2010 HEDIS Aggregate Report for the Medi-Cal Managed Care Program

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

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS California Department of HealthCareServices

In 2009, the Department of Health Care Services (DHCS) held contracts with 21 full-scope health plans and four specialty plans to provide health care services to approximately 3.8 million members enrolled in the Medi-Cal Managed Care (MCMC) Program[1].

The Centers for Medicare and Medicaid Services (CMS) requires that states, through their contracts with managed care plans, measure and report on performance to assess the quality and appropriateness of care and services provided to members. In response, the DHCS implemented a system to provide an objective, comparative review of health plan quality-of-care outcomes and performance measures called the External Accountability Set (EAS). The DHCS designates performance measures on an annual basis and requires plans to report on them.

The DHCS 2010 EAS consisted of 11 performance measures with 21 distinct indicators providing information on access to care for women, adolescents, and children; use of imaging studies for low back pain; screening for diseases such as breast and cervical cancer; weight assessment and counseling for nutrition and physical activity for children and adolescents; care provided to members with chronic diseases such as diabetes; and appropriate treatment for other conditions such as upper respiratory infection (URI) in children and acute bronchitis in adults.

The DHCS based all selected performance measures on the Healthcare Effectiveness Data and Information Set (HEDIS®[2]) developed by the National Committee for Quality Assurance (NCQA). This data set is a nationally recognized and standardized set of performance measures used by consumers, employers, government agencies, legislators, advocates, and potential purchasers to assess the quality of care provided within health plans' Medicare, Medicaid, and commercial lines of business.

As part of the EAS, the DHCS requires plans to undergo a HEDIS Compliance Audit™[3] conducted by an external quality review organization (EQRO). The EQRO assesses plans' information systems (IS) capabilities and compliance with HEDIS specifications to ensure standardized reporting of performance measure results. The DHCS contracted with Health Services Advisory Group, Inc. (HSAG) to perform these on-site compliance audits in 2010, analyze MCMC HEDIS rates objectively, and evaluate each plan's current performance level relative to local and national thresholds and benchmarks.

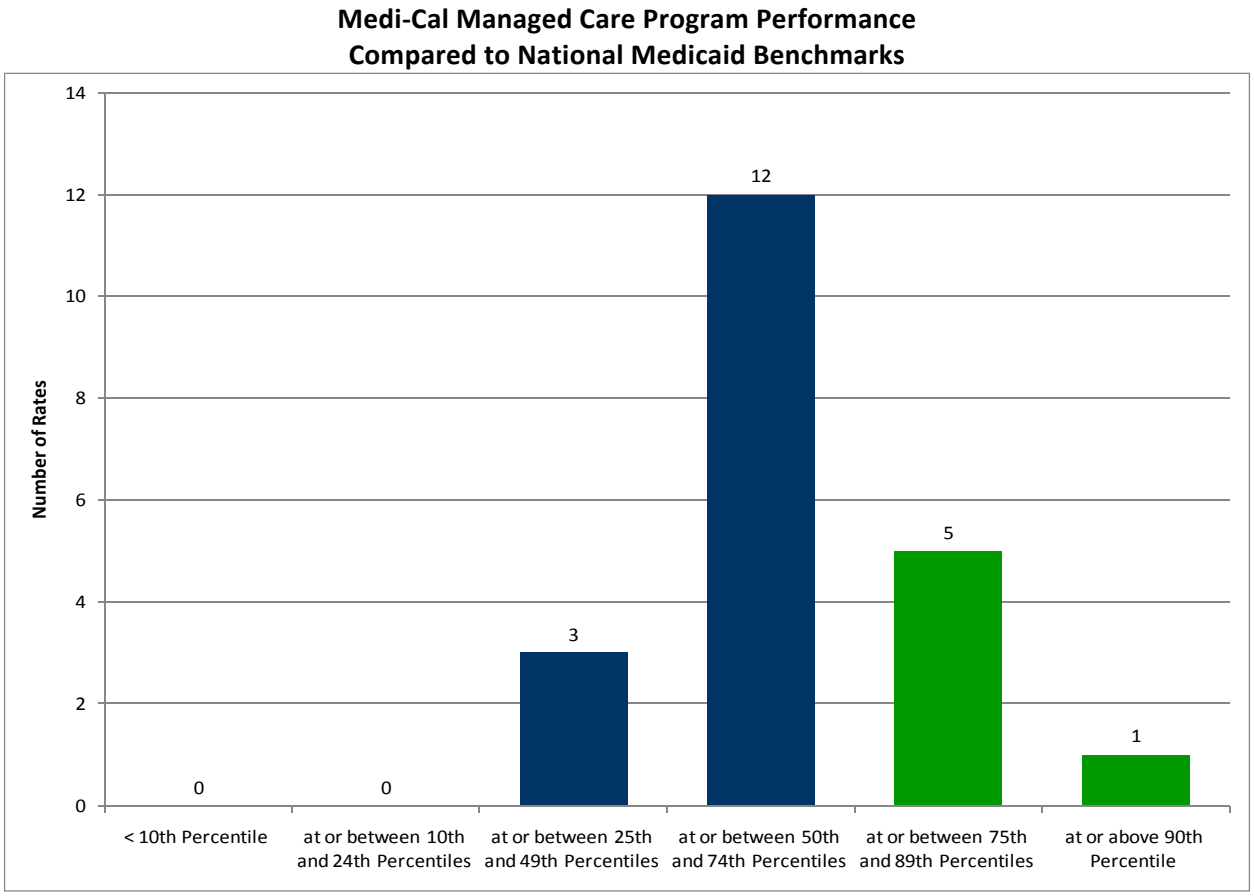
[1] Medi-Cal Managed Care Enrollment Report, December 2009. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: October 4, 2010.
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance.
[3] NQCA HEDIS Compliance Audit™ is a trademark of NCQA.

This report presents MCMC HEDIS 2010 results for the 2009 measurement period of January 1, 2009, through December 31, 2009.

Key Findings

The MCMC Program as a whole demonstrated average performance for most measures, with some strengths noted, as well as areas that need improvement. Compared to 2009 national Medicaid benchmarks, the MCMC Program's 2009 performance was consistent with the 50th percentile with 12 weighted averages falling into this category. The MCMC program performed at or above the 90th percentile for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Assessment: Total* measure. The MCMC program performed between the 75th and 89th percentiles for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, *Use of Imaging Studies for Low Back Pain*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures. The MCMC program performed at or between the 25th and 49th percentiles for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, and *Prenatal and Postpartum Care—Postpartum Care* measures. The MCMC program did not perform below the 25th percentile on any of the measures.

It is important to note that for the *Comprehensive Diabetes Care—Poor Hemoglobin A1c (HbA1c) Control (>9.0 Percent)* rate, where a lower rate represents higher performance, HSAG rotated the percentiles to align with the performance. For example, if the *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)* rate was at or between the 10th and 24th percentiles, it was inverted at or between the 75th and 89th percentiles to represent the level of performance.



The MCMC Program performed better on 10 performance measures and worse on five performance measures in 2010 compared to 2009.

High and Low Performance

Five full-scope plans demonstrated high performance across the EAS, exceeding seven or more of the DHCS's established high performance levels (HPLs), which represent the national Medicaid 90th percentile. San Francisco Health Plan—San Francisco County exceeded the HPL on 11 measures while Central California Alliance for Health—Monterey/Santa Cruz counties, Kaiser Permanente (North)—Sacramento County, and Kaiser Permanente (South)—San Diego County all exceeded the HPL on nine and eight measures respectively, followed by CenCal Health—Santa Barbara County, which had seven measures that exceeded the HPL. The remaining plans had zero to four measures that performed above the HPL.

Three plans showed the greatest opportunity for improvement, with 10 or more performance measures below the DHCS-established minimum performance level (MPL), which represents the national Medicaid 25th percentile. Anthem Blue Cross—Contra Costa County was below the MPL

for 12 measures, followed by Anthem Blue Cross—Sacramento County with 11 measures, and Anthem Blue Cross—Alameda County with 10 measures. All other plans had zero to six measures that performed below the MPL.

In assessing plans' strengths across the performance measures, HSAG noted that the *Comprehensive Diabetes Care—Low-density Lipoprotein-Cholesterol (LDL-C) Control (<100 mg/dL)* and *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)* measures had the highest number of plans, 10 and 11, respectively scoring at or above the HPL. In addition, nine plans performed at or above the HPL for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure.

HSAG noted that the *Prenatal and Postpartum Care—Postpartum Care* measure showed the greatest opportunity for improvement, with 15 plans scoring below the DHCS-established MPL. In addition, 13 plans ranked below the MPL for *Adolescent Well-Care Visits*, and 11 plans performed below the MPL for *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*. Appendix C provides a summary of plan performance across measures relative to the DHCS-established MPLs and HPLs.

Model Type Performance

The County-Operated Health System (COHS) model type outperformed the Geographic Managed Care (GMC) and Two-Plan model types on 18 of the 21 performance measures. The Two-Plan model performed best on the *Cervical Cancer Screening* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling* measures, while the GMC model type outperformed the others on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure.

Because the COHS model type is the only option the MCMC Program provides in certain counties, this structure may have an advantage over other model types on performance measures. With fewer members shifting between plans and a relatively stable provider network, the COHS structure may provide a better opportunity for continuity and coordination of care for members.

Performance Measure Compliance Audit Key Findings

HSAG conducted performance measure validation of all 25 MCMC plans. All plans were able to report valid rates for their DHCS-required measures. With a few exceptions, plans were compliant with the information system standards.

Although plans were able to report valid rates, four plans (Alameda Alliance for Health—Alameda County, CenCal Health—Santa Barbara and San Luis Obispo counties, Contra Costa Health Plan—Contra Costa County, and Kern Family Health Plan—Kern County) experienced challenges with their certified software vendors which impacted both the timeliness of medical record

abstraction and the generation of preliminary administrative rates. Additionally, many plans had issues with abstracting medical records consistent with the technical specifications for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (WCC) measure. Most plans had delayed rate submission to HSAG for auditor review. Vendor issues outside of the plans' control and internal plan resource issues both contributed to the delayed submissions. Late submissions put the plans at risk for a *Not Report (NR)* audit result.

Conclusions and Recommendations

The MCMC Program demonstrates a commitment to monitor and improve the quality of care delivered to its enrollees through its development of an EAS that supports the MCMC Program's overall quality strategy. Each plan's performance contributes to the MCMC Program's overall weighted averages, which were at or above the national Medicaid average for most measures.

The DHCS has implemented a variety of mechanisms to support the improvement efforts of plans. The auto-assignment program offers an increased incentive for plans in the GMC and Two-Plan model types to perform well by rewarding higher-performing plans with increased default membership. Additionally, the DHCS has supported plans in selecting performance measures as formal quality improvement projects (QIPs) to help structure improvement efforts to increase the likelihood of achieving statistically significant improvement and sustained improvement. The DHCS has taken a more active role in reviewing plan QIP proposals to ensure that plans are selecting areas that are actionable and need improvement rather than selecting topics of consistent or high performance. Finally, the DHCS evaluates its EAS and auto-assignment program measures annually to rotate out measures that show consistent, high performance among plans. This allows the DHCS to identify and select new measures as opportunities for improvement.

