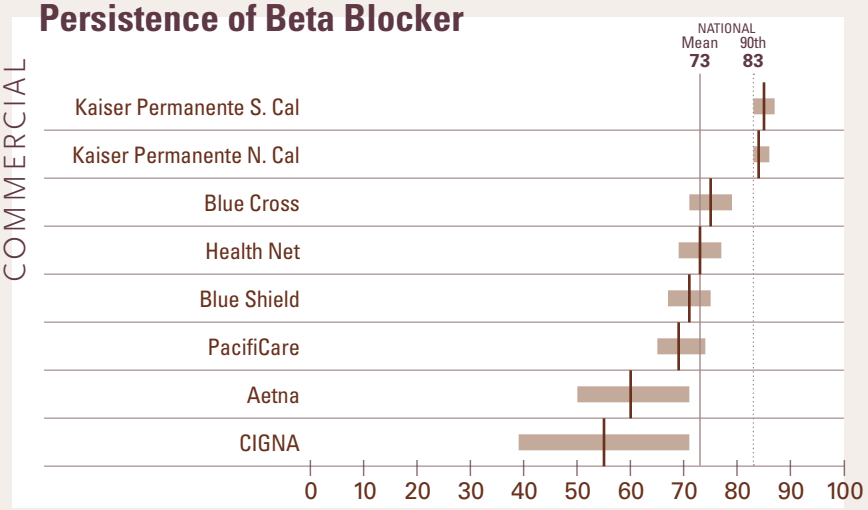
BETA BLOCKER TREATMENT *2 of 2*

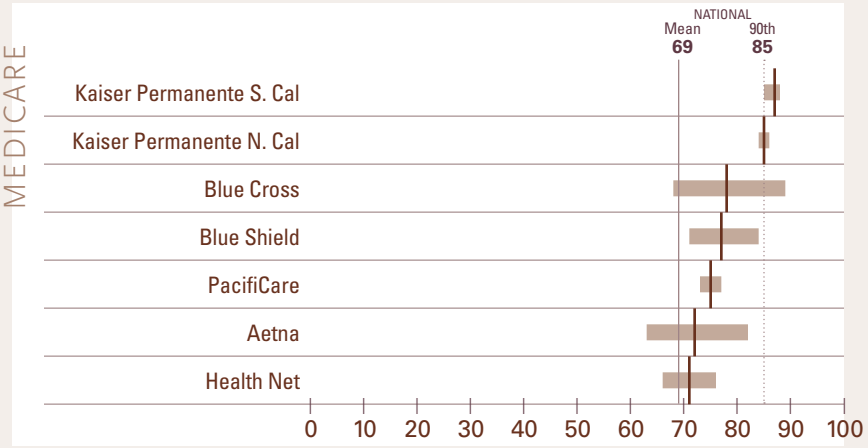
PERSISTENCE OF BETA BLOCKER TREATMENT AFTER HEART ATTACK

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 35 years and older who were discharged from the hospital with a diagnosis of a heart attack and who received beta-blocker treatment for 6 mos after the discharge.

Separate charts display results for commercial and Medicare members.





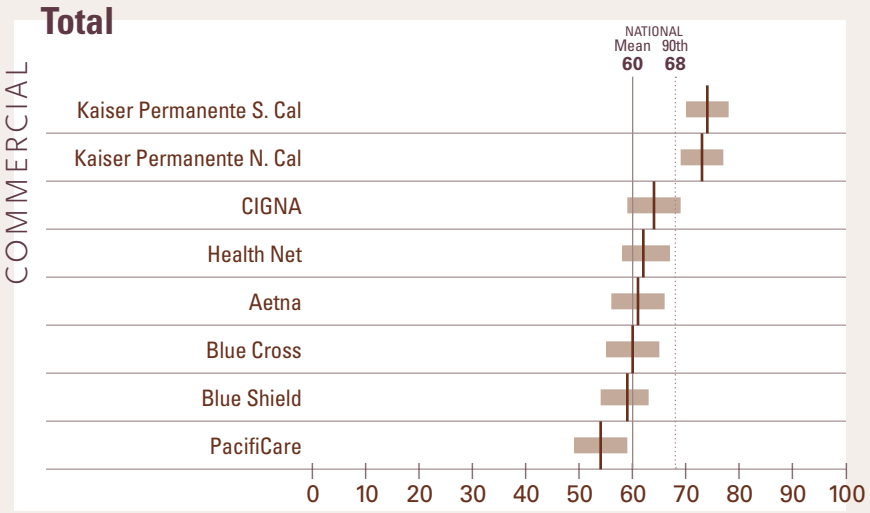
HIGH BLOOD PRESSURE

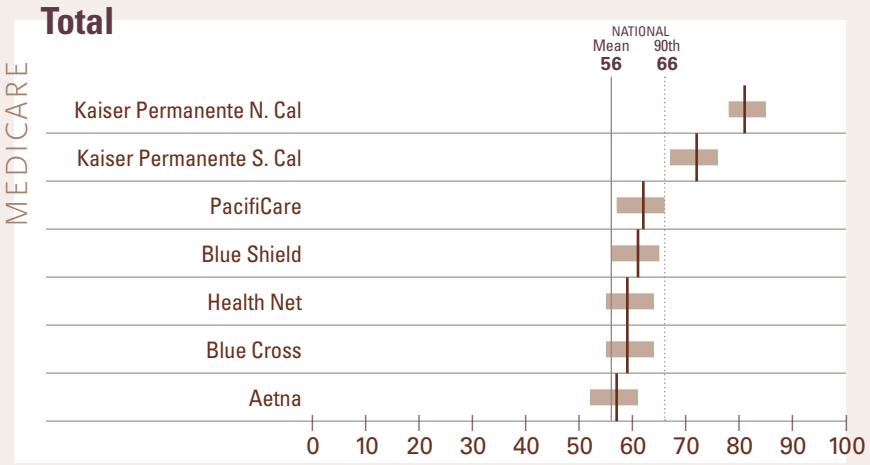
CONTROLLING HIGH BLOOD PRESSURE

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 during 2006. 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. HMOs 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.

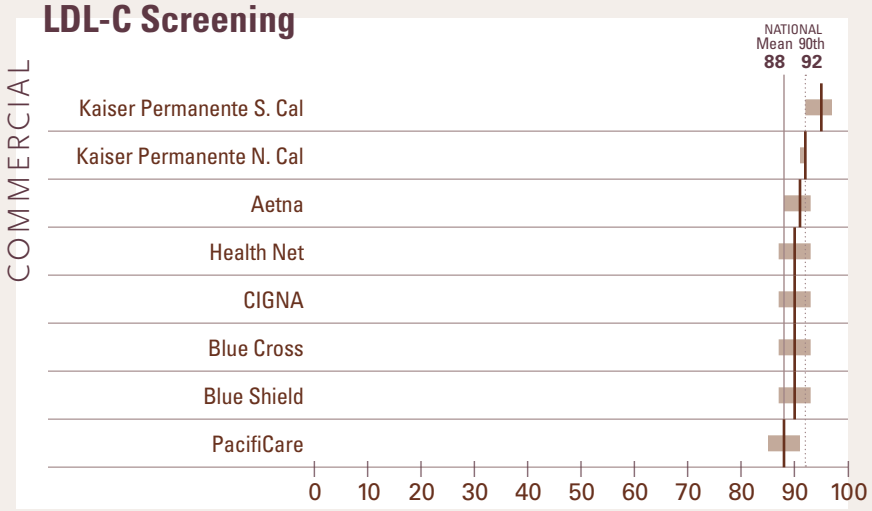
Elevated cholesterol levels can be lowered through a combination of lifestyle changes including a low-fat diet, increased physical activity and, when appropriate, treatment with cholesterol-lowering medications. Physicians routinely screen patients for high cholesterol. It is especially important for 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 test during the year after their hospital discharge.

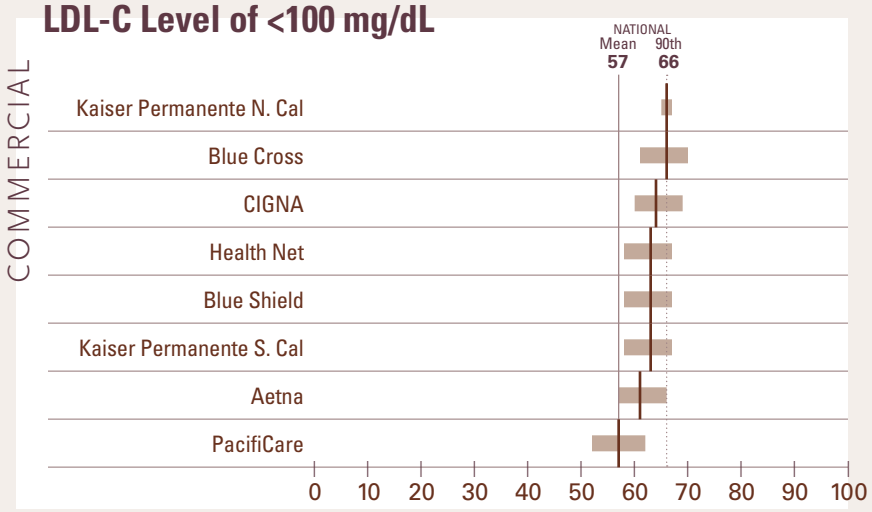
The second measure reflects the percentage of patients with known heart disease who have their cholesterol levels under control. Control for this measure means an LDL cholesterol level less than 100mg/dl. Controlling LDL cholesterol levels is very important in patients with existing heart disease and 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.

LDL-C Screening

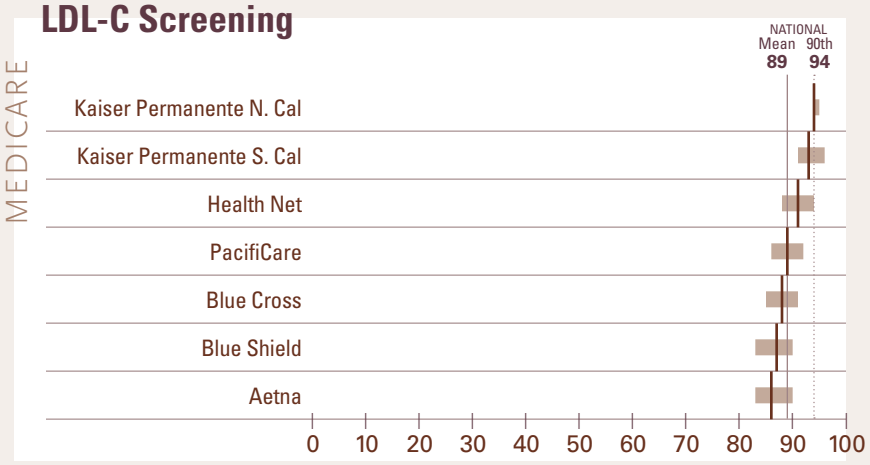


LDL-C Level of <100 mg/dL

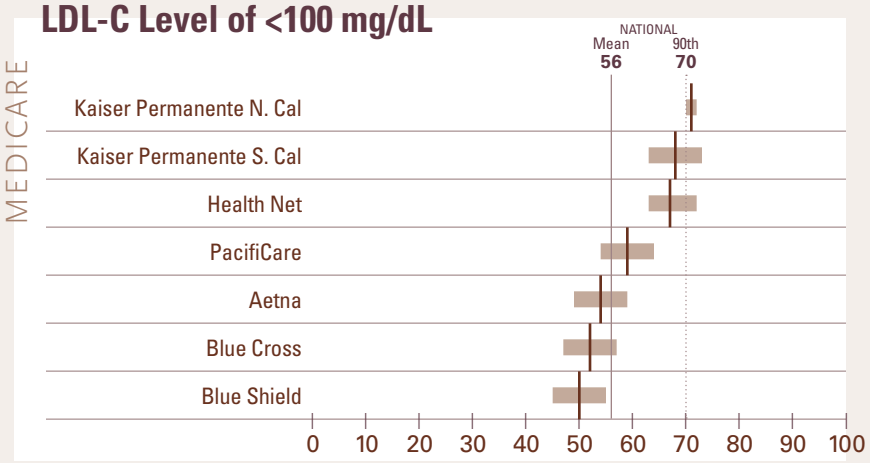


CHOLESTEROL MANAGEMENT *2 of 2*

LDL-C Screening



LDL-C Level of <100 mg/dL

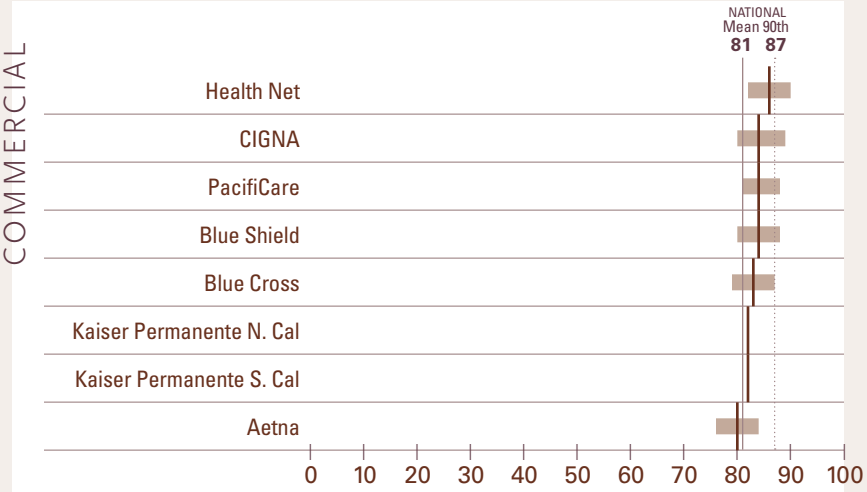


CERVICAL CANCER

CERVICAL CANCER SCREENING

The American Cancer Society estimates that in 2007, about 11,150 cases of invasive cervical cancer will 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 below 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*

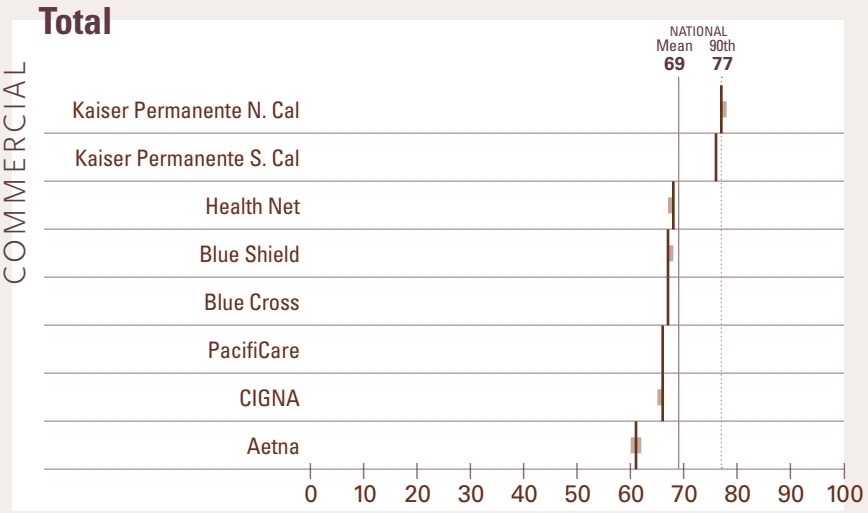
BREAST CANCER SCREENING

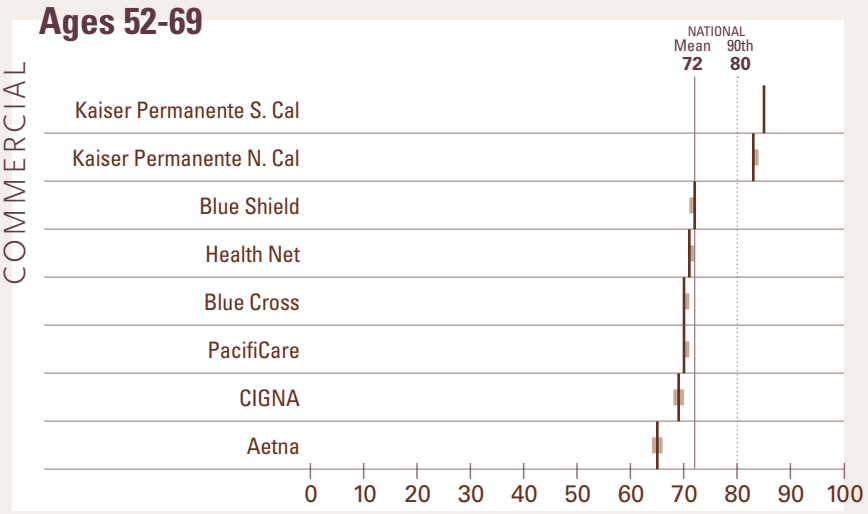
One out of every eight women will develop breast cancer in the course of a 90-year life span. In 2007 in the U.S., about 178,480 women will be diagnosed with invasive breast cancer and 40,460 will die. If detected early, the 5-year survival rate exceeds 95%. Mammograms are among the best early detection 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 2005 and 2006 and had at least one mammogram during that two-year period.