Based on the review of the 2010 HEDIS results, HSAG provides the following recommendations for continued improvement to the DHCS and the plans:

- Plans should consider selecting performance measures with poor rates as the focus for formal QIPs.
- Plans may consider working with other plans as part of a small-group collaborative QIP to address common areas of low performance since this approach has been effective in improving other performance measure rates.
- Plans need to implement targeted intervention strategies that link to identified barriers to increase performance.
- Plans need to use their data to help drive program decisions for targeted interventions.
- Plans need to consider evidence-based strategies when selecting interventions.

- Plans should evaluate whether intervention strategies used to achieve high performance could be applied to other areas of low performance.
- Plans with best practices should share their success in improving performance measures with other plans and state Medicaid programs.
- The DHCS needs to increase its oversight of HEDIS improvement plans by reviewing the content of the improvement plans to ensure that plans are implementing appropriate strategies that link to identified barriers. Additionally, the DHCS needs to require that plans modify or revise interventions that were not successful with improving rates in the previous year(s) of the improvement plan.
- The DHCS may consider selecting one of its low-performing EAS measures for its next statewide collaborative QIP since this approach has been successful with other measures.
- The DHCS should enforce minimum contract performance requirements through progressive penalties with plans that continue to show a pattern of poor performance over consecutive years.

Medi-Cal Managed Care Program Overview

The DHCS administers the Medi-Cal Managed Care (MCMC) Program, California's managed care program for Medicaid recipients. The program serves about half of the Medi-Cal population, with the other half enrolled in fee-for-service Medi-Cal.

During the 2009 measurement year, the DHCS contracted with 21 full-scope plans, three specialty plans, and one prepaid health plan (PHP) operating throughout California in 27 of California's 58 counties, to provide health care services to approximately 3.8 million members enrolled in managed care plans.

Medi-Cal Managed Care Program Delivery System

The DHCS operates the MCMC Program through a service delivery system that encompasses three different plan model types for its full-scope services: the County-Organized Health System (COHS), Geographic Managed Care (GMC), and Two-Plan model types. The DHCS monitors plan performance across model types. Table 2.1 on page 9 shows participating MCMC plans by model type.

County-Organized Health System

In a COHS model, the DHCS contracts with one county organized and operated plan in a county to provide managed care services to all Medi-Cal beneficiaries in that county with very few exceptions. Beneficiaries can choose from a wide network of managed care providers. Beneficiaries in COHS plan counties do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the DHCS. The DHCS currently has contracts with five COHS plans that operate in 11 counties.

Geographic Managed Care

In the GMC model, enrollees choose from three or more commercial plans offered in a county. Beneficiaries with designated mandatory aid codes must enroll in a managed plan. Seniors and individuals with disabilities who are eligible for Medi-Cal benefits under the Supplemental Security Income (SSI) program and a small number of beneficiaries in several other aid codes are not required to enroll in a plan but may choose to do so. These "voluntary" beneficiaries may either

enroll in a managed care plan or receive services through the Medi-Cal fee-for-service (FFS) program. The GMC model type currently operates in San Diego and Sacramento counties.

Two-Plan

In the Two-Plan model, the DHCS contracts with two managed care plans in each county to provide healthcare services to beneficiaries. Most two-plan model counties offer a locally operated, local initiative (LI) plan and a non-governmental commercial plan (CP). Like the GMC model type, the DHCS requires beneficiaries with designated mandatory aid codes to enroll in a plan, while seniors and individuals with disabilities who are eligible for Medi-Cal benefits under the SSI program and a small number of beneficiaries in several other aids codes can voluntarily choose either to enroll in a plan or remain in the FFS program. As in the GMC model, these "voluntary" beneficiaries may either enroll in a managed care plan or receive services through the Medi-Cal FFS program. Currently, the Two-Plan model operates in 12 counties.

Specialty and Prepaid Health Plans

In addition to the full-scope plans, the DHCS, in some instances, contracts with several plans to provide healthcare services to specialized populations (referred to as "specialty plans") and with one plan as a Prepaid Health Plan (PHP). During the 2009 measurement period, the DHCS held contracts with three specialty plans and one PHP operating in a total of seven counties. The DHCS requires each specialty and PHP to report annually on two DHCS-approved performance measures chosen specifically for each plan.

Note: As of June 1, 2011, enrollment in Medi-Cal managed care will become mandatory for seniors and individuals with disabilities who do not have other health coverage (Medi-Cal only) and who live in managed care counties. For more information about this change, see the "Seniors and Persons with Disabilities" page on the DHCS website at http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDEnrollment.aspx.

Table 2.1—Medi-Cal Managed Care Program Plans by Model Type as of October, 2010

Model Type		Plan Name	County
County-Organized Health System		CalOptima	Orange
		CenCal Health	Santa Barbara, San Luis Obispo
		Central California Alliance for Health[1]	Monterey, Santa Cruz, Merced
		Health Plan of San Mateo	San Mateo
		Partnership Health Plan[2]	Napa, Solano, Yolo, Sonoma
Geographic Managed Care		Anthem Blue Cross	Sacramento
		Care 1st	San Diego
		Community Health Group	San Diego
		Health Net	Sacramento
		Health Net	San Diego
		Kaiser Permanente (North)	Sacramento
		Kaiser Permanente (South)	San Diego
		Molina Healthcare	Sacramento
		Molina Healthcare	San Diego
		Western Health Advantage[3]	Sacramento
Two-Plan	**Commercial**	Anthem Blue Cross	Alameda
		Anthem Blue Cross	Contra Costa
		Anthem Blue Cross	Fresno
		Anthem Blue Cross	San Francisco
		Anthem Blue Cross	San Joaquin
		Anthem Blue Cross	Santa Clara
		Health Net	Fresno
		Health Net	Kern
		Health Net	Los Angeles
		Health Net	Stanislaus
		Health Net	Tulare
		Molina Healthcare	Riverside, San Bernardino
	Local Initiative	Alameda Alliance for Health	Alameda
		Anthem Blue Cross	Stanislaus
		Anthem Blue Cross	Tulare
		Contra Costa Health Plan	Contra Costa
		Health Plan of San Joaquin	San Joaquin
		Inland Empire Health Plan	Riverside, San Bernardino
		Kern Family Health Care	Kern
		LA Care Health Plan	Los Angeles
		San Francisco Health Plan	San Francisco
		Santa Clara Family Health	Santa Clara

Specialty and Prepaid Health Plans	AHF Healthcare Centers	Los Angeles
	Family Mosaic Project	San Francisco
	Kaiser PHP[4]	Marin, Sonoma
	SCAN Health Plan	Los Angeles, Riverside, San Bernardino

1. Central California Alliance for Health expanded into Merced County in October 2009; however, Merced County data are not included in the plan's 2010 HEDIS rates.
2. Partnership Health Plan expanded into Sonoma County on October 1, 2009; however, Sonoma County data are not included in the plan's 2010 HEDIS rates.
3. Western Health Advantage terminated its contract with the DHCS effective December 31, 2009; however, the DHCS required the plan to report HEDIS 2010 measures with the exception of the new *Use of Imaging Studies for Low Back Pain* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents* measures.
4. Kaiser PHP terminated its contract with the DHCS for Sonoma County in September 2009; however, Sonoma County data are included in the 2010 HEDIS rates.

How the DHCS Uses Performance Measures

The overall goal of the DHCS is to preserve and improve the health status of all Californians. The MCMC Program provides comprehensive healthcare services to a large population of low-income children and families, as well as to an expanding population of seniors and persons with disabilities. Since the Medi-Cal program serves some of California's most vulnerable populations, the need to evaluate and monitor the quality of health care has remained a key objective for the DHCS in meeting its overall goal.

One mechanism established to monitor accountability for quality health care is the DHCS's implementation of the EAS. The DHCS selects performance measures annually and requires its contracted plans to report rates at the county level unless otherwise specified.

The DHCS expects its plans to implement effective quality improvement systems to monitor, evaluate, and improve performance. These systems include health care claims systems, membership and provider files, and hardware/software management tools that facilitate accurate and reliable reporting of HEDIS measures.

Federal requirements mandate the validation of performance measures. The DHCS satisfies this federal requirement by contracting with an EQRO to conduct performance measure validation. HSAG follows CMS' protocol for validating performance measures by conducting HEDIS Compliance Audits™ for HEDIS measures or using the CMS protocol for validating performance measures for non-HEDIS measures, ensuring that plans report accurate and complete information.

The DHCS shares plan-specific and aggregate HEDIS results with the plans and CMS and releases the results publicly. The DHCS also incorporates these results into its consumer guides for new enrollees and uses the data as part of its annual performance assessment of plans and the MCMC Program as a whole.

In addition, the DHCS gives annual quality awards to plans in recognition of their accomplishments. The criteria for these awards are based largely on plans' HEDIS results for exceptional performance or marked improvement.

Minimum Performance Levels and High Performance Levels

The DHCS establishes both MPLs and HPLs for each required performance measure annually. Using NCQA's *HEDIS 2009 Audit Means, Percentiles, and Ratios*, the DHCS based its MPLs for the 2010 rates on the Medicaid national 25th percentile. Plans are contractually required to perform at or above the established MPL. Plans that have rates below the MPL must submit an improvement plan to the DHCS outlining the steps they will take to improve care. The DHCS established HPLs for the 2010 rates based on the national Medicaid 90th percentile. Plan performance in relation to the MPL and HPL for each measure becomes public record with the release of this report.

It is important to note that for the *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)* rate, where a lower rate represents higher performance, HSAG rotated the percentiles to align with the performance. If the *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)* rate was at or between the 10th and 24th percentiles, it was inverted at or between the 75th and 89th percentiles to represent the level of performance.

Auto-Assignment Program

Currently, six performance measures selected from the EAS are part of the DHCS's auto-assignment program, along with two measures related to plan use of safety net providers. The Department awards more default enrollment to Two-Plan and GMC model plans that score high on these measures and that achieve improvement over time. The auto-assignment program encourages plans to improve and/or maintain quality of care and services provided to their members.

Medi-Cal Managed Care Program's 2010 HEDIS Measures

The DHCS's 2010 EAS for full-scope plans, which uses 2009 measurement year data, includes the following measures:

- *Adolescent Well-Care Visits*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care*
  - *Blood Pressure Control (< 140/90 mm Hg)*
  - *Eye Exam (Retinal) Performed*
  - *Hemoglobin A1c HbA1c Testing*
  - *HbA1c Control (<8.0 Percent)*
  - *LDL-C Screening*
  - *LDL-C Control (<100 mg/dL)*
  - *Medical Attention for Nephropathy*
  - *Poor HbA1c Control (>9.0 Percent)*
- *Prenatal and Postpartum Care*
  - *Timeliness of Prenatal Care*
  - *Postpartum Care*
- *Use of Imaging Studies for Low Back Pain*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
  - *BMI Assessment: Total*
  - *Nutrition Counseling: Total*
  - *Physical Activity Counseling: Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

About HEDIS

HEDIS, developed by NCQA, is a standardized set of 76 performance measures used to provide health care purchasers, consumers, and others with a reliable comparison among health plans. HEDIS data are often used to produce health plan "report cards," analyze quality improvement activities, and benchmark performance. NCQA classifies the broad range of HEDIS measures across eight domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction With the Experience of Care
- Use of Services
- Cost of Care
- Health Plan Descriptive Information
- Health Plan Stability
- Informed Health Care Choices

Performance measures within these domains provide information about a plan's performance in such areas as providing timely access to preventive services, management of members with chronic disease, and appropriate treatment for members with select conditions.

While HEDIS data provide an opportunity to compare plans based on some aspects of health care delivered to members, the intent of the data is not to provide an overall, comprehensive assessment of health care quality for a plan.

The DHCS uses HEDIS data as one component of its overall quality monitoring strategy. Both the DHCS and plans use plan-specific data, aggregate data, and comparisons to state and national benchmarks to identify opportunities for improvement, analyze data, and assess whether previously implemented interventions were effective.

How HEDIS Results are Calculated and Displayed

NCQA developed specific HEDIS methodology to ensure that plans collect data and calculate and report results consistently to allow for plan comparison.

Methodology

To assist plans in standardized reporting, NCQA develops and makes available technical specifications that provide information on how to collect data for each measure, with general guidelines for sampling and calculating rates. The DHCS's EAS requirements for 2010 indicate that plans are responsible for adhering to the *HEDIS 2010 Technical Specifications, Volume 2*.

To ensure that plans calculate and report performance measures consistent with HEDIS specifications and that the results can be compared to other plans' HEDIS results, the plans must undergo an independent audit. NCQA publishes *HEDIS Compliance Audit™: Standards, Policies, and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an IS capabilities assessment and an evaluation of compliance with HEDIS specifications for a plan. The DHCS requires that plans undergo an annual compliance audit conducted by its contracted EQRO..

The HEDIS process begins well in advance of plans reporting their rates. Plans calculated their 2010 HEDIS rates with measurement data from January 1, 2009, to December 31, 2009. Performance measure calculation and reporting typically involves three phases: Pre-On-site, On-site, and Post-On-site.[4]

Pre-On-site Activity (October to December)

- Plans prepare for data collection and the on-site audit.
- Plans complete the HEDIS Record of Administration, Data Management, and Processes (Roadmap), a tool used by plans to communicate information to the auditor about the plans' systems for collecting and processing data for HEDIS.

On-site Activity (January to April)

- Plans conduct data capture and data collection.
- The EQRO conducts on-site audits to assess the plans' capabilities to collect and integrate data from internal and external sources.
- The EQRO provides preliminary audit findings to the plans.

[4] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Calculating Performance Measures: A Protocol for use in Conducting Medicaid External Quality Review Activities.* Final Protocol, Version 1.0. May 1, 2002.

Post-On-site Activity (May to October)

- The EQRO provides final audit reports to plans.
- Plans submit final audited rates to the DHCS (June).
- The EQRO analyzes data and generates the HEDIS aggregate report in coordination with the DHCS.

Data Collection Methodology

NCQA specifies two methods for data capture: the administrative method and the hybrid method.

Administrative Method

The administrative method requires plans to identify the eligible population (i.e., the denominator) using administrative data such as enrollment and claims and encounters. In addition, plans derive the numerator(s), or services provided to members in the eligible population, solely from administrative data sources. Plans cannot use medical records to retrieve information. When using the administrative method, the entire eligible population becomes the denominator because NCQA does not allow sampling.

The DHCS selected EAS measures for which NCQA methodology requires the administrative method to derive rates:

- *Adults' Access to Preventive/Ambulatory Health Services**
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Appropriate Testing for Children With Pharyngitis**
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Breast Cancer Screening*
- *Glaucoma Screening in Older Adults**
- *Persistence of Beta-Blocker Treatment After a Heart Attack**
- *Use of Imaging Studies for Low Back Pain*

* A specialty or PHP plan measure

The administrative method is cost-efficient, but it can produce lower rates due to incomplete data submission by capitated providers.

Hybrid Method

The hybrid method requires plans to identify the eligible population using administrative data and then extract a systematic sample of members from the eligible population, which becomes the denominator. Plans use administrative data to identify services provided to those members. When administrative data do not show evidence that a service was provided, plans then review medical records for those members.

The hybrid method generally produces higher rates but is considerably more labor-intensive. For example, a plan that has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure may perform the hybrid method. After randomly selecting 411 eligible members, the plan finds that 161 members have evidence of a postpartum visit using administrative data. The plan then obtains and reviews medical records for the 250 members who do not have evidence of a postpartum visit using administrative data. Of those 250 members, the plan finds 54 additional members who have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would be (161 + 54)/411, or 52 percent.

In contrast, using the administrative method, if the plan finds that 4,000 members out of the 10,000 had evidence of a postpartum visit using only administrative data, the final rate for this measure would be 4,000/10,000, or 40 percent.

The DHCS-selected EAS measures for which NCQA methodology allows hybrid data collection:

- *Adolescent Well-Care Visits*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Colorectal Cancer Screening**
- *Comprehensive Diabetes Care*
- *Prenatal and Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

* A specialty or prepaid health plan measure

Plans that have complete and robust administrative data may choose to report measures using only the administrative method and avoid labor-intensive medical record review; however, currently only two of the Medi-Cal Managed Care (MCMC) contracted plans report rates in this manner, Kaiser Permanente (North)—Sacramento County and Kaiser Permanente (South)—San Diego County. The Kaiser plans have IS capabilities, primarily due to their closed-system model and electronic medical records, that support administrative-only reporting because medical record review does not generally yield additional data beyond what the plan had already captured administratively.

HEDIS Aggregate Report Data Displays

This report displays 2010 HEDIS results relative to both local and national performance thresholds and benchmarks to compare the quality of services provided to MCMC members. A comparison of performance gives the DHCS and plans the opportunity to identify opportunities to improve care.

National benchmarks displayed in this report include the national Medicaid average and the national commercial average as reported by NCQA. The objectives and goals of the federal *Healthy People 2010* program provide another source of national benchmarks for comparison within this report, as available.[5] Local benchmarks include prior-year MCMC weighted averages and California Healthy Families Program (HFP) weighted averages.[6]

Plans' submission of HEDIS data provides rates calculated to the sixth decimal place. Results in this report are rounded to the first decimal place to be consistent with the display of comparative local and national benchmarks. Some rounded rates may appear the same; however, the more precise rates are not identical. In these instances, the graphs display the correct hierarchy of scores.

Medi-Cal Managed Care Program Weighted Averages

The principal measure of overall MCMC performance on a given measure is the "weighted" average rate. This use of a weighted average, based on each plan's eligible population for that measure, provides the most representative rate for the overall MCMC population. Weighting the MCMC average by each plan's eligible population size ensures that the rate for a health plan with 125,000 members, for example, has a greater impact on the overall MCMC weighted average than the rate for a plan with only 10,000 members.

HSAG computed the 2010 MCMC Program weighted average for each measure using plan-reported rates and weighted these by each plan's reported eligible population size for the measure. Rates reported as *Not Applicable* (*NA*) or *NR* were not included in the calculations of these averages. This is a better estimate of care for all MCMC enrollees than a straight average of MCMC plans' performance.

[5] *Healthy People 2010* is managed by the U.S. Department of Health and Human Services' Office of Prevention and Health Promotion. Healthy People 2010 provides a framework for prevention for the nation by establishing national health objectives and setting national goals to reduce threats. Available at: www.healthypeople.gov.

[6] California Healthy Families Program, California's Children's Health Insurance Program (CHIP), provides health, vision, and dental coverage to children who do not have insurance and who do not qualify for Medi-Cal.

Significance Testing

HSAG used a chi-square test to determine plan-specific differences between 2009 and 2010 rates to assess if a change was statistically significant. The chi-square test was used to judge how likely it is that the difference is real and not the result of chance.

To determine significance for this report, HSAG selected a risk level of 0.05. This risk level, or alpha level, means that five times out of 100 a statistically significant difference will be found between the mean values even if none actually existed (i.e., it happened by chance).

Understanding Sampling Error and Effect Size

Correct interpretation of results for measures collected using the HEDIS hybrid methodology requires an understanding of sampling error. It is rarely possible, logistically or financially, to conduct medical record review for the entire eligible population for a given measure. Measures collected using the HEDIS hybrid method include only a sample from the eligible population, and statistical techniques are used to maximize the probability that the sample results reflect the experience of the entire eligible population.

For results to be generalized to the entire eligible population, the process of sample selection must be such that everyone in the eligible population has an equal chance of being selected. The HEDIS hybrid method prescribes a systematic sampling process of selecting at least 411 members from the eligible population. Health plans may use a 5 percent, 10 percent, 15 percent, or 20 percent oversample to replace invalid cases (e.g., a male selected for *Postpartum Care*).

Figure 3.1 shows that if 411 health plan members are included in a measure, the margin of error is approximately ± 4.9 percentage points. Note that the data in this figure are based on the assumption that the size of the eligible population is greater than 2,000. The smaller the sample included in the measure, the larger the sampling error.

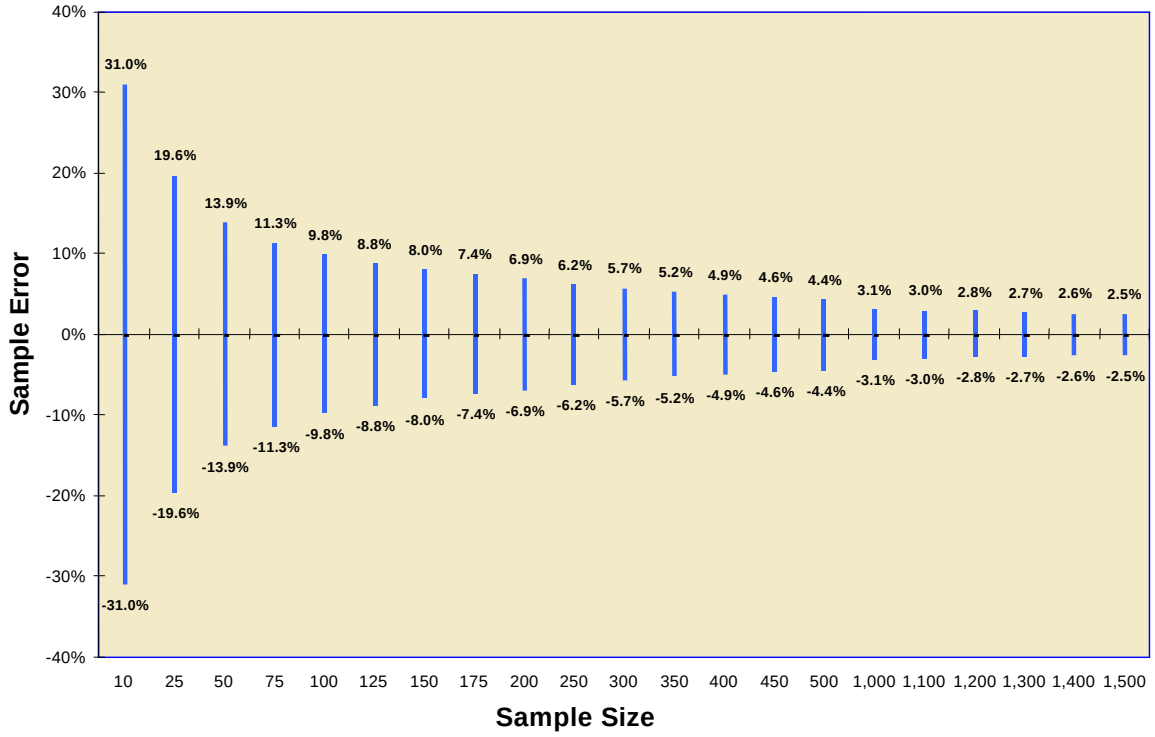


Figure 3.1—Relationship of Sample Size to Sample Error

Effect Size

The difference between two measured rates may not be statistically significant, but may, nevertheless, be important. The judgment of the reviewer is always a requisite for meaningful data interpretation. As Figure 3.1 shows, sample error gets smaller as the sample size gets larger. Consequently, when sample sizes are very large and sampling errors are very small, almost any difference is statistically significant. This does not mean that all such differences are important.