The charts on this 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.

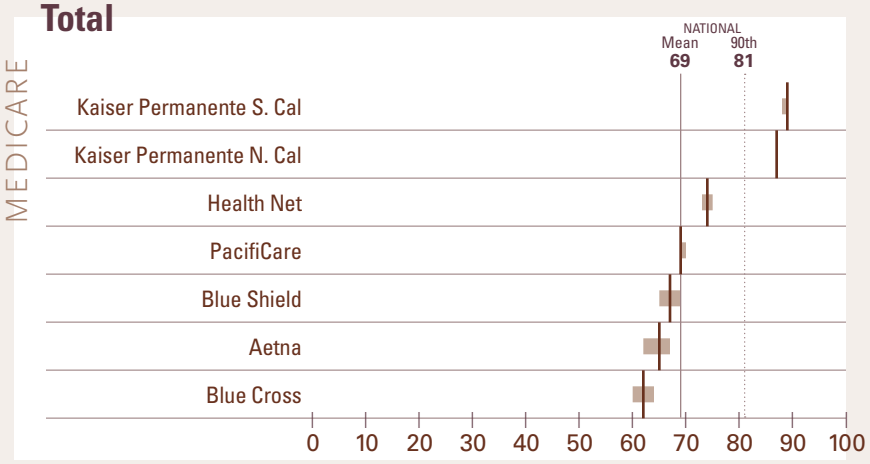
Separate charts display results for commercial and Medicare members.



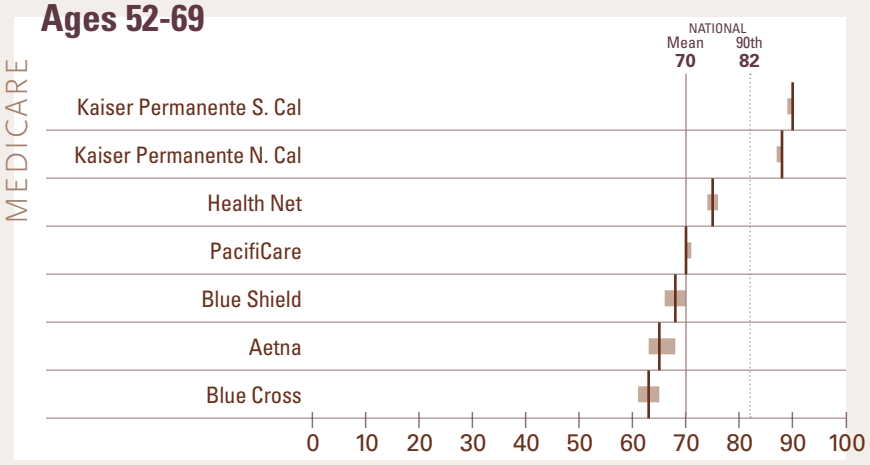


BREAST CANCER *2 of 2*

Total



Ages 52-69

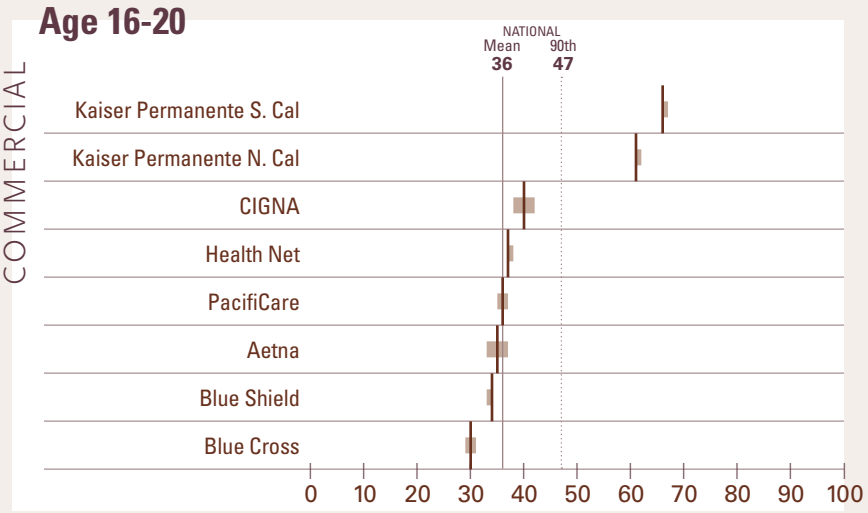


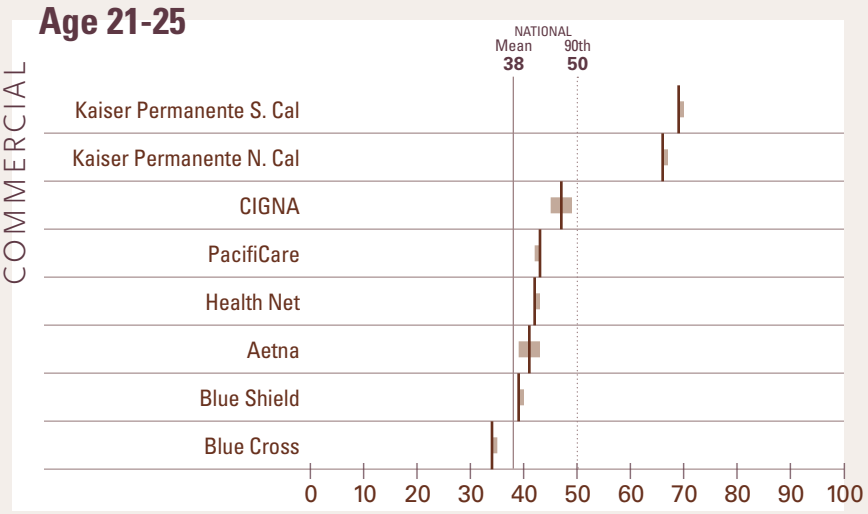
CHLAMYDIA

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 sixteen and twenty-five who received at least one routine screening test for Chlamydia during 2006. Health plans can successfully improve Chlamydia screening rates through distribution of educational materials to both physicians and HMO members.





COLORECTAL CANCER

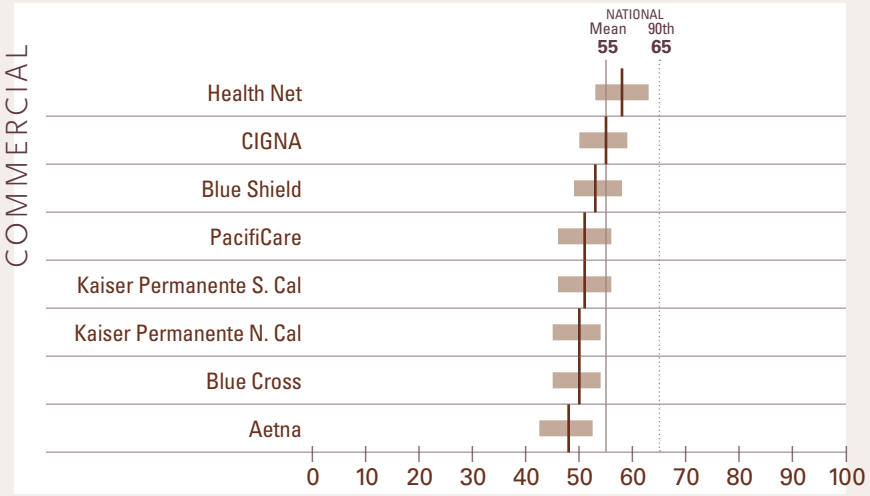
COLORECTAL CANCER SCREENING

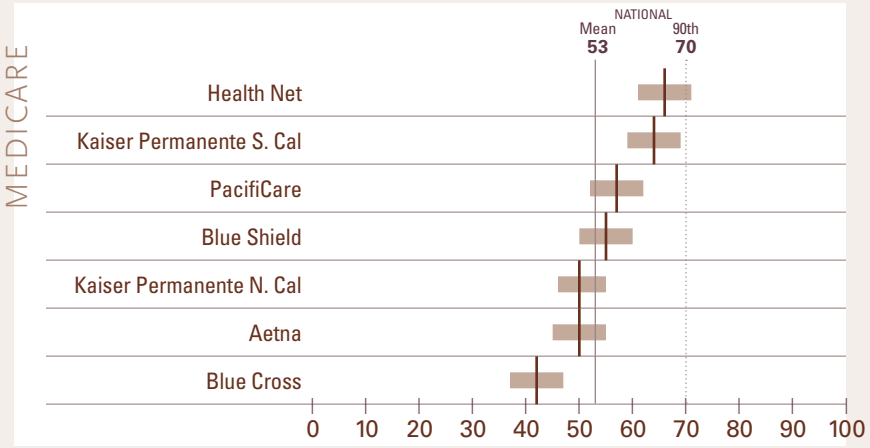
Colorectal cancer—cancer of the colon or rectum—is the second leading cause of cancer-related deaths in the U.S. The American Cancer Society estimates that 52,180 Americans will die of colorectal cancer this year. Colorectal cancer is also one of the most commonly diagnosed cancers in the U.S.; approximately 153,760 new cases will be diagnosed in 2006. 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 2006; a flexible sigmoidoscopy within the last four years prior to 2006; a double contrast barium enema within the last four years prior to 2006; 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.



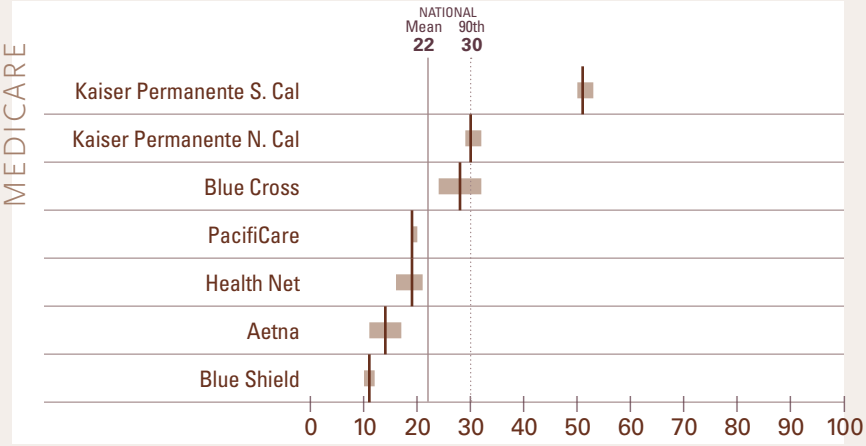


OSTEOPOROSIS

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 percent 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.

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. 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.



ANTIDEPRESSANT MEDICATION *1 of 2*

ANTIDEPRESSANT MEDICATION MANAGEMENT

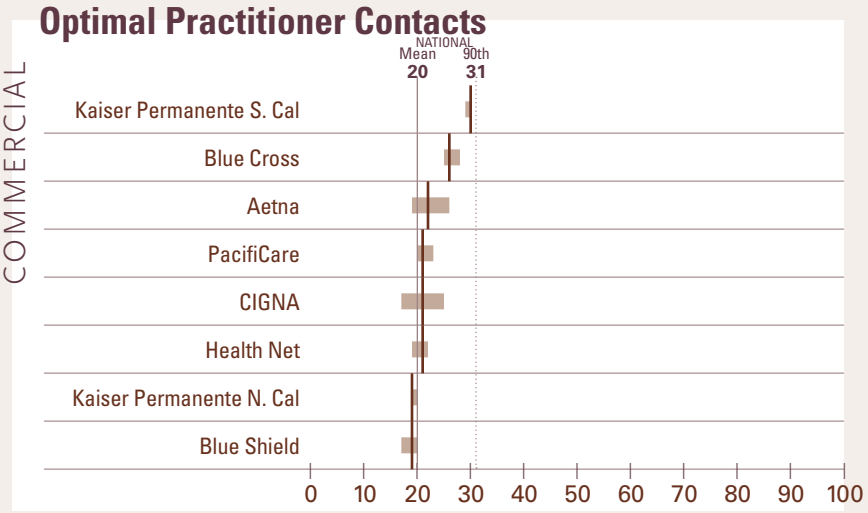
In any given one year period, 5.8% of the population or about 15 million American adults suffer from major depressive illness. If not properly treated with counseling and medications, patients can sometimes experience serious complications. Approximately 70% of patients who are diagnosed with severe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

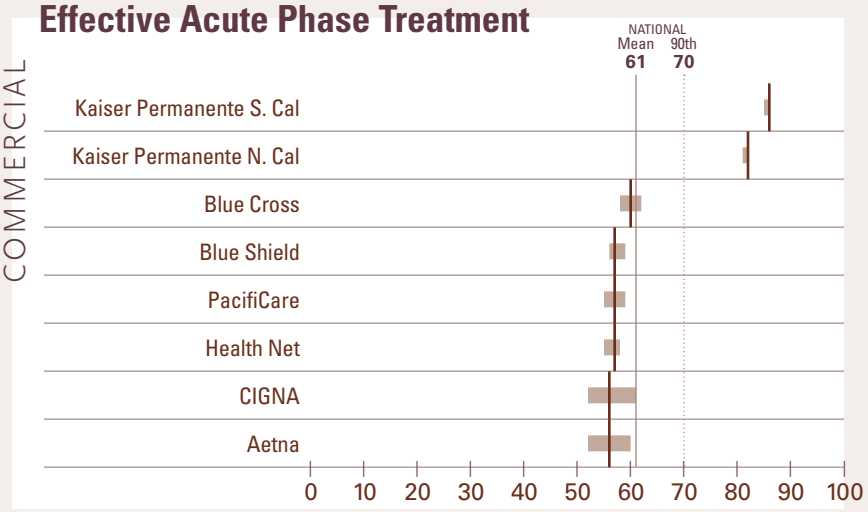
These charts display a three-part measure that looks at different facets of successful pharmacological management of depression. The three components of the measure estimate:

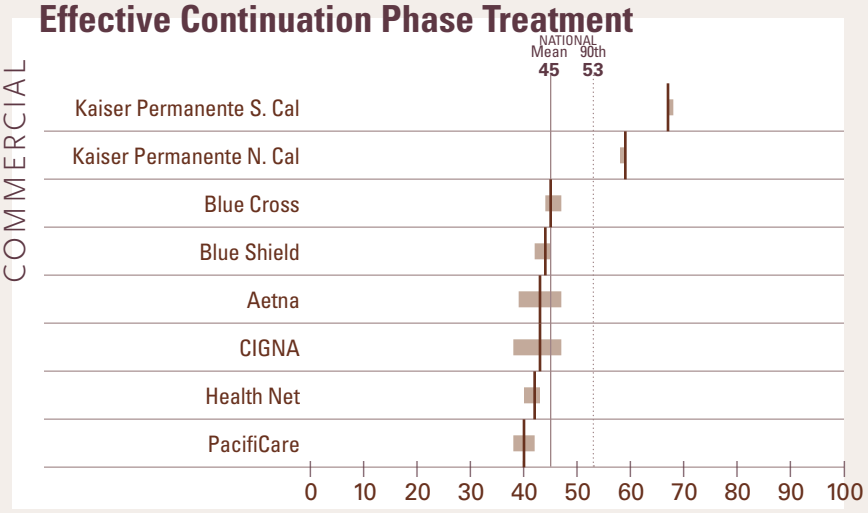
1. Optimal Practitioner Contacts: The percentage of eligible members who received at least three follow-up visits in the 12-week acute treatment phase after a new diagnosis of depression;
2. Effective Acute Phase: The percentage of eligible members who remained on antidepressant medication continuously for 12 weeks after the initial diagnosis;
3. 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, four to nine months. 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.