Effect sizes can be somewhat arbitrary and controversial, but are often used to determine the sample size needed to detect the difference that is desired.

The general guidelines to determine effect size are:

- A "small" difference between means is equal to one fifth the standard deviation.
- A "medium" effect size is equal to one half the standard deviation.
- A "large" effect is equal to 0.8 times the standard deviation.

The HEDIS sample sizes have already considered the effect size. The sampling formula used by HEDIS is sufficient to detect a difference of 10 percentage points. According to the *HEDIS 2010*

Technical Specifications, *Volume 2*, "This was chosen because it is a big enough difference to be actionable, it is not unduly burdensome for data collection, and it is not so small as to be "swamped" by nonsampling error." Sample size is calculated using a two-tailed test of significance between two proportions (alpha=0.5, 80 percent power) and a normal approximation to the binomial with a continuity correction factor also employed.

HEDIS results are intended to be used for decision making based on expected future performance. In this manner, the results of the sample are generalized to the population, and the plan's entire population is considered a "sample" of future populations. When there is no interest in generalizing the results to the population (e.g., there is only interest in the results for the sample), there is no need for significance testing. In these situations, effect sizes are sufficient and suitable.

How to Interpret Results

HEDIS results can differ among plans and even across measures for the same plan. The following questions generally arise when examining these data:

Considerations for Data Interpretation

1. **How accurate are the results?**
2. **How do MCMC rates compare to national percentiles?**
3. **How are MCMC plans performing overall?**

Results Accuracy

The DHCS requires all MCMC plans to have their HEDIS results confirmed by an NCQA HEDIS Compliance Audit™. As a result, HSAG verified all rates in this report as an unbiased estimate of the measure. NCQA designed the HEDIS protocol with its hybrid method, which produces results with a sampling error of ± 5 percent at a 95 percent confidence level.

Sampling error can affect the accuracy of results. Suppose a plan uses the hybrid method to derive a *Prenatal and Postpartum Care* rate of 52 percent. Because of sampling error, the true rate is actually ± 5 percent of this rate—somewhere between 47 percent and 57 percent at a 95 percent confidence level. If the target is a rate of 55 percent, it is uncertain whether the true rate, which is between 47 percent and 57 percent, meets the target level.

To prevent such ambiguity, this report uses a standardized methodology that requires the reported rate to be at or above the threshold level to be considered as meeting the target. For internal

purposes, plans should understand and consider the issue of sampling error when implementing interventions.

Comparing Medi-Cal Managed Care Program Rates to National Percentiles

This report displays the MCMC Program weighted average and compares it to the following local and national benchmarks:

- 2009 National Medicaid Average—The most current available mean rate of all Medicaid plans nationwide that reported rates to NCQA in 2009.
- 2009 National Commercial Average—The most current available mean rate of all commercial plans nationwide that reported rates to NCQA in 2009.
- 2009 California Healthy Families Average—The program's 2009 weighted average rates.
- Healthy People 2010—The available, established, and relevant goals similar to the MCMC Program's EAS.

Medi-Cal Managed Care Plans' Overall Performance

The DHCS establishes performance thresholds annually for minimum performance and high performance. This report displays each plan's rate relative to the established MPL and HPL for each measure, with the highest threshold or rate at the top of the chart, continuing in descending order to the lowest threshold or rate. Using NCQA's *HEDIS 2009 Audit Means, Percentiles, and Ratios,* the DHCS established its MPLs and HPLs for its HEDIS 2010 EAS. The DHCS based the MPLs on the 2009 Medicaid national 25th percentile and the HPLs on the 2009 Medicaid national 90th percentile, which represent the most recent data available from NCQA at the time this report was prepared. Appendix A includes all the HEDIS 2009 national Medicaid percentiles.

For most measures in this report, the 90th percentile indicates the HPL and the 25th percentile represents the MPL. This means that MCMC plans with reported rates above the 90th percentile rank in the top 10 percent of all Medicaid plans nationwide. Similarly, plans reporting rates below the 25th percentile (MPL) rank in the bottom 25 percent nationwide for that measure.

This differs for one measure, *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)*, where lower rates of poor control indicate better care. For this measure, the 10th percentile (rather than the 90th percentile) shows excellent performance, and the 75th percentile (rather than the 25th percentile) shows below-average performance. For this measure only, a *lower* rate indicates better performance.

For two specialty plans, two of the selected performance measures, *Colorectal Cancer Screening* and *Glaucoma Screening in Older Adults*, do not have established national percentiles for the Medicaid population. For these measures HSAG and the DHCS use either the established Medicare or the commercial 25th and 90th percentiles for comparison, depending on the unique characteristics of each specialty plan's population.

HSAG did not compare performances on the *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*, *Comprehensive Diabetes Care—Controlling High Blood Pressure (140/90 mm Hg)*, *Use of Imaging Studies for Low Back Pain*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures since 2010 represents the first year that MCMC plans were required to report these rates.

Performance Trend Analysis

In Appendix B, the column, "2009–2010 Rate Difference," shows, by measure, a comparison between the HEDIS 2009 results and the HEDIS 2010 results for each plan. HSAG used a chi-square test to calculate the statistical significance between plan rates in 2009 and 2010. The table shows the rate difference between 2009 and 2010 graphically using the key below:

↑	Rates in 2010 were significantly higher than they were in 2009.
↓	Rates in 2010 were significantly lower than they were in 2009.
↔	Rates in 2010 were not significantly different than they were in 2009.
Not comparable	A 2009–2010 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Different symbols (▲ ▼) are used to indicate a performance change for *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)*, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant *increase* in the 2010 rate from the 2009 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2010 rate from the 2009 rate.

About Performance Measure Validation

CMS requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with this requirement, the DHCS contracted with HSAG to conduct validation of the selected EAS performance measures. Because all the selected EAS measures for 2010 for regular, full-scope plans are also HEDIS measures, HSAG conducted audits in accordance with the 2010 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that plans must meet, including the criteria for any manual processes used to report HEDIS information. When a plan did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. Plans not fully compliant with all of the IS standards may still report all measures as long as the final reported rate is not significantly biased.

The IS standards include:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry.
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry.
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry.
- IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight.
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry.
- IS 6.0—Member Call Center Data—Capture, Transfer, and Entry (Note: This standard is not covered under the scope of the MCMC Care Program audit).
- IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity.

Audit Results

Through the audit process HSAG assigns each measure an audit result. Audit results include a valid rate (indicated by a numeric result), *NA*, *NR*, and *No Benefit (NB)*.

A numeric result indicates that the plan complied with all HEDIS specifications to produce an unbiased, reportable rate or rates that can be released for public reporting. Although a plan may have complied with all applicable specifications, if the plan's denominator is too small to report (less than 30), the audit result is *NA*. An audit result of *NR* indicates that the rate should not be publicly reported because the measure deviated from HEDIS specifications enough to bias the reported rate significantly or that the plan chose not to report the measure. An *NB* audit result indicates that the plan did not offer the benefit required to report the measure.

HEDIS Reporting Capabilities

Key Findings

Twenty-five contracted plans underwent performance measure validation. Twenty-four of those plans had a HEDIS™ Compliance Audit. Family Mosaic Project (FMP), a specialty plan, reported non-HEDIS measures; therefore, the plan underwent a performance measure validation audit consistent with CMS' protocol for conducting performance measure validation.[7]

Either HSAG's NCQA-certified compliance auditors or HSAG's subcontracted NCQA-certified compliance auditors performed all 25 plan audits for the 2010 reporting year.

Of the 25 audited plans, 20 used an NCQA-certified software vendor to produce rates. All but one of these software vendors achieved full certification status for the reported HEDIS measures. The software vendor that did not achieve full certification status was not certified for sampling methodology; therefore, HSAG reviewed and approved source code submitted by the vendor for sampling methodology and found it to comply with specified requirements. For the five plans that did not use a certified software vendor, HSAG reviewed and approved the source code.

[7] Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, Final Protocol, Version, 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol).

Strengths

All plans were able to report valid rates for their DHCS-required measures. The plans had sufficient transactional systems that captured the required data elements for producing valid rates.

With a few exceptions, HSAG found plans fully compliant with the overall IS standards. For the few plans that did not achieve full compliance with all IS standards, the auditor determined that the deficiencies did not bias any reported rates.

Challenges

HSAG found that some plans' certified software vendors experienced delays in receiving certification, which impacted the timeliness of medical record abstraction and generating preliminary administrative rates.

Some plans had challenges with medical record abstraction being conducted consistent with the technical specifications for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure. This measure was a new DHCS-required measure for 2010. HSAG identified that not all providers were documenting the BMI percentile accurately on the PM-160 form, which many plans used as a supplemental, administrative data source. Although some plans initially failed the medical record validation review, these plans were able address abstraction errors to produce valid rates.

HSAG found that a few plans do not capture complete rendering provider type information from claims and encounters, which limits the plan's ability to use these data to meet the compliance for some measures. This can be challenging for group practices or multi-specialty clinics. While the issue did not impact any plan's ability to report the required measures, plans had to rely more heavily on medical record review for hybrid measures. Therefore, this offers an opportunity for improvement.

Most of the plans did not meet NCQA's timeline of June 1, 2010, for submitting their rates to HSAG for auditor review. Both vendor issues outside of the plans' control and internal plan resource issues contributed to the delayed submissions. Late submissions put the plans at risk for a *NR* audit result.

Recommendations

Based on the results of the audit findings, HSAG provides the following recommendations for improved reporting capabilities by the plans:

- Educate providers on the WCC requirements for recording BMI for each population within the measure and accurately completing the PM-160 form to ensure that the data from this source are valid.
- Scrutinize the claims process to ensure that the rendering provider detail is required from all sources, including group practices.
- Perform more vigorous and comprehensive oversight of all vendors by implementing a formal monitoring and feedback process for each vendor. Items to consider are: timeliness, quality assurance standards, staffing, data exchange verification queries, and performance guarantees.
- Improve information interactive data submission system (IDSS) submission timeliness to reduce the risk of *NR* results.

Adolescent Well-Care Visits

Measure Definition

This *Adolescent Well-Care Visits* measure reports the percentage of adolescents 12 to 21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician or gynecologist (OB/GYN) during the measurement year.