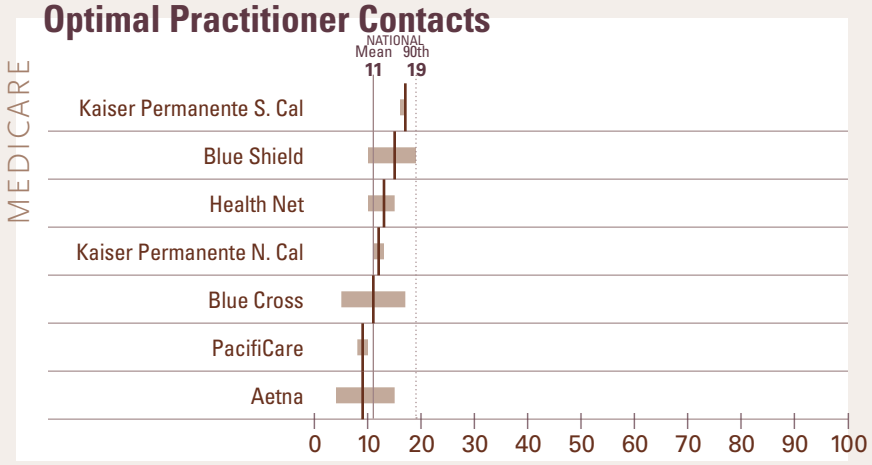




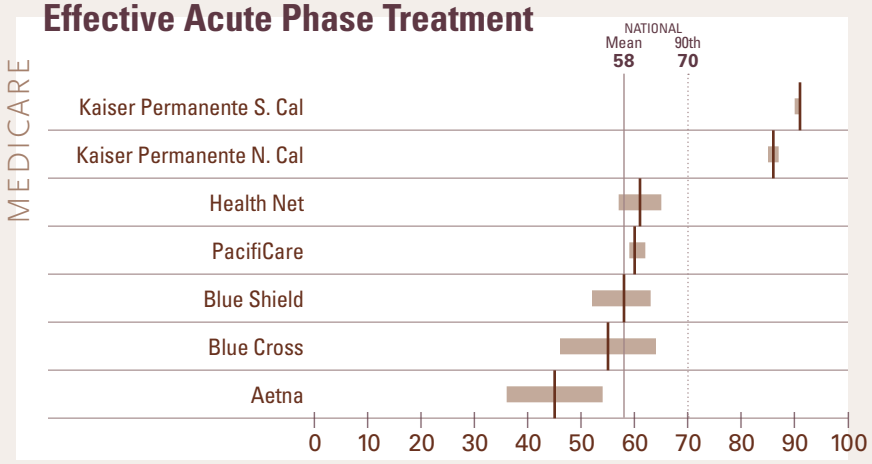


ANTIDEPRESSANT MEDICATION *2 of 2*

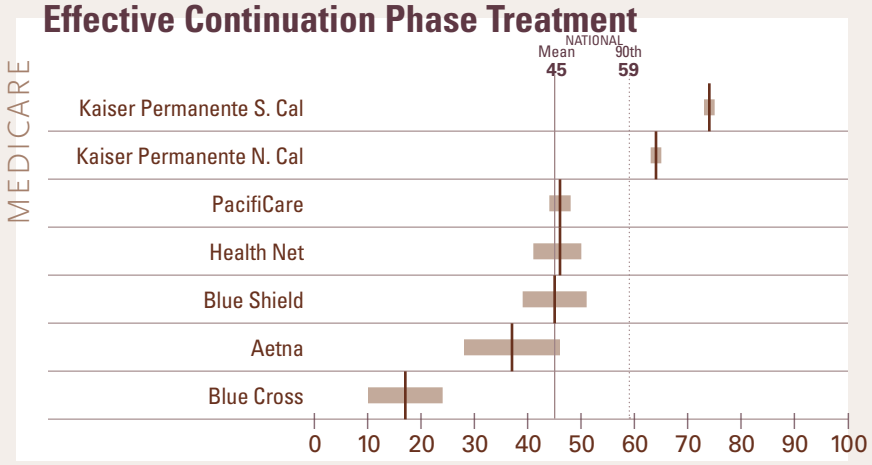
Optimal Practitioner Contacts



Effective Acute Phase Treatment



Effective Continuation Phase Treatment



MENTAL ILLNESS *1 of 2*

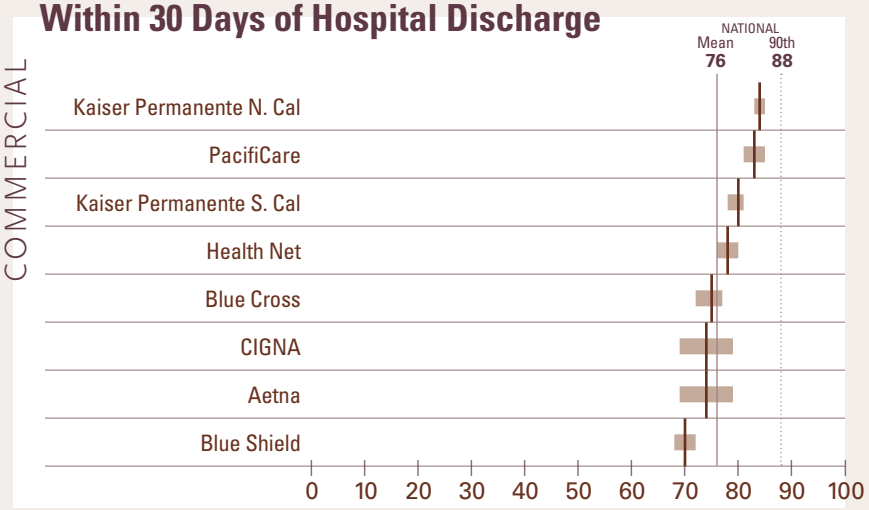
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

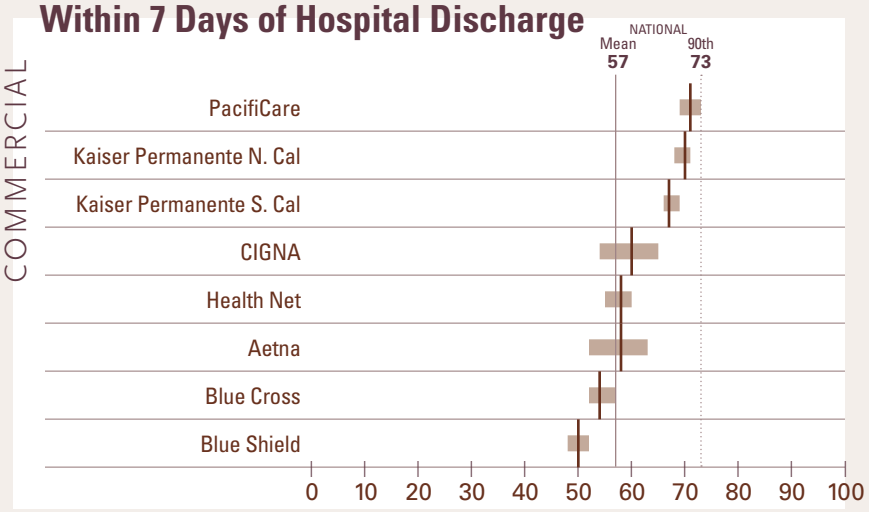
Mental illnesses such as depression, schizophrenia, and anxiety are real health conditions that, if untreated, can be as disabling and serious as cancer and heart disease. Fortunately, advances in mental health research and the availability of newer, more effective medication have broadened the treatment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

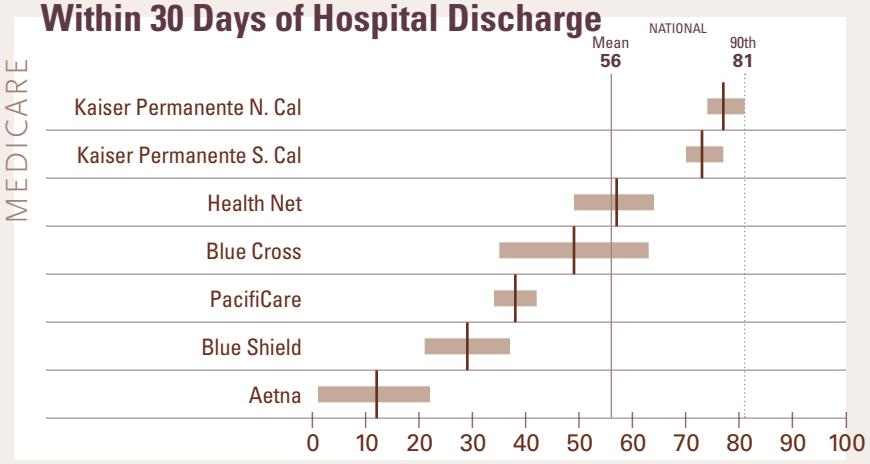
Separate charts display results for commercial and Medicare members.



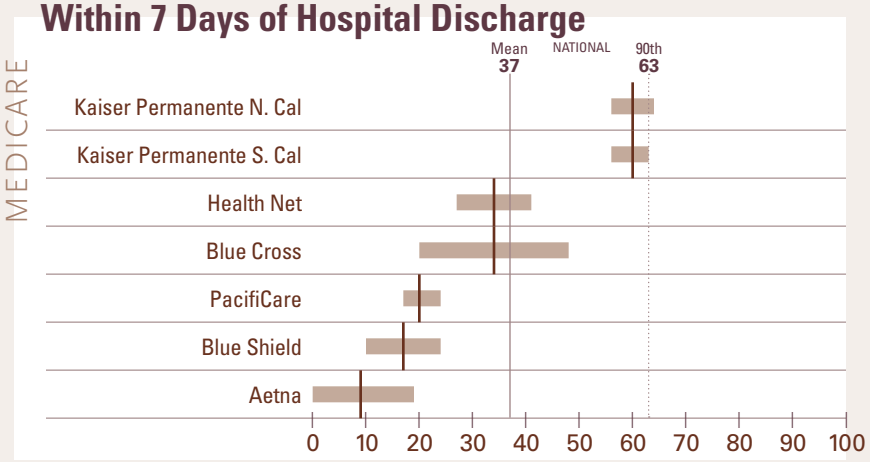


MENTAL ILLNESS *2 of 2*

Within 30 Days of Hospital Discharge



Within 7 Days of Hospital Discharge



ACUTE BRONCHITIS

INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS

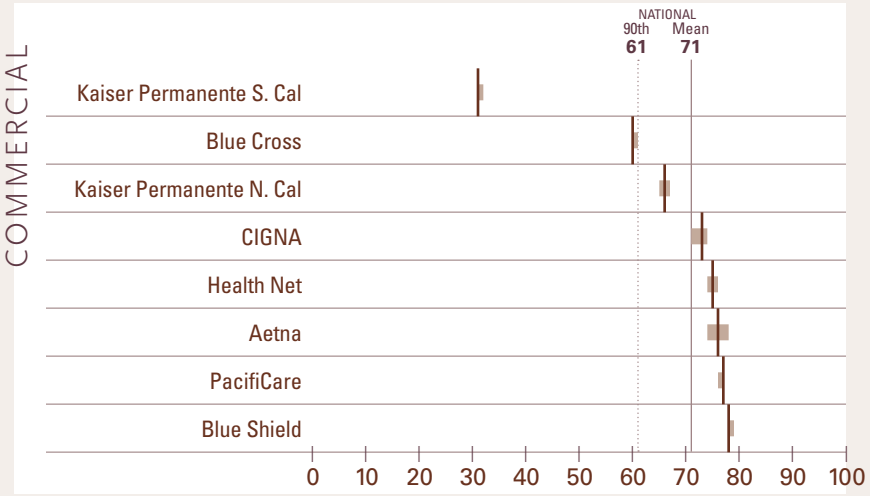
In the United States, about 5% of adults self-report an episode of acute bronchitis each year, and up to 90% of these persons seek medical attention. In 1997, adults in the United States made more than 10 million office visits for bronchitis. As a result, acute bronchitis consistently ranks among the 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 nonbacterial cause (greater than 90%), antibiotics are prescribed 65 percent to 80 percent of the time. A lower rate indicates better performance.

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 dispensed an antibiotic prescription.

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



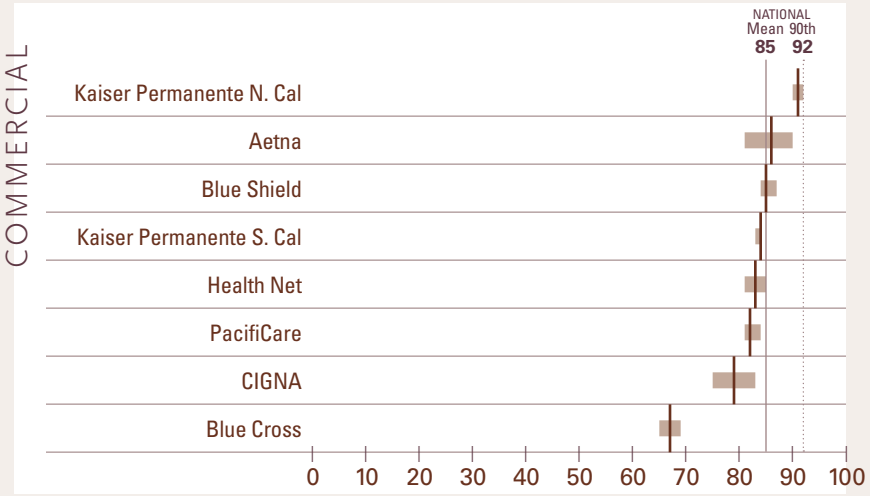
ANTI-RHEUMATIC DRUG THERAPY

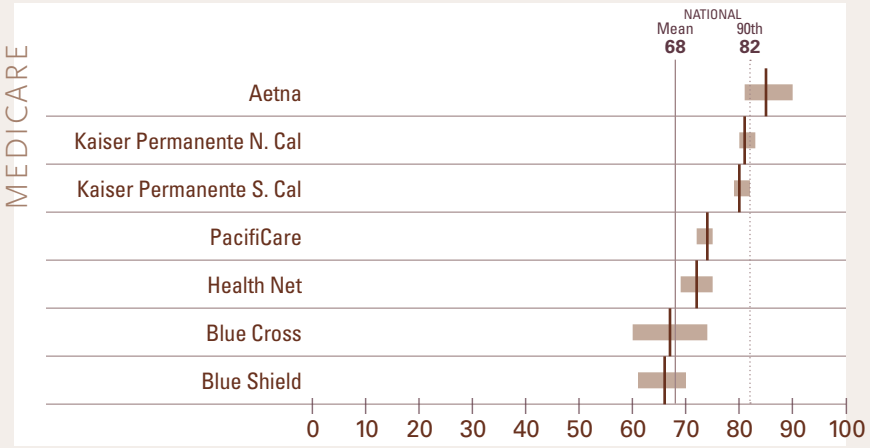
DISEASE MODIFYING ANTI-RHEUMATIC DRUG THERAPY

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.





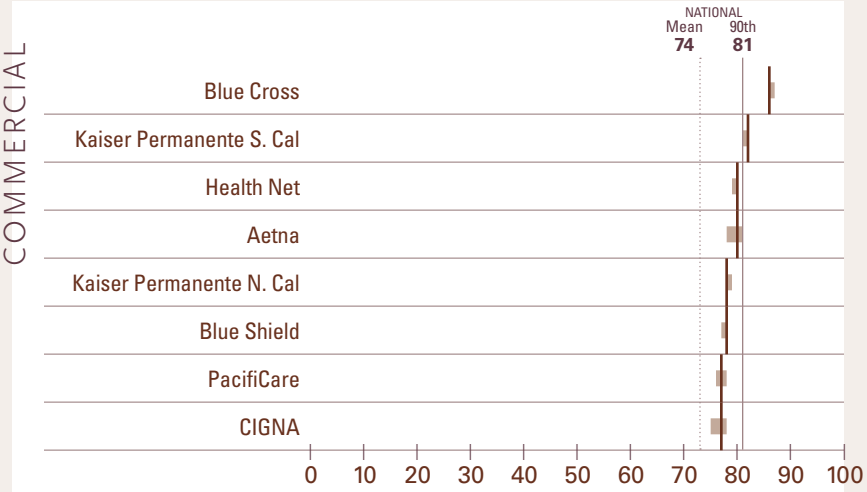
LOW BACK PAIN IMAGING

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 e.g. 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.

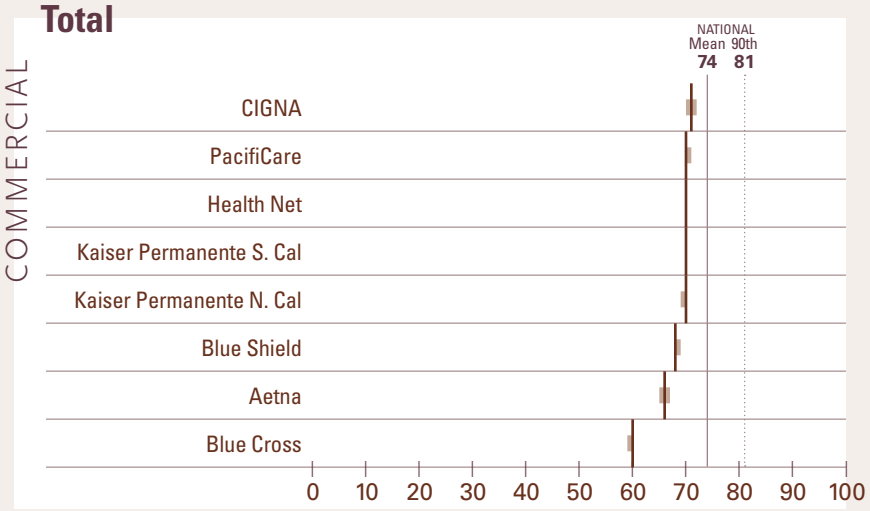
Appropriate monitoring of drug therapy remains a significant issue to guide therapeutic decision making and provides largely unmet opportunities for improvement in care for patients on persistent medications.

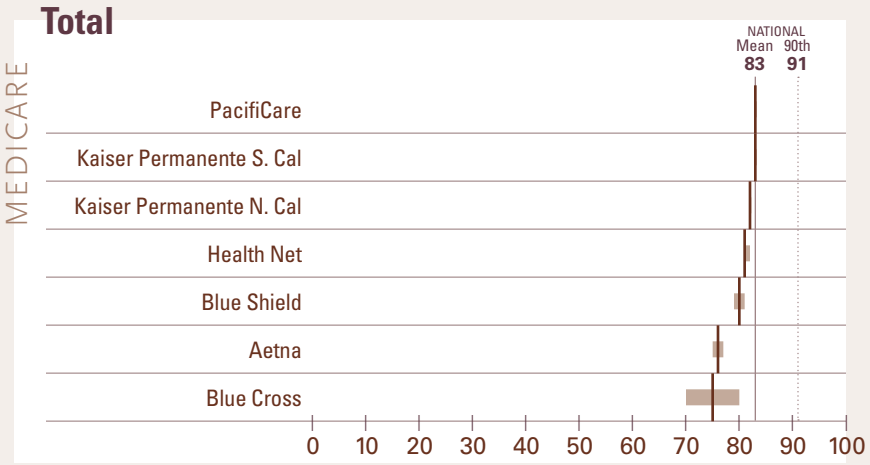
This measure is used to assess the percentage of health plan members 18 years of age and older who received at least a 180-days supply of ambulatory medication therapy for the following medications:

- 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

DRUGS TO BE AVOIDED IN THE ELDERLY

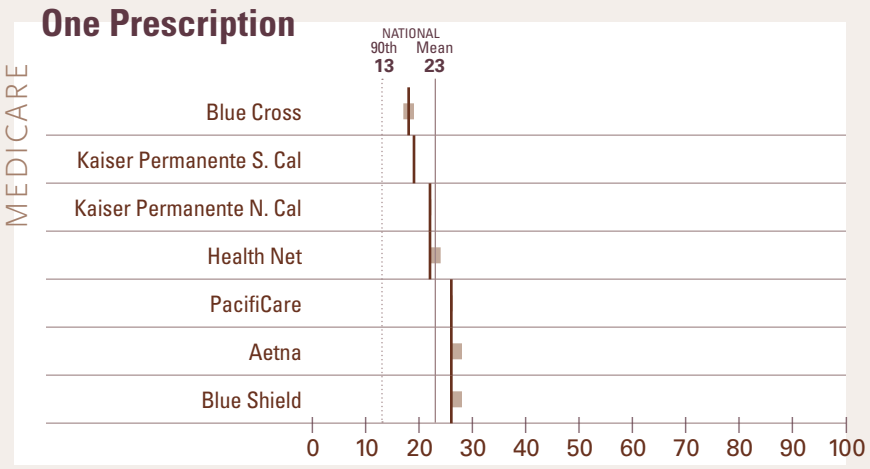
With an increasing focus on patient safety, NCQA introduced new HEDIS patient safety measures assessing the safe use of medications in the Medicare population, in 2006. Certain medications are associated with increased risk of harm from drug side-effects and drug toxicity and pose a concern for patient 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.

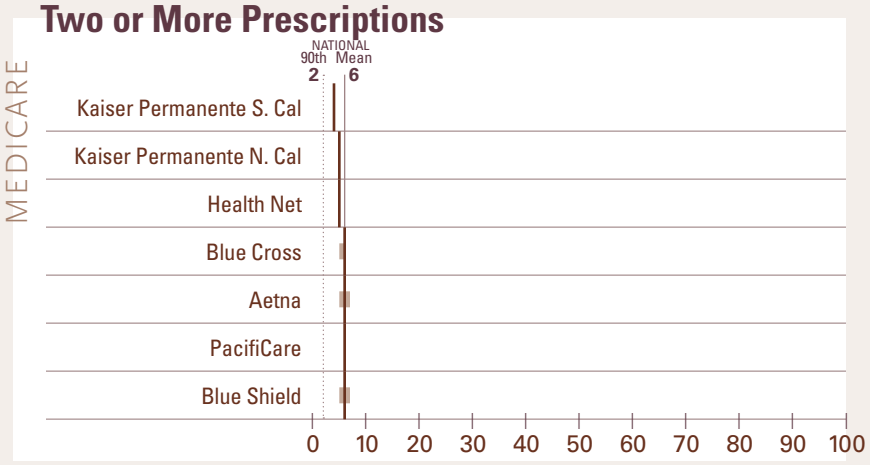
Reducing prescriptions of high-risk drugs in the elderly represents an opportunity to reduce the costs associated with the harm from medications (i.e., hospitalizations from drug toxicity) and encourage clinicians to consider safer, alternative medications. Reducing unnecessary prescribing will also 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.

Drugs to Be Avoided 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 drug to be avoided in the elderly.
- The percentage of Medicare members 65 years of age and older who received at least two different drugs to be avoided by the elderly.

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



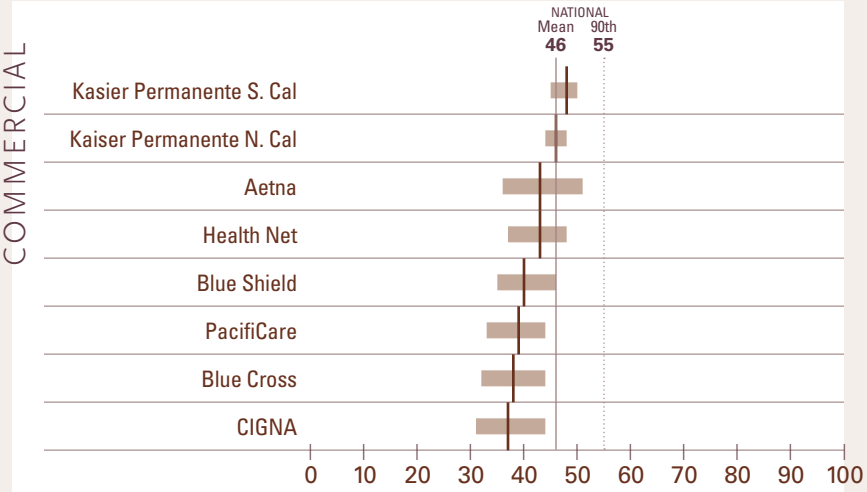


FLU SHOT

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 2006. 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.



SERVICE MEASURES INTRODUCTION

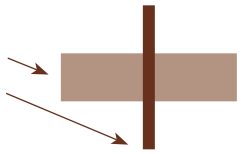
MEASURES OF ACCESS/AVAILABILITY OF CARE

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.

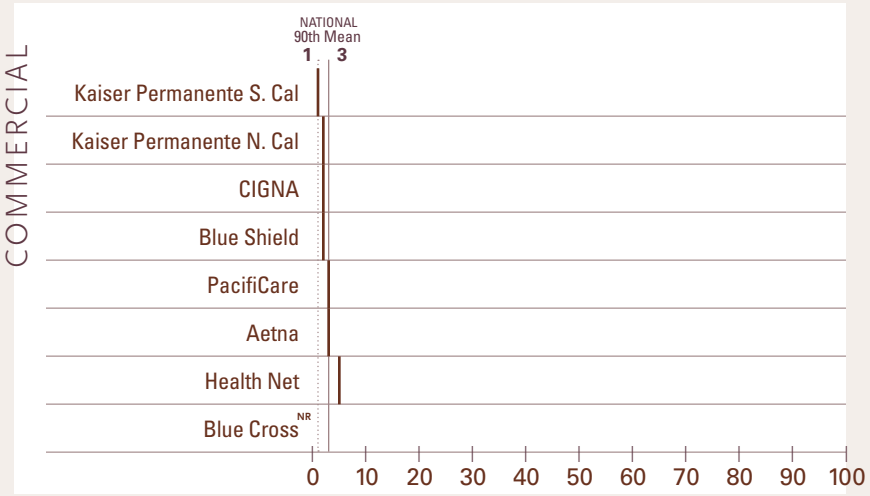
CALL ABANDONMENT

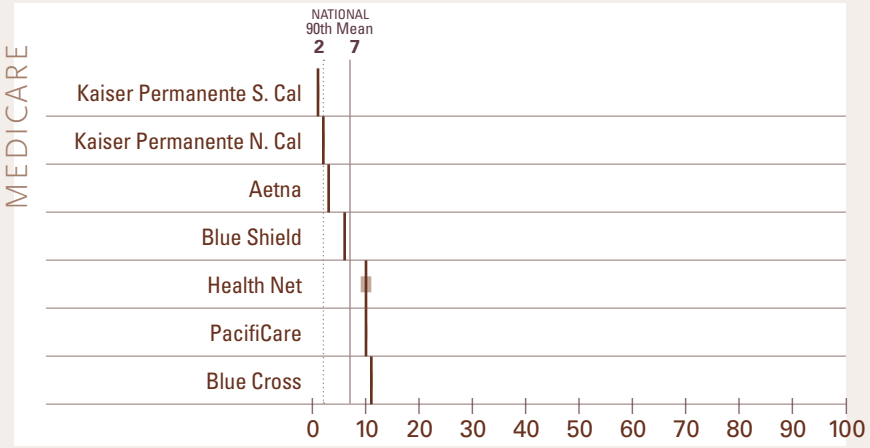
CALL ABANDONMENT

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 voice.

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

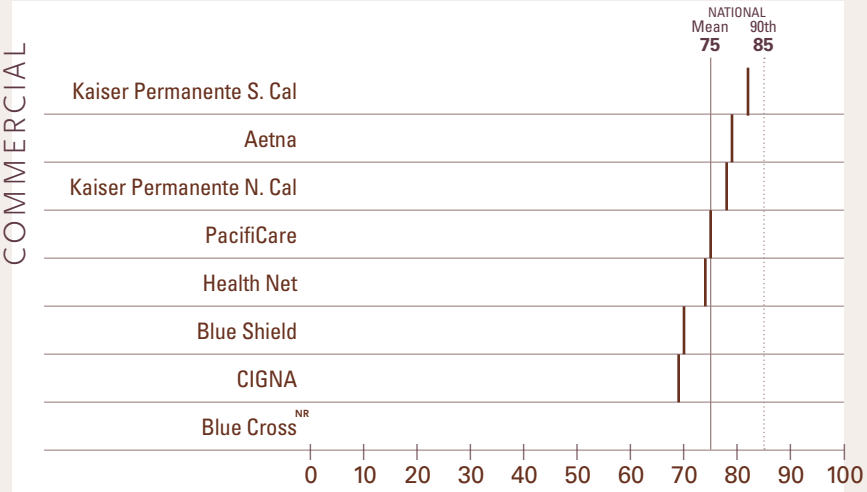
NR - Not reported.

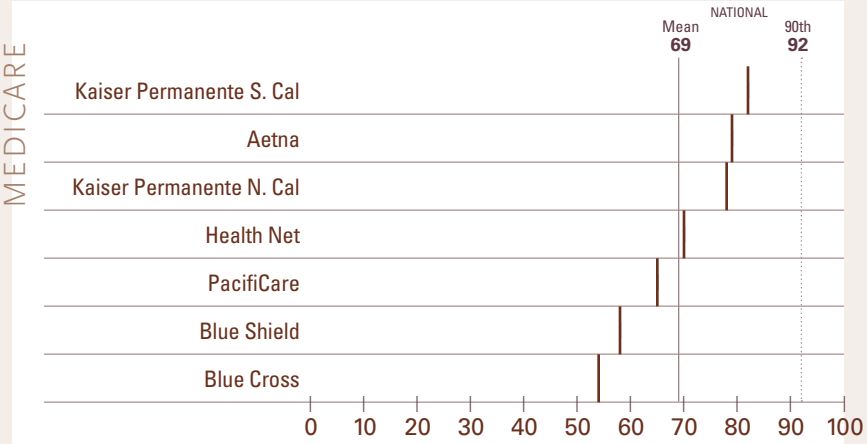
CALL ANSWER TIMELINESS

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 HMOs to evaluate patients' experience and satisfaction with their health 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.

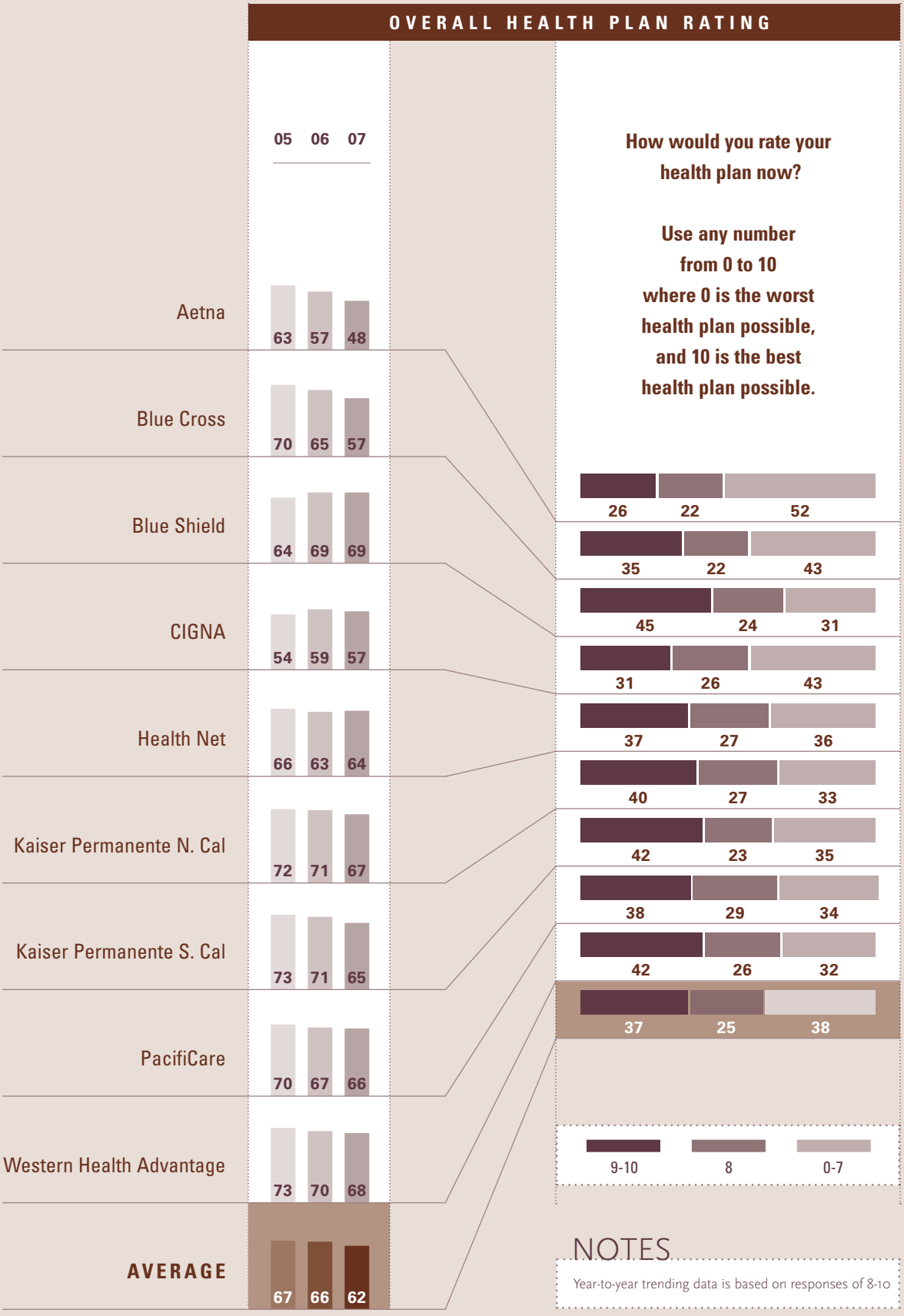
In early 2007, approximately 23,000 members received questionnaires asking them to evaluate their experiences with their health plan during 2006. The research firm tabulated and reported the results based on answers from members who replied to the survey. Findings shown in this report include responses 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.