Importance

Adolescents have a unique set of health care needs. Social experiences and changes in cognitive abilities lead many adolescents to experiment with activities that can threaten current health or have long-term health consequences. At least half of adolescents engage in health risk behaviors such as smoking, alcohol and drug use, aggressive behavior, and a sedentary lifestyle.[8] Furthermore, over 80 percent of adults who are addicted to tobacco began smoking as adolescents. Adolescents who begin drinking before age 15 are four times as likely to be alcohol dependent as those who delay drinking until at least age 21.[9]

Physicians can play a unique role in the counseling of young people about their behaviors and risks to their health. Annual visits can reinforce health promotion messages, identify at-risk adolescents, and build relationships that foster open disclosure of future health information. Furthermore, regular health care visits aid in the prevention, early diagnosis, and treatment of health care conditions so that the transition from youth to adulthood is a healthy one. Adolescent well-care visits can help prevent the following physical, mental, and emotional health issues:[10]

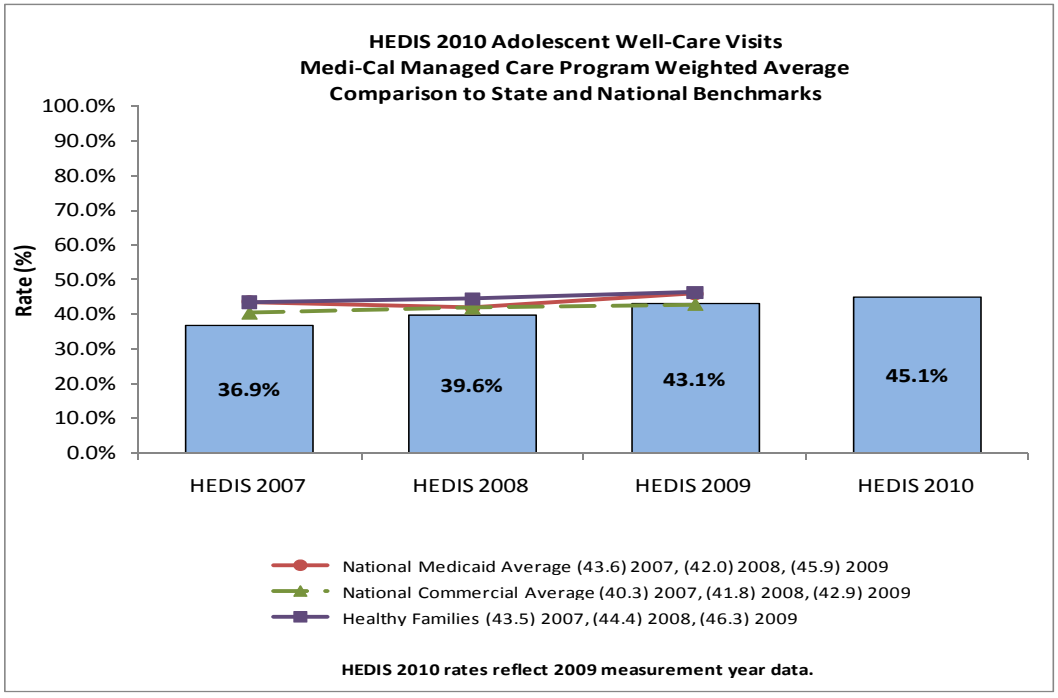
- Hypertension, hyperlipidemia, and other illnesses.
- The use and abuse of alcohol, tobacco, and other drugs.
- Severe or recurrent depression and suicide.
- Physical, sexual, and emotional abuse.
- Infectious diseases.

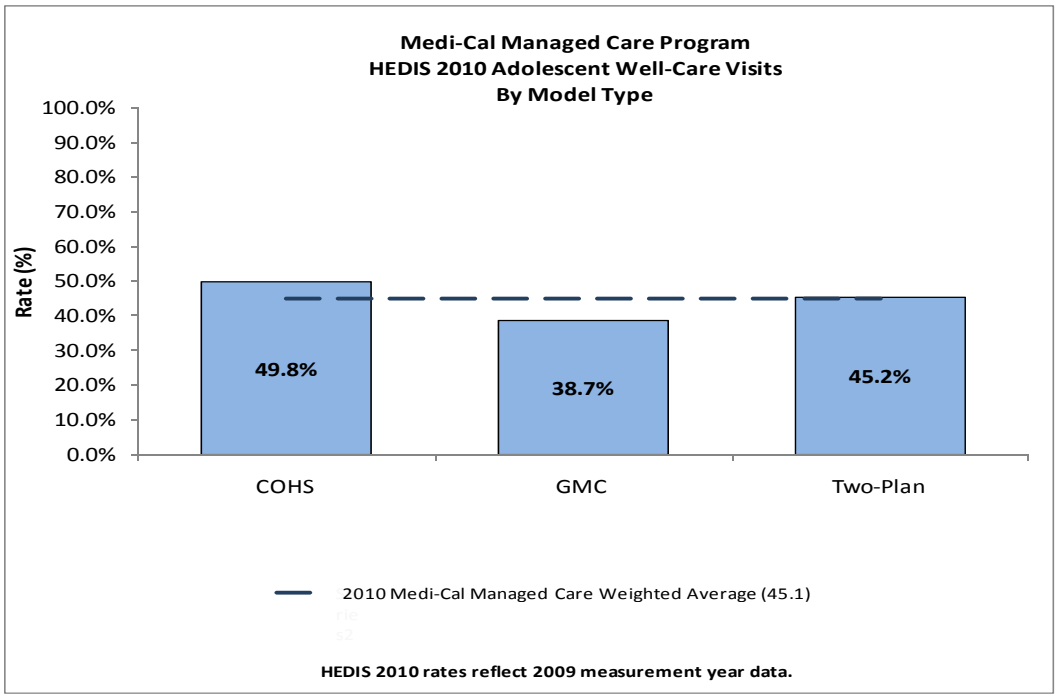
[8] The Robert Wood Johnson Foundation with the Child and Health Measurement Initiative. *A Portrait of Adolescents in America, 2001*. Available at: http://cahmi.org/ViewDocument.aspx?DocumentID=88. Accessed on: April 27, 2010.
[9] MacKay AP, Duran C. *Adolescent Health in the United States, 2007*. National Center for Health Statistics. 2007.
[10] American Medical Association. Guidelines for Adolescent Preventive Services (GAPS). Available at: http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf. Accessed on: April 27, 2010.

The American Medical Association's (AMA's) Guidelines for Adolescent Preventive Services recommend that all adolescents 11 to 21 years of age have an annual preventive services visit that focuses on both the biomedical and psychosocial aspects of health.[11] Adolescents, however, tend to have greater difficulty obtaining appropriate health care services on their own due to developmental characteristics and lack of experience negotiating medical systems. They often need specialized planning to respond to their needs for confidentiality, quality service, and coordination of care.[12]

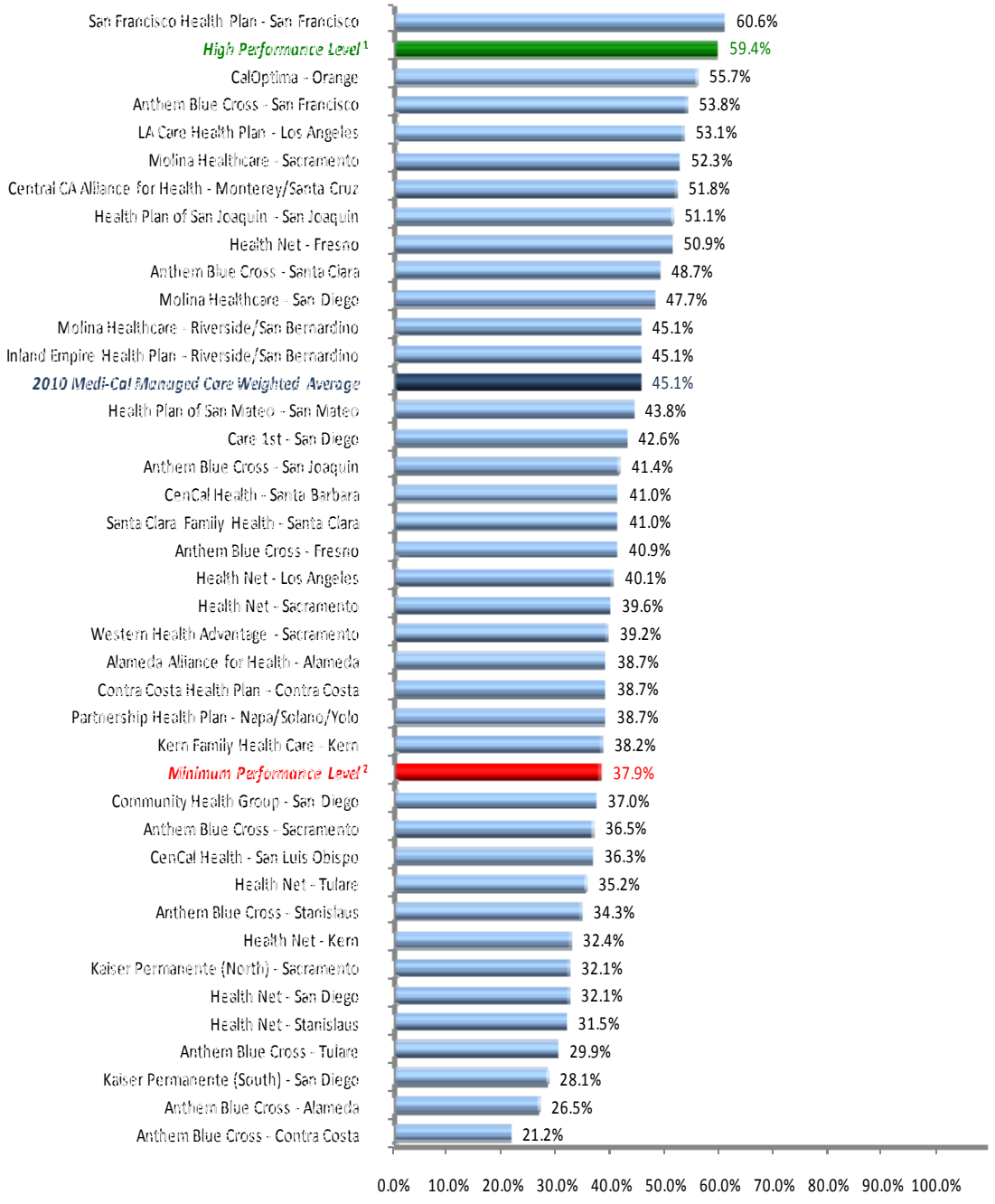
[11] American Medical Association. Guidelines for Adolescent Preventive Services (GAPS). Available at: http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf. Accessed on: April 27, 2010.

[12] National Adolescent Health Information Center. Assuring the Health of Adolescents in Managed Care: A Quality Checklist for Planning and Evaluating Components of Adolescent Health Care. Available at: http://nahic.ucsf.edu/downloads/Assuring_Hlth_Checklist.pdf. Accessed on: August 26, 2010.


HEDIS 2010 Adolescent Well-Care Visits
Medi-Cal Managed Care Program Weighted Average
Comparison to State and National Benchmarks
Rate (%)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
36.9%
39.6%
43.1%
45.1%
HEDIS 2007
HEDIS 2008
HEDIS 2009
HEDIS 2010
National Medicaid Average (43.6) 2007, (42.0) 2008, (45.9) 2009
National Commercial Average (40.3) 2007, (41.8) 2008, (42.9) 2009
Healthy Families (43.5) 2007, (44.4) 2008, (46.3) 2009
HEDIS 2010 rates reflect 2009 measurement year data.


Medi-Cal Managed Care Program
HEDIS 2010 Adolescent Well-Care Visits
By Model Type
Rate (%)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
49.8%
38.7%
45.2%
COHS
GMC
Two-Plan
2010 Medi-Cal Managed Care Weighted Average (45.1)
HEDIS 2010 rates reflect 2009 measurement year data.