HEALTH PLAN *1 of 3*

MEMBER SURVEY

OVERALL HEALTH PLAN RATING

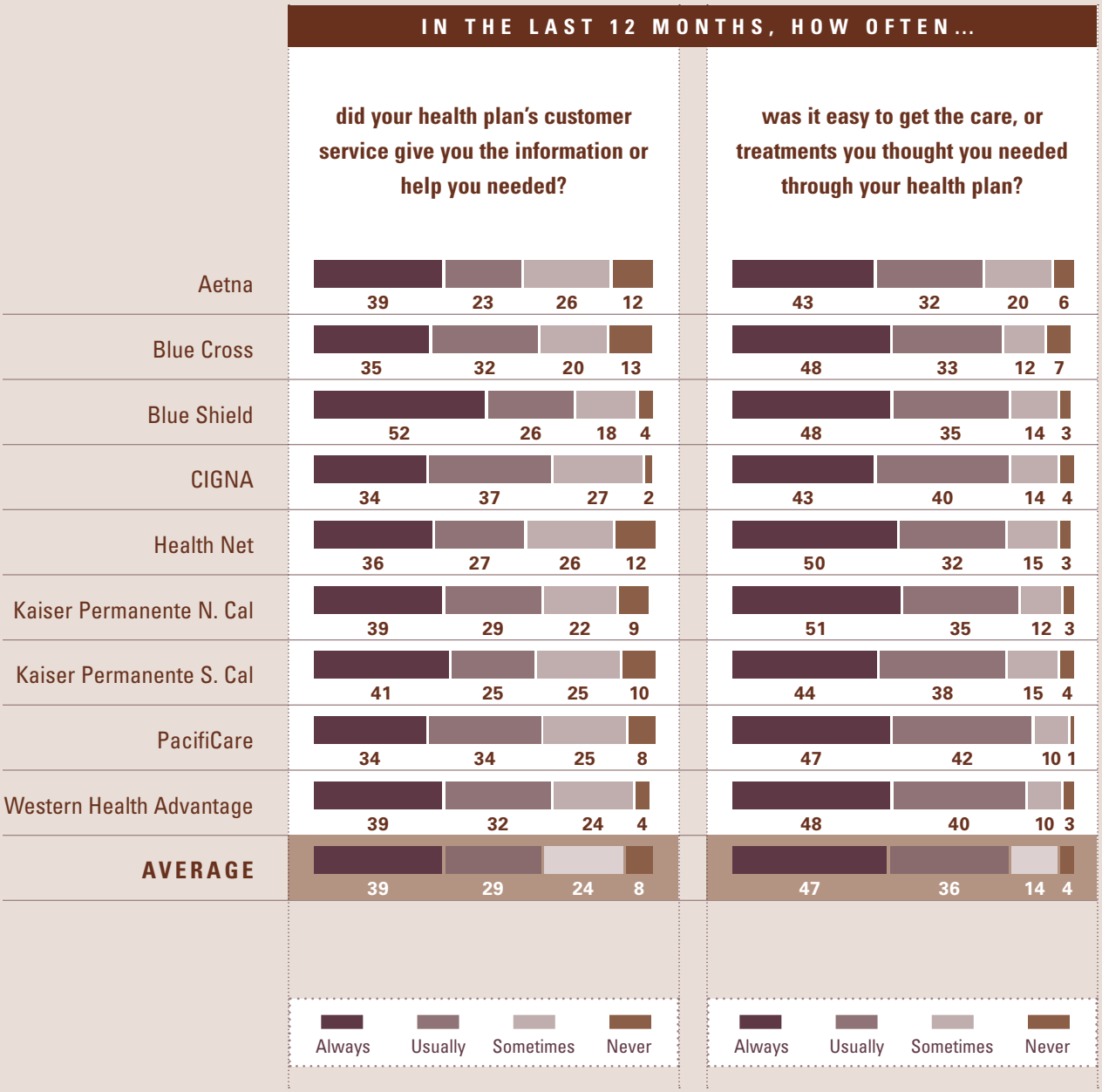


NOTES

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

HEALTH PLAN *2 of 3*

MEMBER SURVEY



HEALTH PLAN *3 of 3*

MEMBER SURVEY

	IN THE LAST 12 MONTHS...			
	have you visited your health plan's website?			please rate your health plan's website on ease of use
	Yes	No Internet access	Not aware health plan has website	
Aetna	NR	NR	NR	NR NR NR NR
Blue Cross	44%	14%	0%	30 57 11 3
Blue Shield	32%	5%	5%	22 66 10 2
CIGNA	NR	NR	NR	NR NR NR NR
Health Net	25%	6%	0%	18 71 10 1
Kaiser Permanente N. Cal	45%	3%	1%	25 62 11 2
Kaiser Permanente S. Cal	NR	NR	NR	NR NR NR NR
PacifiCare	27%	4%	4%	14 65 19 1
Western Health Advantage	22%	4%	3%	9 77 14 1
AVERAGE	32%	6%	2%	21 65 12 2

Very Easy | Easy | Difficult | Very Difficult

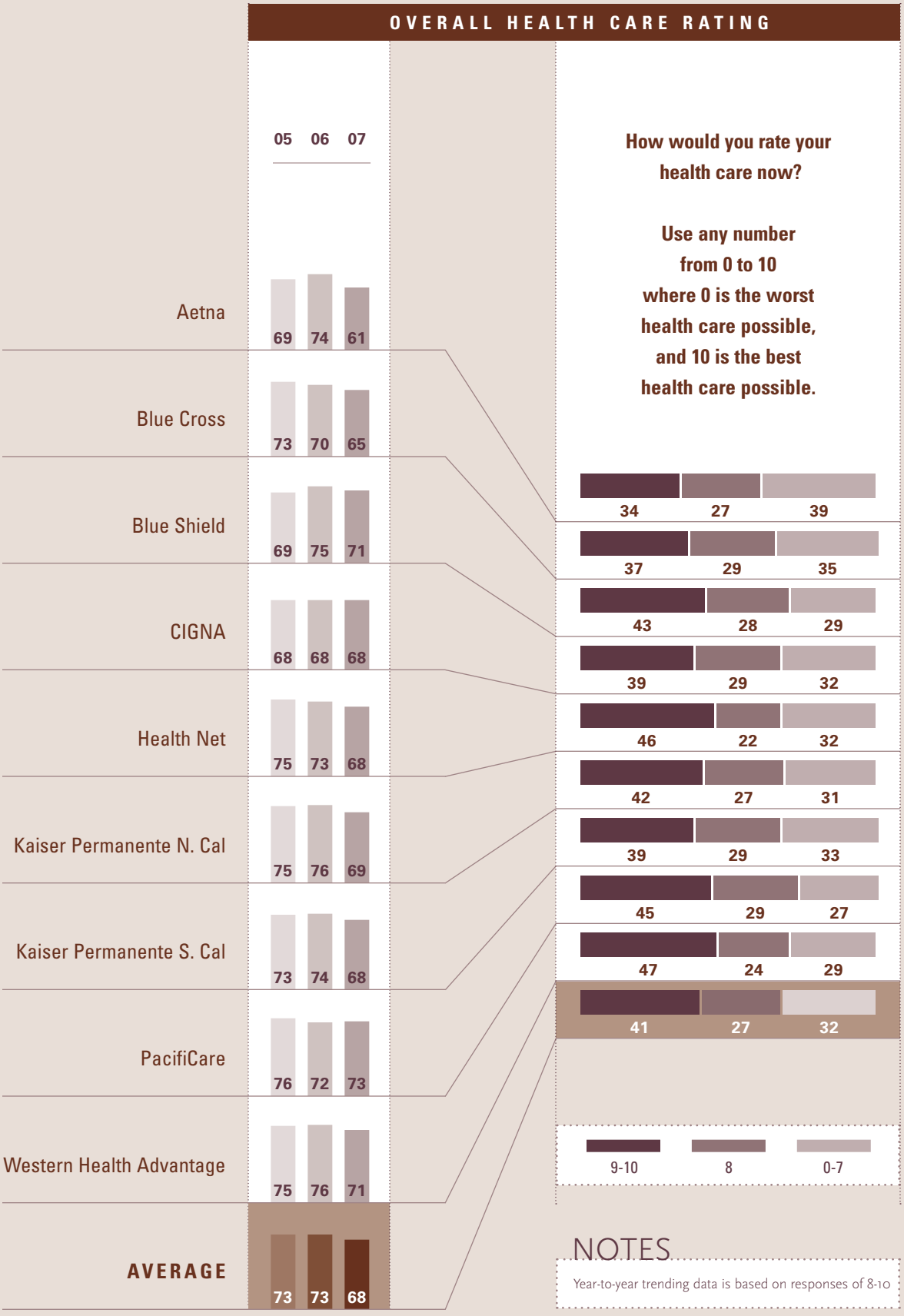
NOTES

NR - Results not available

HEALTH CARE *1 of 5*

MEMBER SURVEY

OVERALL HEALTH CARE RATING



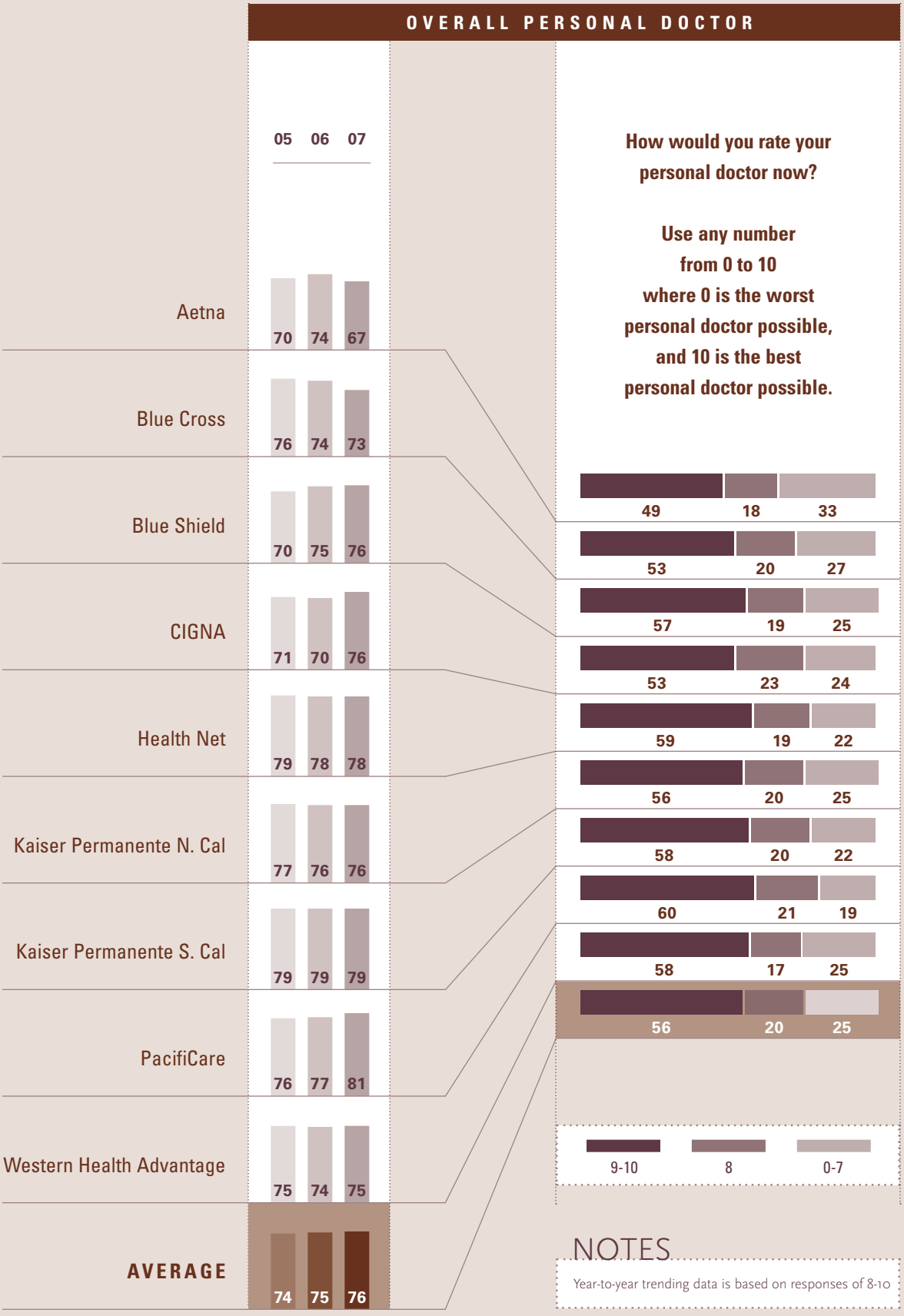
NOTES

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

HEALTH CARE *2 of 5*

MEMBER SURVEY

OVERALL PERSONAL DOCTOR

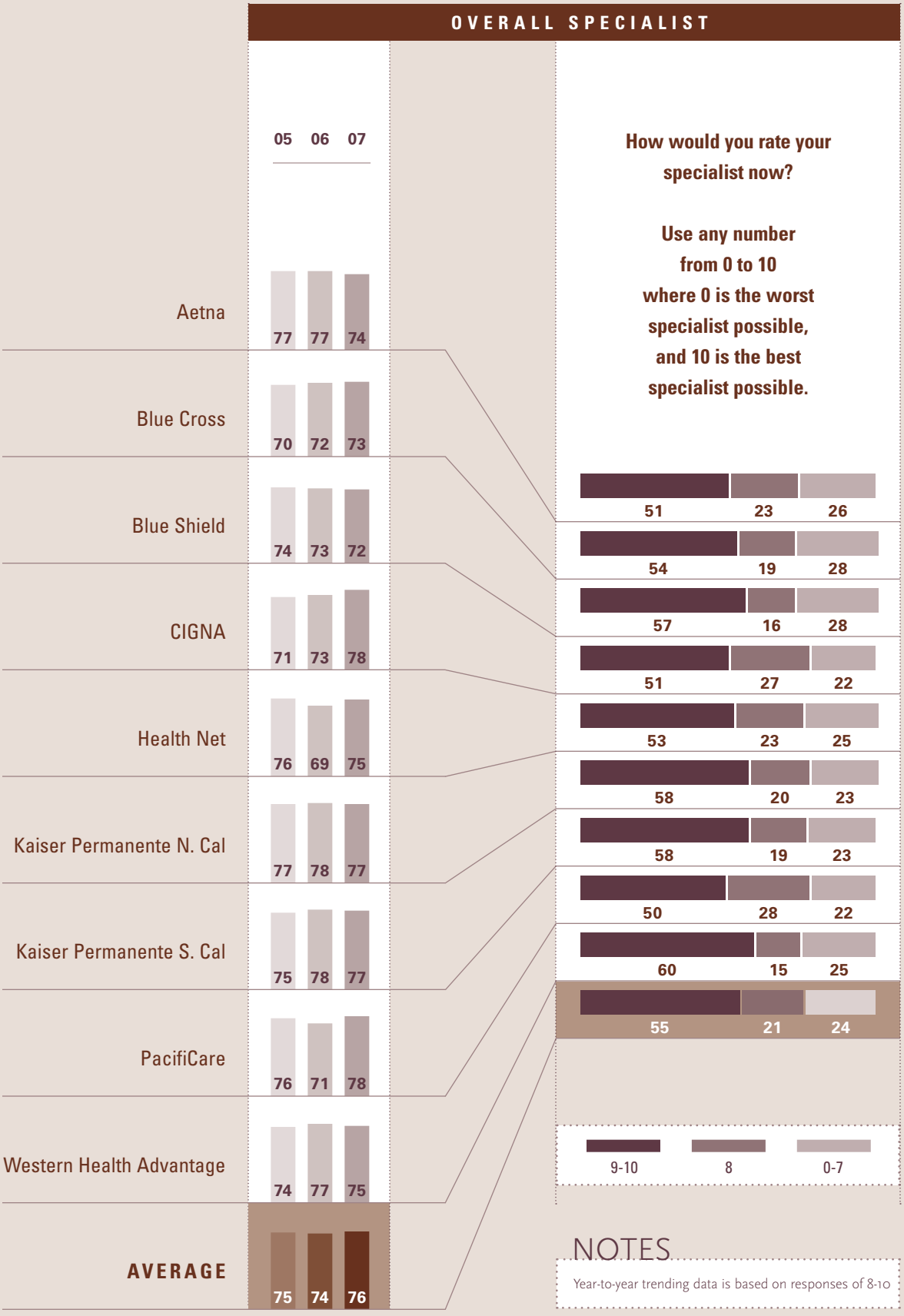


NOTES

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

HEALTH CARE *3 of 5*

MEMBER SURVEY

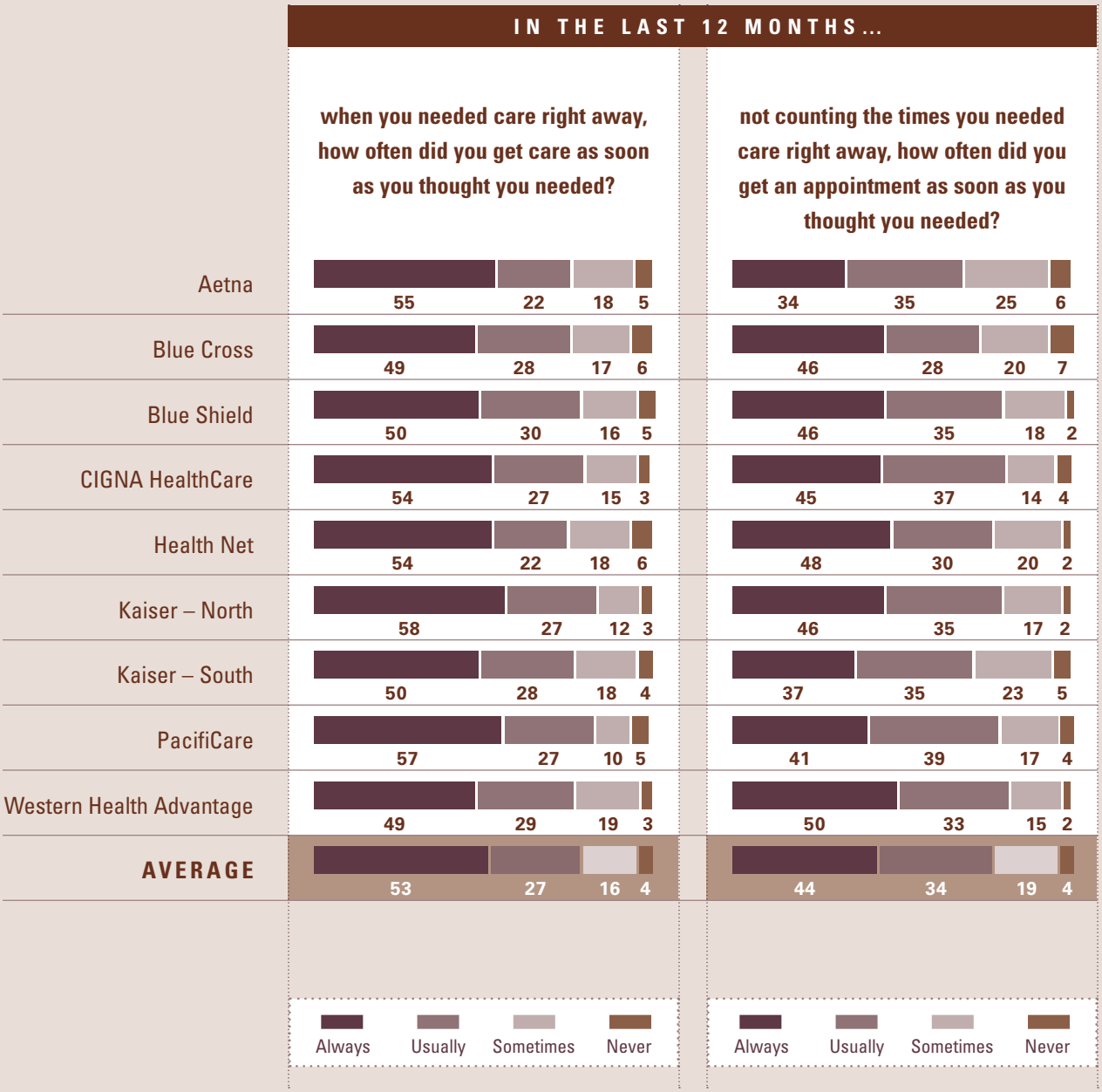


NOTES

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

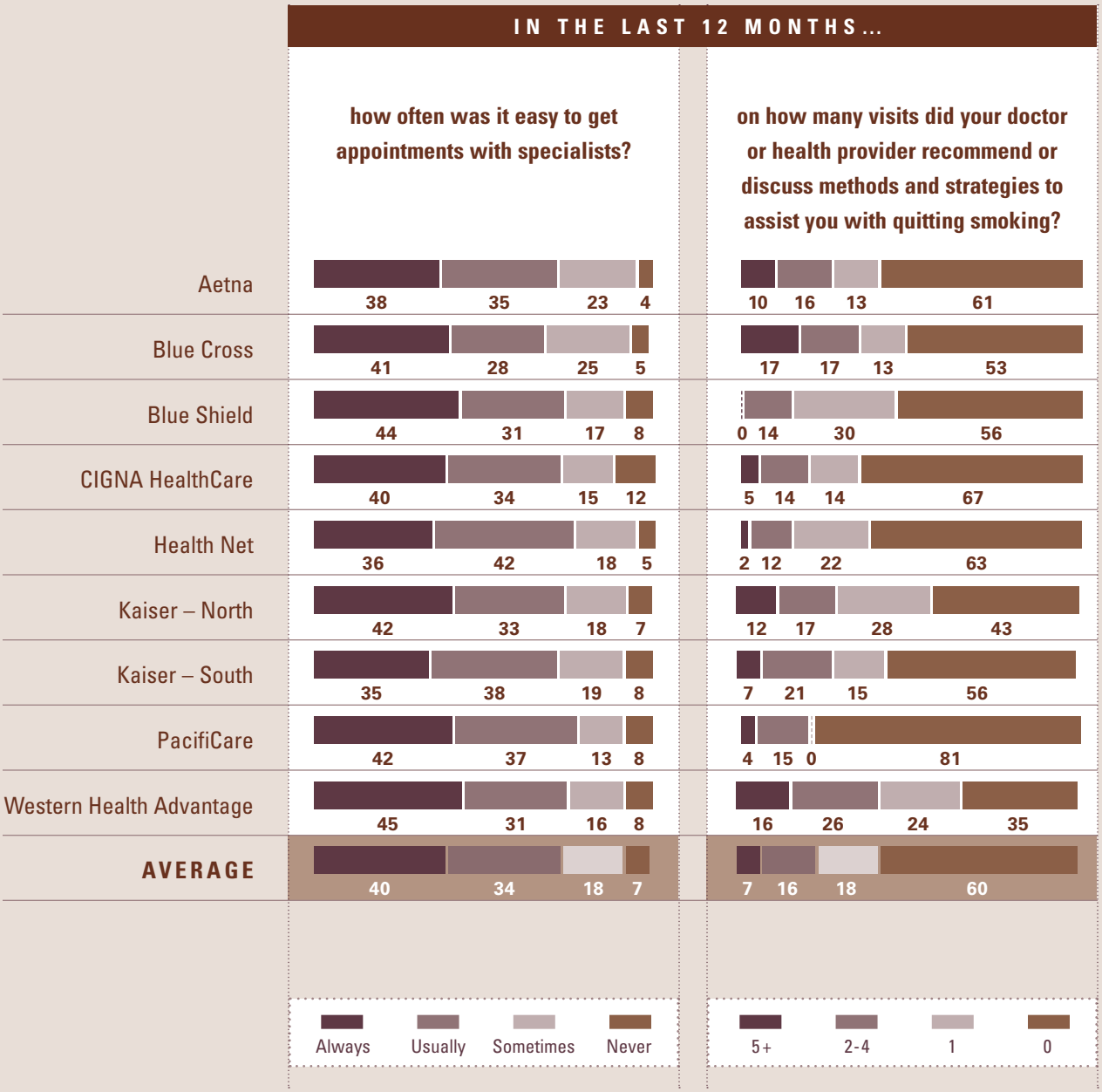
HEALTH CARE *4 of 5*

MEMBER SURVEY



HEALTH CARE *5 of 5*

MEMBER SURVEY



TREND DATA INTRODUCTION

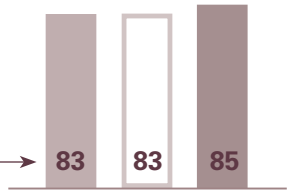
MEASURES OF EFFECTIVENESS OF CARE

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 and service 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 2005 results. Changes not noted with an arrow are not meaningful and may be due to random chance.

HOW TO READ THESE GRAPHS

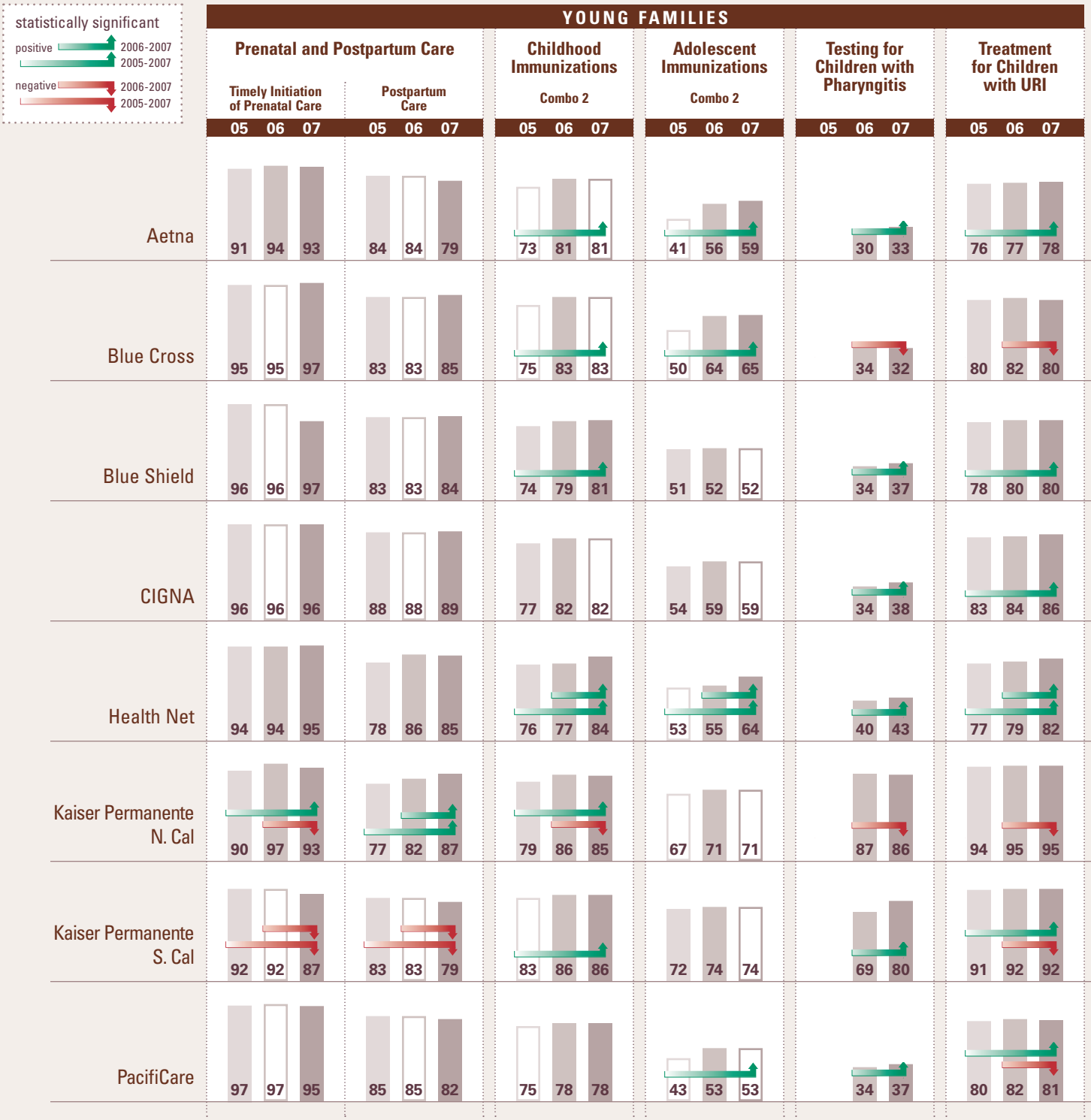


Not all data are required to be collected yearly. Therefore, the hollow bars in the graphs on the following pages indicate that the health plan elected to honor the NCQA rotation strategy for that measurement year and therefore the most recently available data reported by the health plan may be from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

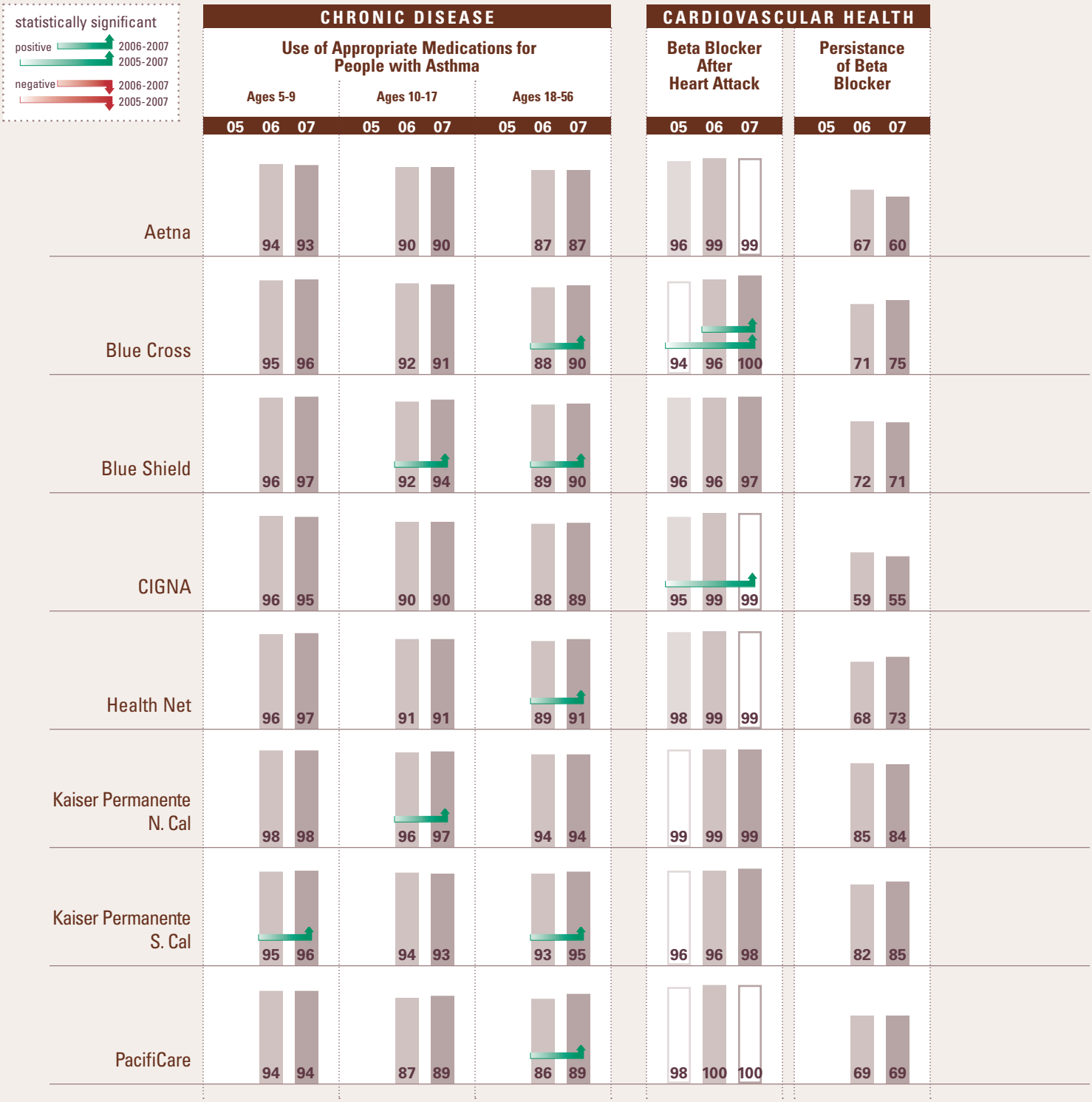
NOTES

NR – Not reported.

TREND DATA COMMERCIAL *1 of 6*



TREND DATA COMMERCIAL *2 of 6*



TREND DATA COMMERCIAL *3 of 6*

TREND DATA COMMERCIAL *4 of 6*

TREND DATA COMMERCIAL *5 of 6*

TREND DATA COMMERCIAL *6 of 6*

TREND DATA MEDICARE *1 of 4*

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 2003 results. Changes not noted with an arrow are not meaningful and may be due to random chance.