Medi-Cal Managed Care
HEDIS 2010 Adolescent Well-Care Visits



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's 2010 weighted average for the *Adolescent Well-Care Visits* measure has increased gradually since 2007, consistent with national trends for Medicaid and commercial averages.

Despite the overall MCMC weighted average increase, the number of plans' rates falling below the MPL increased to 13 in 2010 compared to six in 2009.

The DHCS statewide collaborative QIP to improve the screening, counseling, and health education that adolescents receive from PCPs, in place from 2004 through 2007, may have contributed to many plans' ongoing success with performance improvement in this area. Although many plans have maintained steady and increased performance, eight plans showed a statistically significant decrease between 2009 and 2010 rates compared to only two plans with statistically significant decreases between 2008 and 2009.

High and Low Performers

Only one plan, San Francisco Health Plan—San Francisco County, scored above the established HPL of 59.4 percent. Anthem Blue Cross in five counties (out of nine), one of CenCal Health's counties, Community Health Group—San Diego County, four of Health Net's counties, and both of Kaiser Permanente's counties performed below the DHCS-established MPL in 2010.

Five of the plans showed statistically significant improvement in 2010 compared with their 2009 rates, while eight plans showed statistically significant decreases.

The COHS model type outperformed the GMC and Two-Plan model types and the MCMC Program's 2010 weighted average.

Best Practices

Improve Access

Open access appointments can increase compliance by expanding provider availability.[13] Provider evening or weekend clinic hours can help accommodate parents who cannot take time off from work. For example, one Saturday a month could be set aside for children and adolescents, with clinicians designated to perform well visits on that day. Visits on certain days could be made available on a walk-in, first-come, first-serve basis. Additionally, providers should encourage parents to schedule their next visit before leaving the clinic. Plans also may consider improved access to transportation as a strategy to increase well-visit compliance.

Reminder Systems

Postcards are an easy and effective tool for increasing well-visits. They can be sent to parents as a reminder to schedule their adolescents' well-visit. To be most effective, postcards should include contact information for either doctors' offices near the member's address or the member's assigned PCP. In addition, age-specific forms detailing what services should be provided and why they are important to the well-being of the child can help educate parents.

Physician Education

Quarterly provider reports that highlight adolescents in need of well-visits are useful for promoting visit reminders and helping providers track their performance. Members who saw a doctor but did not have a well-visit can be flagged as missed opportunities. To make this information pertinent to providers, their performance may be tied to a recognition program for providers who display outstanding performance. Another practice that can improve well visit compliance is for plans to educate providers on proper billing codes for well-child visits, which can improve accurate reporting of well-care visits provided.

Additionally, electronic tracking tools and provider prompts are associated with greater provider satisfaction rates as well as increased well-care visit rates.

[13] O'Connor ME, Matthews BS, Gao D. Effect of Open Access Scheduling on Missed Appointments, Immunizations, and Continuity of Care for Infant Well-Child Care Visits. *Archives of Pediatrics & Adolescent Medicine.* 2006; 160: 889-893.

Appropriate Treatment for Children With Upper Respiratory Infection

Measure Definition

The *Appropriate Treatment for Children With Upper Respiratory Infection* measure reports the percentage of enrolled members who were three months through 18 years of age during the measurement year, who were given a diagnosis of a URI, and who were not dispensed an antibiotic prescription on or three days after the episode dates.

Importance

Antibiotic overuse in children has become a common problem, aggravated by parental pressure for antibiotics.[14] As a result, many bacterial infections are becoming resistant to antibiotics, creating a lack of effective treatment for these infections and making it harder and harder to treat patients.

According to the National Center for Health Statistics (NCHS), approximately 75 percent of antibiotics prescribed in the ambulatory setting are for the treatment of five respiratory infections, one of which is URI.[15] The use of antibiotics is highest among children; therefore, the pediatric age group is the initial focus of inappropriate antibiotic use.[16] Since the origin of most URIs is viral, the prescribing of antibiotics for the treatment of a majority of URIs is inappropriate. The use of antibiotics is only appropriate for URIs of bacterial origin.[17]

Although a majority of physicians realize that antibiotics will not hasten the resolution of a cold, they are often prescribed in an attempt to prevent bacterial complications. However, data indicate that this is not an effective strategy and that antibiotics do not change the course or outcomes of URI.[18]

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[14] McCaig LF, Besser RE, Hughes JM. Trends in Antimicrobial Prescribing Rates for Children and Adolescents. *The Journal of the American Medical Association.* 2002; 287(23): 3096-3102.

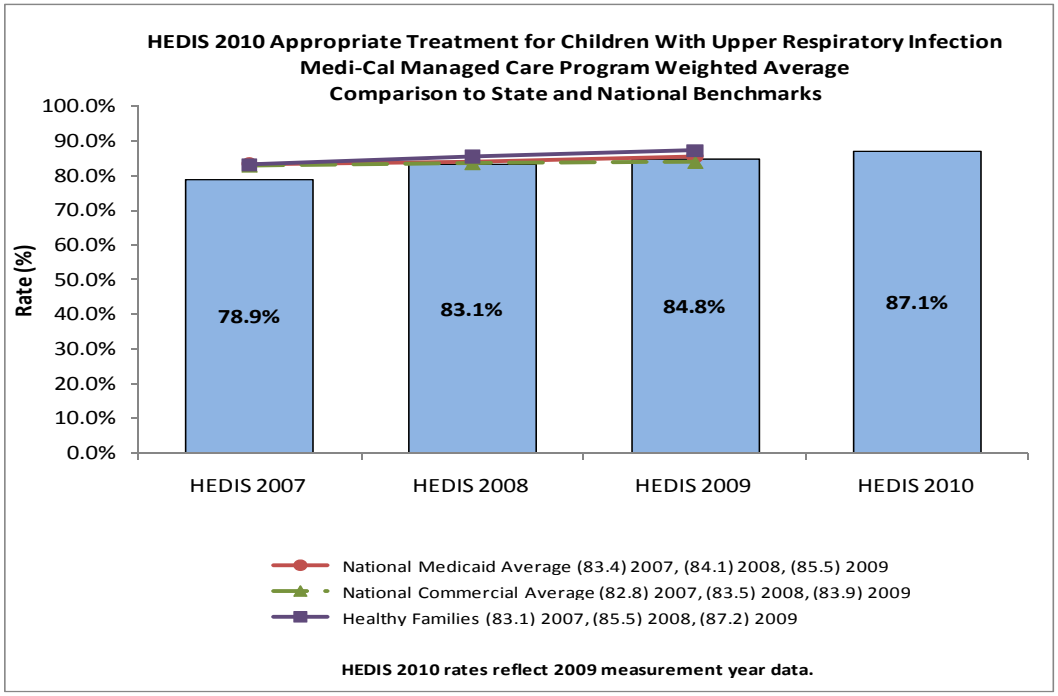
[15] Gonzales R, Malone DC, Maselli JH, et al. Excessive Antibiotic Use for Acute Respiratory Infections in the United States. *Clinical Infectious Disease.* 2001; 33(6): 757-762.

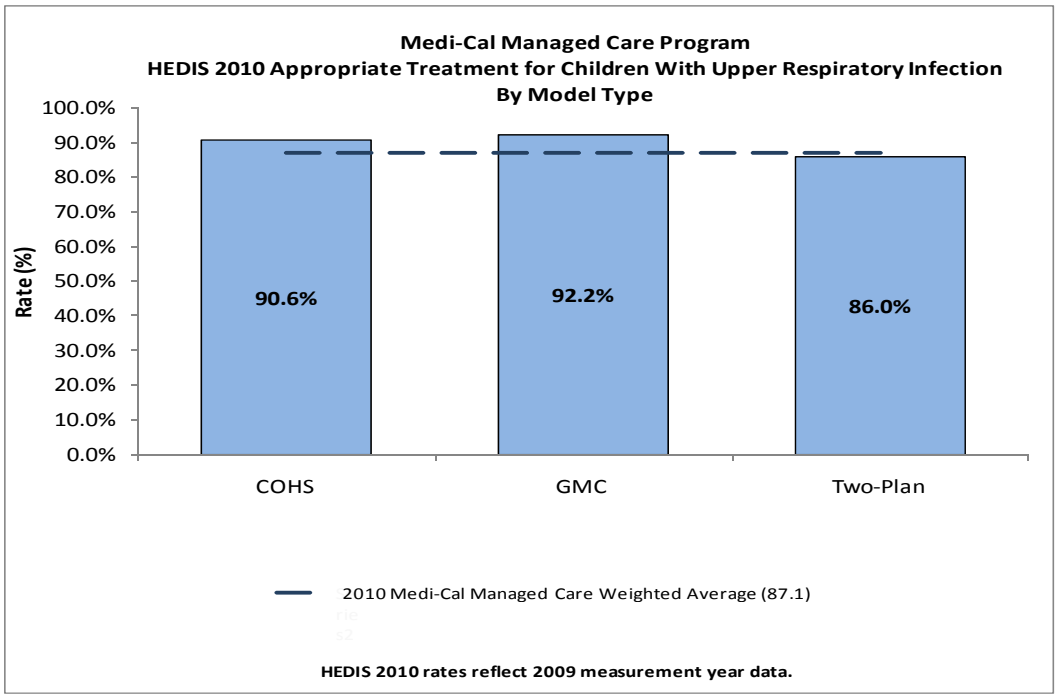
[16] Dowell SF, Schwartz B, Phillips WR, et al. Appropriate Use of Antibiotics for URIs in Children: Part II. Cough, Pharyngitis and the Common Cold. *American Family Physician.* 1998. Available at: http://www.aafp.org/afp/981015ap/dowell.html. Accessed on: April 13, 2010.

[17] The Centers for Medicare & Medicaid Services. *2010 Physician Quality Reporting Initiative Measure Specifications Manual for Claims and Registry Reporting of Individual Measures.* Version 4.1.