TREND DATA MEDICARE *2 of 4*

TREND DATA MEDICARE *3 of 4*

TREND DATA MEDICARE *4 of 4*

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 2007 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 2007 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 2007 PAS because of the financial support and assistance from participating physician groups and the following health plans:

Aetna Health of California
Blue Cross of California
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 2007 Patient Assessment Survey (PAS) evaluated patients' experience with the care they received from 145 distinct medical groups and IPAs in Northern and Southern California (this represents 183 reporting units). These physician groups ranged in size from 2,500 to 2.8 million members. The results were calculated from 63,608 individual patients who responded to the survey, for an overall response rate of 38.4%. 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 145 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 received from providers
- Interactions between the patient and physician (i.e., communication)
- Access to primary and specialty care for urgent and non-urgent 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 (2006) 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.

NOTES

∉ – Responses were fewer than 100.

✻ – Overall repsonse rate <25%.

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

NR – Results not available.

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.

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	84	86	87	74	89
AllCare IPA	83	86	88	76	89
Alta Bates Medical Group	83	87	85	74	89
Bakersfield Family Medical Center	81 ▼	86	83	71 ▼	87
Bay Valley Medical Group	85	87	87	76	89
Brown & Toland Medical Group	85 ▲	89	87	77	90
Camino Medical Group	87 ▲	91 ▲	89 ▲	84 ▲	92 ▲
Central Valley Medical Group	85	89	86	78	90
Chinese Community Health Care Association	83	87	84	69 ▼	85 ▼
GEMCare	81 ▼	85	81 ▼	69 ▼	87
Golden State Physicians Medical Group	81 ▼	79 ▼	85	70 ▼	86 ▼
Hill Physicians Medical Group - East Bay	84	88	86	78	91 ▲
Hill Physicians Medical Group - Sacramento	83	81 ▼	88	73	86 ▼
Hill Physicians Medical Group - San Francisco	86 ▲	88	88 ▲	78	91 ▲
Hill Physicians Medical Group - San Joaquin	85	86	89 ▲	75	89
Hill Physicians Medical Group - Solano	86 ▲	89	88	78	92 ▲
Humboldt-Del Norte IPA	85	88	89 ▲	80 ▲	92 ▲
John Muir Physician Network	86 ▲	89	85	76	89
Kaiser Permanente Medical Group - Central Valley	82	86	85	77	89
Kaiser Permanente Medical Group - Diablo Service	85	87	86	78	89
Kaiser Permanente Medical Group - Fresno	83	87	83	77	88
Kaiser Permanente Medical Group - Greater Southern Alameda	83	87	88	80 ▲	90
Kaiser Permanente Medical Group - Napa Solano	84	89	89 ▲	79 ▲	90 ▲
Kaiser Permanente Medical Group - North Valley	83	86	87	78 ▲	89
Kaiser Permanente Medical Group - Oakland/Richmond	84	85	89 ▲	80 ▲	88
Kaiser Permanente Medical Group - Redwood City	85	86	89 ▲	79 ▲	91 ▲
Kaiser Permanente Medical Group - San Francisco	84	86	89 ▲	80 ▲	89
Kaiser Permanente Medical Group - San Rafael	82	86	86	79 ▲	88
Kaiser Permanente Medical Group - Santa Clara	85	91 ▲	88	82 ▲	91 ▲
Kaiser Permanente Medical Group - Santa Rosa	85 ▲	87	89 ▲	80 ▲	90
Kaiser Permanente Medical Group - Santa Teresa	85	89	90 ▲	81 ▲	93 ▲
Kaiser Permanente Medical Group - South Sacramento	85	87	88	80 ▲	90 ▲
Kaiser Permanente Medical Group - South San Francisco	85	86	86	76	88
Key Medical Group, Inc.	82	85	86	74	88
Marin IPA	85 ▲	86	88	77	90
Medcore Medical Group/Omni IPA	84	86	87	74	90
Mercy Medical Group	83	86	86	76	88
Mills-Peninsula Medical Group	86 ▲	87	88	75	90
NorthBay Healthcare Group	87 ▲	89	88 ▲	77	91 ▲
Palo Alto Medical Foundation, PA Division	88 ▲	90 ▲	86	83 ▲	91 ▲
Physicians Integrated Medical Group	84	87	87	71 ▼	89
Physicians Medical Group of San Jose	82	85	82 ▼	76	87
CALIFORNIA STATEWIDE AVERAGE	**83**	**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	86	89 ▲	79 ▲	89
San Jose Medical Group	83	88	85	78	89
Santa Clara County IPA	83	88	85	76	88
Santa Cruz Medical Foundation	84	89 ▲	86	80 ▲	90 ▲
Sante Community Physicians IPA	84	86	84	76	88
Sierra Nevada Medical Associates	83	84 ▼	88 ▲	77	89
Solano Regional Medical Group	84	88	85	79 ▲	89
Sonoma County Primary Care IPA	85 ▲	89	84	81 ▲	89
Sutter Delta Medical Group	87 ▲	87	92 ▲	82 ▲	93 ▲
Sutter Gould Medical Foundation	86 ▲	88	88 ▲	75	91 ▲
Sutter Independent Physicians	83	84 ▼	88 ▲	75	88
Sutter Medical Group	87 ▲	90 ▲	89 ▲	81 ▲	91 ▲
Sutter Medical Group of the Redwoods	86 ▲	89	90 ▲	80 ▲	91 ▲
Sutter West Medical Group	87 ▲	90 ▲	88	82 ▲	91 ▲
UC Davis Health System	85	89	87	77	90 ▲
Woodland Clinic Medical Group	86 ▲	89	88	79 ▲	90 ▲
CALIFORNIA STATEWIDE AVERAGE	**83**	**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
	Patient Access	Office Staff Interactions	Emergency Instructions
Affinity Medical Group	79 ▲	87 ▲	71 ▼
AllCare IPA	78 ▲	86	83
Alta Bates Medical Group	76	86	ϕ
Bakersfield Family Medical Center	73	84	62 ▼
Bay Valley Medical Group	77 ▲	86	76 ▼
Brown & Toland Medical Group	77	87 ▲	92
Camino Medical Group	77 ▲	87 ▲	92
Central Valley Medical Group	77 ▲	85	90
Chinese Community Health Care Association	73	82	86
GEMCare	74	87 ▲	88
Golden State Physicians Medical Group	75	84	94
Hill Physicians Medical Group - East Bay	80 ▲	87 ▲	90
Hill Physicians Medical Group - Sacramento	77 ▲	85	90
Hill Physicians Medical Group - San Francisco	80 ▲	88 ▲	90
Hill Physicians Medical Group - San Joaquin	77 ▲	87 ▲	90
Hill Physicians Medical Group - Solano	77 ▲	87 ▲	90
Humboldt-Del Norte IPA	81 ▲	88 ▲	96 ▲
John Muir Physician Network	78 ▲	85	86
Kaiser Permanente Medical Group - Central Valley	79 ▲	87 ▲	100 ▲
Kaiser Permanente Medical Group - Diablo Service	77 ▲	84	100 ▲
Kaiser Permanente Medical Group - Fresno	77 ▲	86	100 ▲
Kaiser Permanente Medical Group - Greater Southern Alameda	77 ▲	86	100 ▲
Kaiser Permanente Medical Group - Napa Solano	77 ▲	84	100 ▲
Kaiser Permanente Medical Group - North Valley	77 ▲	86	100 ▲
Kaiser Permanente Medical Group - Oakland/Richmond	76	86	100 ▲
Kaiser Permanente Medical Group - Redwood City	78 ▲	86	100 ▲
Kaiser Permanente Medical Group - San Francisco	76	85	100 ▲
Kaiser Permanente Medical Group - San Rafael	76	84	100 ▲
Kaiser Permanente Medical Group - Santa Clara	77 ▲	87 ▲	100 ▲
Kaiser Permanente Medical Group - Santa Rosa	78 ▲	87 ▲	100 ▲
Kaiser Permanente Medical Group - Santa Teresa	77 ▲	85	100 ▲
Kaiser Permanente Medical Group - South Sacramento	79 ▲	86	100 ▲
Kaiser Permanente Medical Group - South San Francisco	78 ▲	83	100 ▲
Key Medical Group, Inc.	75	84	ϕ
Marin IPA	80 ▲	88 ▲	ϕ
Medcore Medical Group/Omni IPA	76	85	81
Mercy Medical Group	74	84	84
Mills-Peninsula Medical Group	79 ▲	87 ▲	84
NorthBay Healthcare Group	75	86	93
Palo Alto Medical Foundation, PA Division	79 ▲	88 ▲	80
Physicians Integrated Medical Group	77 ▲	86	ϕ
CALIFORNIA STATEWIDE AVERAGE	**74**	**84**	**89**

NORTHERN CALIFORNIA *4 of 4*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY		AFTER HOURS
	Patient Access	Office Staff Interactions	Emergency Instructions
Physicians Medical Group of San Jose	76	84	92
Physicians Medical Group Of Santa Cruz	75	85	100 ▲
San Jose Medical Group	76	84	ϕ
Santa Clara County IPA	78 ▲	85	91
Santa Cruz Medical Foundation	70 ▼	83	88
Sante Community Physicians IPA	74	84	84
Sierra Nevada Medical Associates	80 ▲	88 ▲	82
Solano Regional Medical Group	74	89 ▲	91
Sonoma County Primary Care IPA	83 ▲	90 ▲	65 ▼
Sutter Delta Medical Group	79 ▲	89 ▲	90
Sutter Gould Medical Foundation	78 ▲	86	94
Sutter Independent Physicians	78 ▲	86	98
Sutter Medical Group	81 ▲	88 ▲	100
Sutter Medical Group of the Redwoods	79 ▲	85	92
Sutter West Medical Group	78 ▲	86 ▲	98
UC Davis Health System	73	84	100 ▲
Woodland Clinic Medical Group	77 ▲	88 ▲	100 ▲
CALIFORNIA STATEWIDE AVERAGE	**74**	**84**	**89**

SOUTHERN CALIFORNIA *1 of 6*

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	82	89	81 ▼	71 ▼	85 ▼
Alamitos IPA	82	88	83	75	88
All Care Medical Group	*	* ∉	* ∉	*	*
Alliance Physicians	79 ▼	84 ▼	80 ▼	66 ▼	85 ▼
Alliance Pioneer Medical Corp	83	87	88	74	90
Allied Physicians of California	83	87	83	73	88
AltaMed Health Services	*	*	* ∉	*	*
AMVI Medical Group	82	84	87	75	88
Anaheim Memorial IPA	82	86	81 ▼	73	86
Antelope Valley/Pegasus Medical Group	78 ▼	78 ▼	86	72	85 ▼
AppleCare Medical Group Downey Region	84	89	83	71 ▼	88
AppleCare Medical Group St. Francis	*	* ∉	*	*	*
Axminster Medical Group	82	84 ▼	86	72	86
Bay Area Community Medical Group	82	85	80 ▼	71 ▼	84 ▼
Beaver Medical Group	85 ▲	90 ▲	86	77	89
Bright Medical Associates	84	87	88	78	90
Bristol Park Medical Group	84	89 ▲	86	77	88
Cedars-Sinai Health Associates	83	84 ▼	84	75	87
Cedars-Sinai Medical Group	83	87	84	73	88
Centinela Valley IPA	80 ▼	∉	85	67 ▼	85 ▼
Centre For Health Care	82	88	81 ▼	74	88
Choice Medical Group	77 ▼	81 ▼	82 ▼	65 ▼	82 ▼
Community Medical Group of the West Valley, Inc.	82 ▼	84 ▼	84	74	85 ▼
Desert Medical Group, Inc	84	89	82	76	87
Edinger Medical Group	85 ▲	91 ▲	81 ▼	80 ▲	88
Empire Physicians Medical Group	81 ▼	85	78 ▼	70 ▼	84 ▼
Facey Medical Group	82 ▼	87	85	67 ▼	86
Family Care Specialists Medical Group	82	88	85	70 ▼	88
Family Practice Medical Group of San Bernardino	84	86	88	77	89
Gateway Medical Group, Inc.	83	88	82	72	87
Genesis Healthcare	83	88	80 ▼	72	86 ▼
Glendale Physicians Alliance	82	87	84	71 ▼	87
Greater Covina Medical Group	81 ▼	85	82	67 ▼	85 ▼
Greater Newport Physicians	85	89	86	76	89
Greater Tri-Cities IPA	83	84	85	78	87
Guardian Medical Associates IPA	78 ▼	85	82 ▼	72 ▼	86 ▼
HealthCare Partners IPA	84	85	89 ▲	77	89
HealthCare Partners Medical Group	84	89	83	79 ▲	88
Hemet Community Medical Group	78 ▼	81 ▼	77 ▼	70 ▼	83 ▼
High Desert Medical Group	75 ▼	77 ▼	77 ▼	64 ▼	78 ▼
High Desert Medical Group - California Desert IPA	75 ▼	73 ▼	82 ▼	64 ▼	81 ▼
High Desert Medical Group - Heritage Victor Valley	74 ▼	76 ▼	76 ▼	62 ▼	81 ▼
CALIFORNIA STATEWIDE AVERAGE	**83**	**87**	**85**	**75**	**88**

SOUTHERN CALIFORNIA *2 of 6*

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
High Desert Primary Care Medical Group	80 ▼	∉	81 ▼	63 ▼	84 ▼
Imperial County Physicians Medical Group	84	87	83	73	89
Inland HealthCare Group	85	90 ▲	85	75	90
Korean American Medical Group	*	*	* ∉	*	*
Lakeside Medical Group	81 ▼	85	83	71 ▼	86 ▼
Lakewood Health Plan Inc.	82	87	82 ▼	71 ▼	86 ▼
Loma Linda University HealthCare	83	89	84	74	87
Memorial HealthCare IPA	85 ▲	89 ▲	87 ▲	80 ▲	89 ▲
Memorial HealthCare IPA - Long Beach	83	87	86	78 ▲	89
Mercy Physicians Medical Group	85 ▲	89	86	78	89
MidCoast Care Inc	82 ▼	85	87	75	88
Mission Hospital Affiliated Physicians	84	86	88	81 ▲	90
Monarch HealthCare	82	86	81 ▼	74	86
Noble AMA IPA	78 ▼	78 ▼	81 ▼	70 ▼	82 ▼
Northridge Medical Group	82	85	84	70 ▼	87
Nuestra Familia Medical Group, Inc.	*	* ∉	* ∉	*	*
Oasis IPA	81 ▼	85	79 ▼	72	86 ▼
Ojai Valley Community Medical Group	85 ▲	91 ▲	83	82 ▲	89
Omnicare Medical Group	80 ▼	86	80 ▼	69 ▼	86
Orange Coast Memorial IPA	86 ▲	90 ▲	88	81 ▲	90
Pacific Independent Physicians Association	82	86	82 ▼	74	87
Penn Elm Medical Group	86 ▲	88	89 ▲	78	89
Physician Associates of the Greater San Gabriel Valley	83	88	81 ▼	72	86 ▼
Physicians' Healthways IPA	81 ▼	84 ▼	78 ▼	69 ▼	82 ▼
Pinnacle Medical Group	79 ▼	81 ▼	81 ▼	73	82 ▼
Pioneer Medical Group	84	84	85	74	87
Pomona Valley Medical Group, Inc.	85	90 ▲	86	74	90
Premier Physician Network	80 ▼	85	80 ▼	68 ▼	85 ▼
Presbyterian Health Physicians	84	83 ▼	87	74	88
Primary Care Associates Medical Group	83	88	81 ▼	74	87
PrimeCare	79 ▼	83 ▼	83	73	85 ▼
Prospect Healthsource Medical Group, Inc	79 ▼	81 ▼	80 ▼	68 ▼	83 ▼
Prospect Medical Group	81 ▼	85	81 ▼	69 ▼	85 ▼
Prospect Northwest Orange County Medical Group	80 ▼	85	82	69 ▼	86 ▼
Prospect Professional Care Medical Group	82	85	82 ▼	70 ▼	86
Redlands Yucaipa Medical Group	84	86	88	74	89
Regal Medical Group	81 ▼	88	81 ▼	74	87
Riverside Medical Clinic	84	87	89 ▲	75	89
Riverside Physician Network	83	87	84	72	88
San Bernardino Medical Group	86 ▲	89	87	80 ▲	90
San Diego Physicians Medical Group	83	84 ▼	86	74	87
San Luis Obispo Select IPA	79 ▼	77 ▼	86	73	87
Sansum Clinic	84	87	87	79 ▲	89
CALIFORNIA STATEWIDE AVERAGE	**83**	**87**	**85**	**75**	**88**

SOUTHERN CALIFORNIA *3 of 6*

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
Santa Barbara Select IPA	82	83 ▼	88	78	88
Scripps Clinic Medical Group	86 ▲	89	87	78	89
Scripps Mercy Medical Group	87 ▲	93 ▲	88 ▲	83 ▲	92 ▲
SeaView IPA	83	87	86	74	88
Sharp Community Medical Group - Chula Vista	86 ▲	88	86	76	89
Sharp Community Medical Group - Coronado	86 ▲	88	84	76	89
Sharp Community Medical Group - Graybill	86 ▲	90 ▲	88	83 ▲	91 ▲
Sharp Community Medical Group - Grossmont	86 ▲	89	85	77	89
Sharp Community Medical Group - Inland North	85	89	82 ▼	76	88
Sharp Community Medical Group - Metro San Diego	84	87	86	76	88
Sharp Mission Park Medical Group	85	89	86	80 ▲	90 ▲
Sharp Rees-Stealy Medical Centers	86 ▲	87	88	76	90
Sierra Primary Care Medical Group, Inc.	81 ▼	87	82	64 ▼	86
Southern Cal. Permanente Medical Group - Baldwin Park	84	87	89 ▲	75	91 ▲
Southern Cal. Permanente Medical Group - Bellflower	82	86	89	68 ▼	89
Southern Cal. Permanente Medical Group - Fontana	85 ▲	89	88	76	90
Southern Cal. Permanente Medical Group - Kern County	83	86	86	75	89
Southern Cal. Permanente Medical Group - Los Angeles	84	89	88	72	91 ▲
Southern Cal. Permanente Medical Group - Orange County	83	86	89 ▲	74	89
Southern Cal. Permanente Medical Group - Panorama City	83	87	88	70 ▼	90
Southern Cal. Permanente Medical Group - Riverside	83	87	86	73	89
Southern Cal. Permanente Medical Group - San Diego	84	88	86	71 ▼	90
Southern Cal. Permanente Medical Group - South Bay	84	89	87	72	90
Southern Cal. Permanente Medical Group - West LA	83	88	88	74	90
Southern Cal. Permanente Medical Group - Woodland Hills	84	87	89 ▲	74	90
St. Joseph Heritage Medical Group	86 ▲	89	86	75	89
St. Joseph Hospital Affiliated Physician	85	87	87	75	90
St. Jude Affiliated Physicians	86 ▲	87	87	75	90
St. Jude Heritage Medical Group	85 ▲	90 ▲	83	76	89
St. Mary IPA	83	85	87	72	89
St. Vincent IPA	84	89	86	72	89
Talbert Medical Group	84	88	87	76	89
The Industry Health Network	86 ▲	∉	90 ▲	80 ▲	92 ▲
Torrance Hospital IPA	84	86	84	76	88
UCLA Medical Group	86 ▲	92 ▲	85	76	90
UCSD Healthcare Network	81 ▼	89	84	76	89
United Family Care	82	84	86	77	88
Universal Care Medical Group	*	* ∉	*	*	*
Upland Medical Group	81 ▼	83 ▼	79 ▼	70 ▼	83 ▼
Valley Care IPA	88 ▲	92 ▲	84	80 ▲	90
Verdugo Hills Medical Group	84	90 ▲	84	73	90
CALIFORNIA STATEWIDE AVERAGE	**83**	**87**	**85**	**75**	**88**

SOUTHERN CALIFORNIA *4 of 6*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY		AFTER HOURS
	Patient Access	Office Staff Interactions	Emergency Instructions
Affiliated Doctors of Orange County	75	83	87
Alamitos IPA	76	86	88
All Care Medical Group	*	*	ϕ
Alliance Physicians	64 ▼	78 ▼	NR
Alliance Pioneer Medical Corp	77 ▲	85	94
Allied Physicians of California	71 ▼	82	82
AltaMed Health Services	*	*	80
AMVI Medical Group	74	83	ϕ
Anaheim Memorial IPA	75	84	ϕ
Antelope Valley/Pegasus Medical Group	70 ▼	82	100 ▲
AppleCare Medical Group Downey Region	71	84	86
AppleCare Medical Group St. Francis	*	*	98 ▲
Axminster Medical Group	68 ▼	81 ▼	81
Bay Area Community Medical Group	70 ▼	81 ▼	ϕ
Beaver Medical Group	75	87 ▲	ϕ
Bright Medical Associates	70 ▼	85	89
Bristol Park Medical Group	75	85	100 ▲
Cedars-Sinai Health Associates	73	82 ▼	ϕ
Cedars-Sinai Medical Group	71 ▼	81 ▼	ϕ
Centinela Valley IPA	68 ▼	80 ▼	89
Centre For Health Care	76	83	100 ▲
Choice Medical Group	67 ▼	79 ▼	85
Community Medical Group of the West Valley, Inc.	70 ▼	81 ▼	77 ▼
Desert Medical Group, Inc	71 ▼	84	85
Edinger Medical Group	75	84	90
Empire Physicians Medical Group	71 ▼	81 ▼	82
Facey Medical Group	69 ▼	79 ▼	83
Family Care Specialists Medical Group	67 ▼	77 ▼	92
Family Practice Medical Group of San Bernardino	79 ▲	87	ϕ
Gateway Medical Group, Inc.	72	82 ▼	93
Genesis Healthcare	74	82 ▼	93
Glendale Physicians Alliance	72 ▼	82	92
Greater Covina Medical Group	72	83	84
Greater Newport Physicians	79 ▲	87 ▲	96 ▲
Greater Tri-Cities IPA	78 ▲	86	96
Guardian Medical Associates IPA	61 ▼	74 ▼	ϕ
HealthCare Partners IPA	77	86	ϕ
HealthCare Partners Medical Group	75	84	ϕ
Hemet Community Medical Group	65 ▼	75 ▼	ϕ
High Desert Medical Group	64 ▼	80 ▼	92
High Desert Medical Group - California Desert IPA	67 ▼	79 ▼	92
High Desert Medical Group - Heritage Victor Valley	66 ▼	78 ▼	92
CALIFORNIA STATEWIDE AVERAGE	**74**	**84**	**89**

SOUTHERN CALIFORNIA *5 of 6*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY		AFTER HOURS
	Patient Access	Office Staff Interactions	Emergency Instructions
High Desert Primary Care Medical Group	62 ▼	80 ▼	100 ▲
Imperial County Physicians Medical Group	71 ▼	83	67
Inland HealthCare Group	69 ▼	81 ▼	82
Korean American Medical Group	*	*	96
Lakeside Medical Group	71 ▼	83	92
Lakewood Health Plan Inc.	73	83	84
Loma Linda University HealthCare	64 ▼	82 ▼	100 ▲
Memorial HealthCare IPA	75 ▲	86 ▲	78
Memorial HealthCare IPA - Long Beach	75	85	78
Mercy Physicians Medical Group	80 ▲	87	92
MidCoast Care Inc	76	86	84
Mission Hospital Affiliated Physicians	78 ▲	85	ϕ
Monarch HealthCare	75	84	78
Noble AMA IPA	70 ▼	77 ▼	ϕ
Northridge Medical Group	75	81 ▼	ϕ
Nuestra Familia Medical Group, Inc.	*	*	89
Oasis IPA	71 ▼	81 ▼	82
Ojai Valley Community Medical Group	79 ▲	87 ▲	75 ▼
Omnicare Medical Group	71 ▼	82 ▼	92
Orange Coast Memorial IPA	75	86	ϕ
Pacific Independent Physicians Association	72	83	81
Penn Elm Medical Group	76	86	ϕ
Physician Associates of the Greater San Gabriel Valley	75	86	96 ▲
Physicians' Healthways IPA	71 ▼	80 ▼	ϕ
Pinnacle Medical Group	69 ▼	82	ϕ
Pioneer Medical Group	75	83	74
Pomona Valley Medical Group, Inc.	72 ▼	83	ϕ
Premier Physician Network	74	80 ▼	ϕ
Presbyterian Health Physicians	71 ▼	85	82
Primary Care Associates Medical Group	74	82 ▼	84
PrimeCare	70 ▼	82 ▼	100 ▲
Prospect Healthsource Medical Group, Inc	71 ▼	82 ▼	94
Prospect Medical Group	73	82	ϕ
Prospect Northwest Orange County Medical Group	75	83	88
Prospect Professional Care Medical Group	72	82	88
Redlands Yucaipa Medical Group	75	87 ▲	ϕ
Regal Medical Group	75	84	86
Riverside Medical Clinic	69 ▼	83	100 ▲
Riverside Physician Network	73	83	ϕ
San Bernardino Medical Group	74	86	ϕ
San Diego Physicians Medical Group	78 ▲	82 ▼	98 ▲
San Luis Obispo Select IPA	73	81 ▼	80
Sansum Clinic	71 ▼	84	96 ▲
CALIFORNIA STATEWIDE AVERAGE	**74**	**84**	**89**

SOUTHERN CALIFORNIA *6 of 6*

PHYSICIAN GROUP RESULTS

▲ significantly above statewide average
▼ significantly below statewide average

	PATIENT ASSESSMENT SURVEY		AFTER HOURS
	Patient Access	Office Staff Interactions	Emergency Instructions
Santa Barbara Select IPA	82 ▲	86	67 ▼
Scripps Clinic Medical Group	75	87 ▲	ϕ
Scripps Mercy Medical Group	78 ▲	89 ▲	ϕ
SeaView IPA	74	83	ϕ
Sharp Community Medical Group - Chula Vista	77 ▲	86	90
Sharp Community Medical Group - Coronado	79 ▲	88 ▲	90
Sharp Community Medical Group - Graybill	78 ▲	86	90
Sharp Community Medical Group - Grossmont	75	86	90
Sharp Community Medical Group - Inland North	77 ▲	84	90
Sharp Community Medical Group - Metro San Diego	76	85	90
Sharp Mission Park Medical Group	77 ▲	86	94
Sharp Rees-Stealy Medical Centers	75	88 ▲	96 ▲
Sierra Primary Care Medical Group, Inc.	68 ▼	82	22 ▼
Southern Cal. Permanente Medical Group - Baldwin Park	70 ▼	85	100 ▲
Southern Cal. Permanente Medical Group - Bellflower	72	84	100 ▲
Southern Cal. Permanente Medical Group - Fontana	75	86	100 ▲
Southern Cal. Permanente Medical Group - Kern County	72	85	100 ▲
Southern Cal. Permanente Medical Group - Los Angeles	72	84	100 ▲
Southern Cal. Permanente Medical Group - Orange County	70 ▼	85	100 ▲
Southern Cal. Permanente Medical Group - Panorama City	70 ▼	85	100 ▲
Southern Cal. Permanente Medical Group - Riverside	75	87 ▲	100 ▲
Southern Cal. Permanente Medical Group - San Diego	73	87	100 ▲
Southern Cal. Permanente Medical Group - South Bay	72	86	100 ▲
Southern Cal. Permanente Medical Group - West LA	69 ▼	84	100 ▲
Southern Cal. Permanente Medical Group - Woodland Hills	72	83	100 ▲
St. Joseph Heritage Medical Group	71 ▼	83	100 ▲
St. Joseph Hospital Affiliated Physician	72	84	94
St. Jude Affiliated Physicians	77 ▲	86	ϕ
St. Jude Heritage Medical Group	72 ▼	83	ϕ
St. Mary IPA	75	86	100 ▲
St. Vincent IPA	77	87 ▲	86
Talbert Medical Group	72	86	94
The Industry Health Network	78 ▲	88	ϕ
Torrance Hospital IPA	75	85	93
UCLA Medical Group	72	83	100 ▲
UCSD Healthcare Network	68 ▼	84	100 ▲
United Family Care	66 ▼	82	100 ▲
Universal Care Medical Group	*	*	81
Upland Medical Group	71 ▼	81 ▼	ϕ
Valley Care IPA	76	86	ϕ
Verdugo Hills Medical Group	77 ▲	83	100 ▲
CALIFORNIA STATEWIDE AVERAGE	**74**	**84**	**89**

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:

LINDA SMITH, *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;*

ANDY AMSTER, MSPH, *Southern California Permanente Medical Group, 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 HEALTHCARE *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.*

USE OF THE REPORT

USER AGREEMENT

Recipients of the annual California Health Plan Performance report are subject to the following guidelines:

1. For non-health plan users, the CCHRI format may be reproduced in its entirety, or may be altered subject to the following requirements.
   - The performance strata (average, above and below) for each plan may not be altered or deviate in any way from the strata designated by CCHRI.
   - Health plans may be eliminated from displays, but the user may not alter results or strata for the plans and measures displayed.
   - The numeric scores may be presented without the accompanying symbols, but if symbols are used, they must show the performance ranking indicated by CCHRI. Rankings of average, above average and below average may not deviate from those designated by CCHRI.
   - Similarly, any bolding, shading or highlighting must denote plan performance as designated by CCHRI.
2. The report card, pages 3–16, may be reproduced and distributed separately from the rest of the report as long as they are reproduced and used in their entirety.
3. Health plans may refer to, display or reproduce only their own performance results, and are subject to the guidelines noted in numbers 1 and 2 above. Health plans may not compare their performance to other health plan(s), with the exception of the all-plan mean, within advertisements or marketing and promotional material. Specifically:
   - Plans may use only their own results and may not refer to other plans or their scores.
   - Plans may use their own numeric scores and the performance rankings (above average, average and below average) associated with the scores.
   - Plans may report the all-plan mean in conjunction with their scores and performance rankings.
   - Plans may not cite other plans' results or make any type of comparisons, other than with the all-plan mean.
   - Plans may note the number of "above average" scores received but must also cite the total number of indicators in the domain being reported (e.g., effectiveness of care or member experience).
4. Recipients may not otherwise alter this report format without written permission of CCHRI.
5. Publications that are not related to media, health plan or employer reporting of results must receive permission from CCHRI. Requests for permission to reproduce materials in external publications should be directed to the CCHRI Executive Committee, c/o Pacific Business Group on Health.

PARTICIPANTS

PBGH PURCHASER MEMBERS

Aerojet Corporation
APL Limited
Automobile Club of Southern California
Bechtel Corporation
California Public Employees' Retirement System
California State Automobile Association
Chevron Corporation
Cisco Systems
Costco Wholesale Corporation
Del Monte Foods
FedEx Express
Gen Corp. (Aerojet)
General Electric Company
Intel Corporation
Longs Drug Stores
McKesson Corporation
Men's Wearhouse
Mervyn's
Pacific Gas and Electric Company
Pitney Bowes
Safeway Inc.
Silicon Valley Employers Forum
Southern California Edison
Stanford University
Stanislaus County
Target Corporation
The Clorox Company
Union Bank of California
University of California
Varian, Inc.
Varian Medical Systems, Inc.
Verizon Communications
Wells Fargo & Company

HEALTH PLANS

Aetna Health of California
Blue Cross of California
Blue Shield of California
CIGNA
Health Net of California
Kaiser Permanente Northern California
Kaiser Permanente Southern California
PacifiCare, AUnitedHealthcare Company
Western Health Advantage

STATEWIDE PROVIDER ORGANIZATIONS

California Hospital Association (CHA)
California Medical Association (CMA)
California Association of Physician Groups (CAPG)
Permanente Medical Groups (PMG)

CCHRI EXECUTIVE COMMITTEE

Douglas Allen, MD, MMM, *Greater Newport Physicians IPA*
James Barber, *California Healthcare Association*
Michael Belman, MD, *Blue Cross of California*
Gifford Boyce-Smith, MD, *Blue Shield of California*
Sandra Bressler, JD, *California Medical Association*
John Brookey, MD, *Southern California Permanente Medical Group*
Jeff Flick, *Centers for Medicare and Medicaid Services*
David Hopkins, PhD, *Pacific Business Group on Health*
Lance Lang, MD, *Health Net of California*
Cynthia Peete, PhD, *University of California*
Sharon Ricciuti, RN, MSN, MHSA, *PacifiCare of California*
Heather Wales, *Wells Fargo & Company*
Melissa Welch, MD, *Aetna Health of California*
Mary Wieg, *California Public Employees' Retirement System*
Ann Woo, PharmD, *California Association of Physician Groups*

STAFF

Ted vonGlahn, *Director, PBGH*
Serwar Ahmed, *Manager, PBGH*
Cheryl Damberg, Ph.D., *PBGH*
David Hopkins, Ph.D., *Director, PBGH*
Cathie Markow, *Senior Manager, PBGH*

CONSULTANTS

Dana Safran, *The Health Institute*
William Rogers, *The Health Institute*

DESIGN

Tenfold, *www.ten-fold.com*

California Cooperative Healthcare Reporting Initiative

A Collaborative of Healthcare Purchasers, Plans and Providers in California

CCHRI c/o PBGH
221 MAIN STREET, SUITE 1500
SAN FRANCISCO, CA 94105
PHONE: 415-281-8660
FAX: 415-281-0960