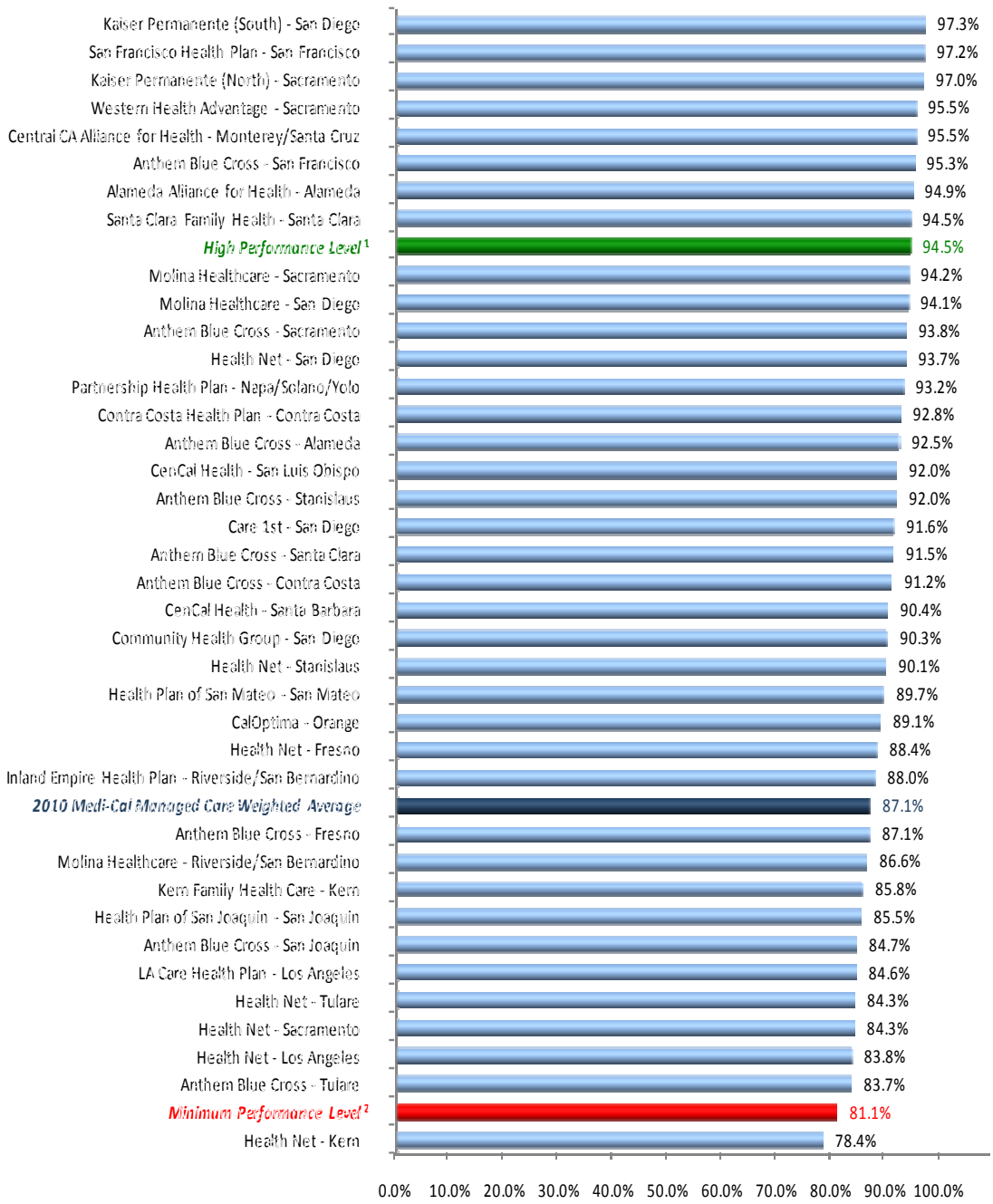
[18] Dowell SF, Schwartz B, Phillips WR, et al. Appropriate Use of Antibiotics for URIs in Children: Part II. Cough, Pharyngitis and the Common Cold. *American Family Physician.* 1998. Available at: http://www.aafp.org/afp/981015ap/dowell.html. Accessed on: April 13, 2010.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Appropriate Treatment for Children With Upper Respiratory Infection



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's 2010 weighted average for the *Appropriate Treatment for Children With Upper Respiratory Infection* measure has gradually increased since 2007. The MCMC Program's 2010 weighted average was above both the 2009 national Medicaid and commercial averages.

High and Low Performers

Eight plans met or exceeded the established HPL of 94.5. Six of these plans also exceeded the HPL in 2009. Only one plan, Health Net—Kern County, was below the MPL. Health Net—Kern County also was the only plan in 2009 to fall below the MPL. Fourteen plans showed statistically significant improvement in 2010 compared with their 2009 rates, and two plans showed a statistically significant decrease.

The GMC model type outperformed the COHS and Two-Plan model types and the MCMC Program's 2010 weighted average.

Best Practices

Parental Education

For the pediatric population, parental pressure is one of the main reasons that antibiotics are prescribed inappropriately. Therefore, educating parents about the appropriateness of different treatments has been found to be the single most important factor in reducing inappropriate prescribing of antibiotics.[19] Approaches for educating parents include providing educational materials, displaying posters and information sheets in the waiting room and exam room, mailing information to the household, providing brochures, and providing bags or kits of alternative treatments.[20]

Provider Education

Educational interventions for providers should focus on describing the appropriate diagnosis and treatment of URI. Methods to target providers include educational newsletters, seminars, workshops, and written materials. Mass media campaigns (e.g., e-cards and billboards) that target all clinicians have also been found to be effective. Another method of ensuring appropriate prescribing practices is for plans to conduct a medical audit on antibiotic prescribing and provide feedback to providers.[21] A plan could send providers a "Quick Reference Card" that encourages

[19] Razon Y, Ashkenazi S, Cohen A, et al. Effect of Educational Intervention on Antibiotic Prescription Practices for Upper Respiratory Infections in Children: A Multicentre Study. *Journal of Antimicrobial Chemotherapy*. 2005; 56: 937-940.
[20] Arroll B. "Non-Antibiotic Treatments for Upper-Respiratory Tract Infections (common cold)." *Respiratory Medicine*. 2005; 99: 1477-1484.
[21] Razon Y, Ashkenazi S, Cohen A, et al. Effect of Educational Intervention on Antibiotic Prescription Practices for Upper Respiratory Infections in Children: A Multicentre Study. *Journal of Antimicrobial Chemotherapy*. 2005; 56: 937-940.

them to access their results online, including their current rates for appropriately testing or treating URI.[22] It is also important that providers receive education on proper billing/coding.[23]

Decision Support Systems

The use of decision support systems based on evidence-based guidelines can improve the effectiveness and efficiency of prescribing decisions. Decision support systems aid providers in making clinical decisions (e.g., an algorithm for antibiotic prescribing).[24] Many prescribing applications include information on pathogens, diagnosis, medication, and treatment; the use of these applications can lead to improved adherence to clinical guidelines.[25,26]

Delayed Prescribing Practices

Delayed prescribing practices are used to delay the prescribing of antibiotics unless a patient has continuing, severe symptoms for a specified time after an initial visit with a provider. Delayed prescribing practices result in a reduction of overall use of antibiotics. Studies recommend delaying prescribing antibiotics from 48 to 72 hours. In one study, delaying the prescribing of antibiotics for 48 hours resulted in 62 percent of patients not requiring antibiotics.[27]

[22] SelectHealth. HEDIS 2009 Report. Available at: http://selecthealth.org/Static/Files/hedisreport.pdf. Accessed on: May 21, 2010.
[23] Health Services Advisory Group. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.
[24] Ranji SR, Steinman MA, Shojania, KG, et al. Interventions to Reduce Unnecessary Antibiotic Prescribing: A Systematic Review and Quantitative Analysis. *Medical Care.* 2008; 46: 847-862.
[25] Sintchenko V, Coiera E, Gilbert GL. Decision Support Systems for Antibiotic Prescribing. *Current Opinion in Infectious Disease.* 2008; 21: 573-579.
[26] Agency for Healthcare Research and Quality. Real-Time Decision and Documentation Support Increases Adherence to Recommended Care for Respiratory Infections, Diabetes, and Heart Disease. *AHRQ Health Care Innovations Exchange.* Available at: http://www.innovations.ahrq.gov/content.aspx?id=2431. Accessed on: June 1, 2010.
[27] Little P. "Delayed Prescribing—A Sensible Approach to the Management of Acute Otitis Media" *The Journal of the American Medical Association.* 2006; 296(10): 1290-1291.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Measure Definition

The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure assesses the percentage of members 18 to 64 years of age with a primary diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Importance

While only about 5 percent of adults report an episode of acute bronchitis each year, 90 percent seek treatment.[28] Acute bronchitis consistently ranks among the top 10 conditions that account for the most ambulatory office visits to U.S. physicians. The majority of acute bronchitis cases (more than 90 percent) have a nonbacterial cause (i.e., are viral in origin) making the prescribing of antibiotics for the treatment of acute bronchitis inappropriate. However, antibiotics are prescribed for the treatment of acute bronchitis 65 percent to 80 percent of the time.[29] Furthermore, over 90 percent of smokers with acute bronchitis receive antibiotics; however, there is no evidence that smokers are in greater need of antibiotics than nonsmokers.[30]

Routine antibiotic treatment of acute bronchitis does not have a consistent impact on duration, severity of illness, or potential complications.[31]

Recent studies suggest that the reasons for unnecessary antibiotic prescribing are more complex, having as much or more to do with patient and physician expectations than with physicians' diagnostic skills. Patient satisfaction with care for acute bronchitis depends more on physician-patient communication than on antibiotic treatment.[32]

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[28] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C: NCQA; 2009.

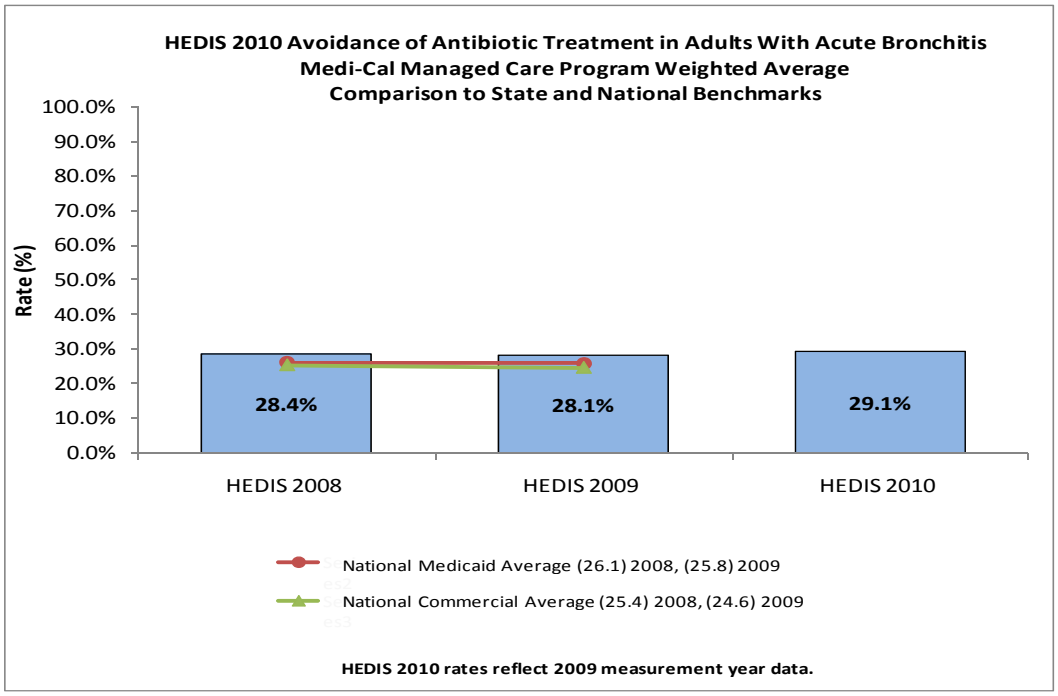
[29] Agency for Healthcare Research and Quality. "Avoidance of antibiotic treatment in adults with acute bronchitis." *National Quality Measures Clearinghouse.* Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=14939. Accessed on: May 21, 2010.

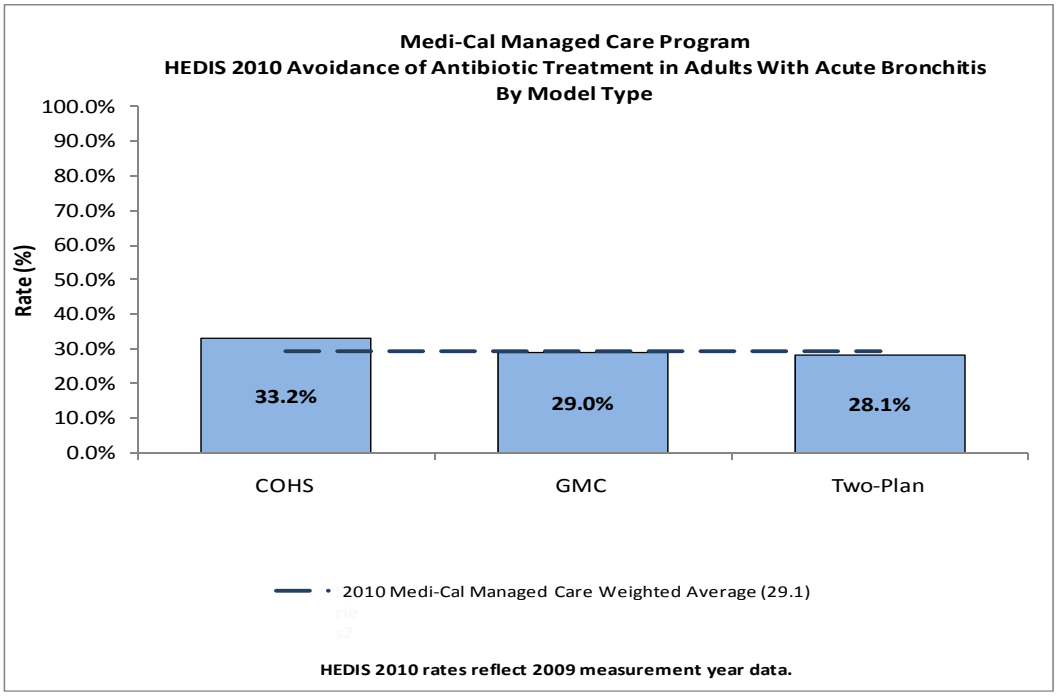
[30] Braman SS. "Chronic Cough Due to Acute Bronchitis: ACCP Evidence-Based Clinical Practice Guidelines." *Chest.* 2006; 129: 95S-103S.

[31] Gonzales R, Bartlett JG, Besser RE, et al. Principles of Appropriate Use for Treatment of Uncomplicated Acute Bronchitis: Background. *Annals of Internal Medicine.* 2001; 134: 521-529.

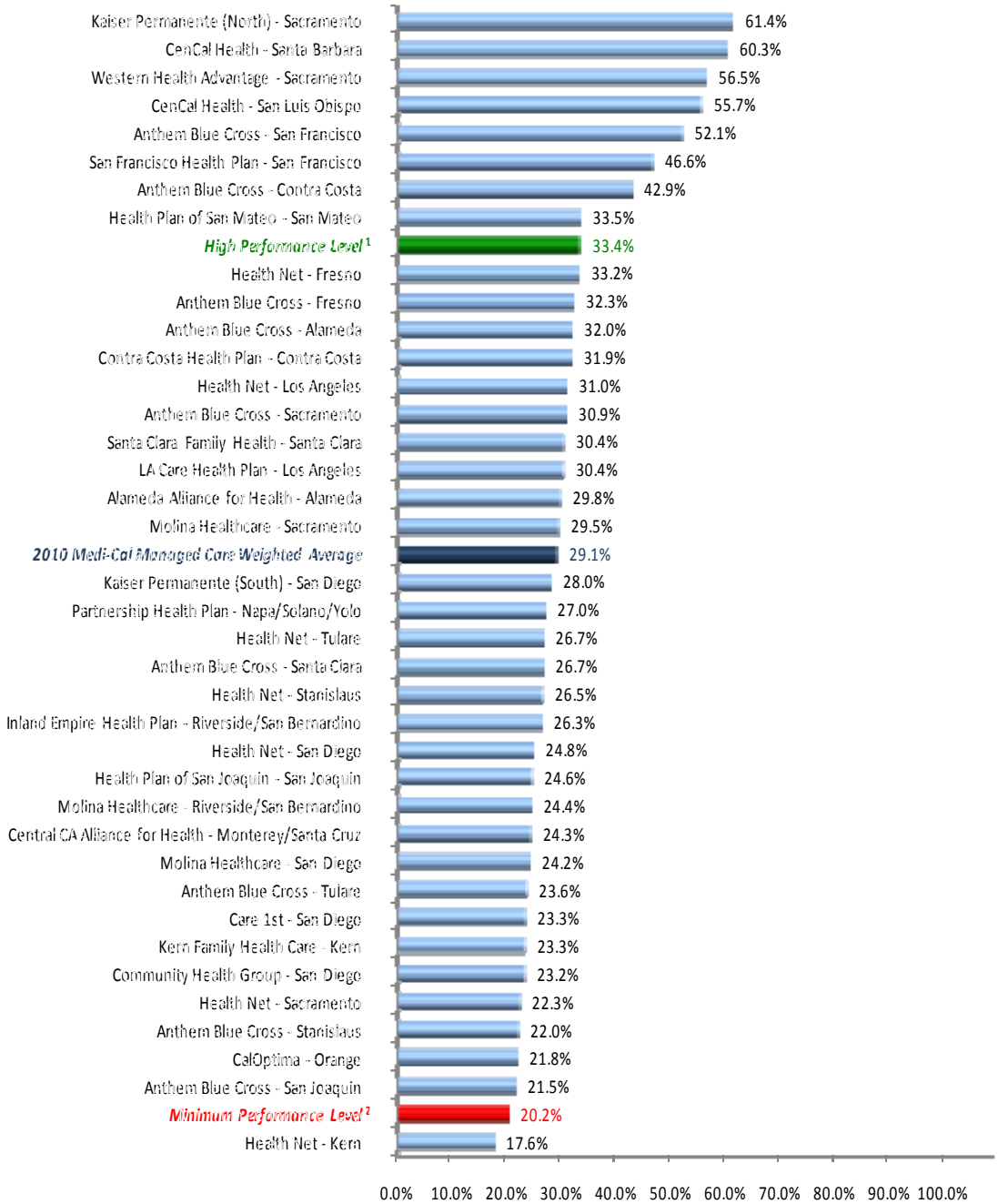
[32] Scott JG, Cohen D, DiCicco-Bloom B, et al. Antibiotic Use in Acute Respiratory Infections and the Ways Patients Pressure Physicians for a Prescription. *The Journal of Family Practice.* 2001; 50(10): 853-858.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's 2010 weighted average for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure increased from the 2009 weighted average. Furthermore, the 2010 MCMC weighted average exceeded both the 2009 national Medicaid and commercial averages. For this measure only, prior to 2008, plans reported an inverted rate. Beginning in 2008, a higher rate indicated better performance; therefore, HSAG omitted the 2007 MCMC weighted average from the table since trending was not comparable for that year.

High and Low Performers

Eight plans performed above the DHCS-established HPL, and only one health plan, Health Net—Kern County performed below the MPL. Anthem Blue Cross in Contra Costa and San Francisco counties, CenCal Health—Santa Barbara County, Kaiser Permanente (North)—Sacramento County, and Western Health Advantage—Sacramento County showed continued high performance exceeding the HPL in 2009 and 2010. Four plans had statistically significant increases in 2010 compared to their 2009 rates, while three plans showed statistically significant decreases.

The COHS model type outperformed the GMC and Two-Plan model types, as well at the MCMC 2010 Program weighted average.

Best Practices

Patient Education

There is a need to increase patient awareness about not only the dangers of antibiotic use for treating acute bronchitis but also the lack of effectiveness. Patient education should emphasize that the condition does not require antibiotic treatment and that antibiotic treatment is not recommended. Furthermore, the use of the term "chest cold" has been associated with a decrease in a patient's belief that they need an antibiotic. In one study, 44 percent of patients thought that antibiotics were more important for acute bronchitis compared to 11 percent for chest colds. For those patients whose acute bronchitis may be associated with smoking, smoking cessation advice/tools can help to reduce the symptoms of acute bronchitis caused by smoking.[33]

[33] Braman SS. Chronic Cough Due to Acute Bronchitis: ACCP Evidence-Based Clinical Practice Guidelines. *Chest.* 2006; 129: 95S-103S.

Provider Education

Educational interventions for providers should focus on describing the appropriate diagnosis and treatment of acute bronchitis. Physicians should be educated about the subtle approaches patients use to pressure them for antibiotic treatment and should be shown techniques for responding to these pressures without prescribing antibiotics unnecessarily. In one study of physician prescribing practices, physicians prescribed antibiotics inappropriately in 80 percent of encounters with patient pressures.[34]

In addition to the above mentioned best practices, many of the same best practices discussed for *Appropriate Treatment for Children With Upper Respiratory Infection* may also be used as best practices for *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*. These include:

- Provider education[35]
- Conducting medical audits on antibiotic prescribing and providing feedback to the provider[36]
- Decision support systems[37,38]
- Delayed prescribing practices[39]

[34] Scott JG, Cohen D, DiCicco-Bloom B, et al. Antibiotic Use in Acute Respiratory Infections and the Ways Patients Pressure Physicians for a Prescription. *The Journal of Family Practice.* 2001; 50(10): 853-858.

[35] Razon Y, Ashkenazi S, Cohen A, et al. Effect of educational intervention on antibiotic prescription practices for upper respiratory infections in children: a multicentre study. *Journal of Antimicrobial Chemotherapy.* 2005; 56: 937-940.

[36] Ibid.

[37] Sintchenko V, Coiera E, Gilbert GL. Decision Support Systems for Antibiotic Prescribing. *Current Opinion in Infectious Disease.* 2008; 21: 573-579.

[38] Agency for Healthcare Research and Quality. Real-Time Decision and Documentation Support Increases Adherence to Recommended Care for Respiratory Infections, Diabetes, and Heart Disease. *AHRQ Health Care Innovations Exchange.* Available at: http://www.innovations.ahrq.gov/content.aspx?id=2431. Accessed on: June 1, 2010.

[39] Little P. "Delayed Prescribing—A Sensible Approach to the Management of Acute Otitis Media" *The Journal of the American Medical Association.* 2006; 296(10): 1290-1291.

Breast Cancer Screening

Measure Definition

The *Breast Cancer Screening* measure is reported using only the administrative method. This measure calculates the percentage of women 40 through 69 years of age who had a mammogram in the prior two years.

Importance

Breast cancer is the most prevalent cancer among women and is the second leading cause of cancer deaths among women in the United States.[40] Women in the United States have a one in eight lifetime risk of developing breast cancer.[41] The American Cancer Society estimates that during 2010 there will be 207,090 new cases of female breast cancer and 40,230 deaths in the United States, as a result of this disease. The American Cancer Society also projects that 21,130 women will be newly diagnosed with breast cancer in California during 2010.[42]

Since breast cancer is not thought to be preventable, early detection of cancer through screening tests is the preeminent method to reduce mortality.[43] In addition, treatment is more effective and remission is more likely when breast cancer is detected early.[44] Screenings typically detect tumors at an earlier stage of development (i.e., Stage I) than those found outside of screening and detect cancer in 85 percent of women without symptoms.[45,46] For women 50 to 69 years of age, mammogram screenings decrease breast cancer mortality by up to 35 percent.[47]

In addition to personal losses, breast cancer accounts for substantial costs to the U.S. health care system. Breast cancer accounts for 20 to 25 percent of all cancer costs.[48] It is estimated that breast

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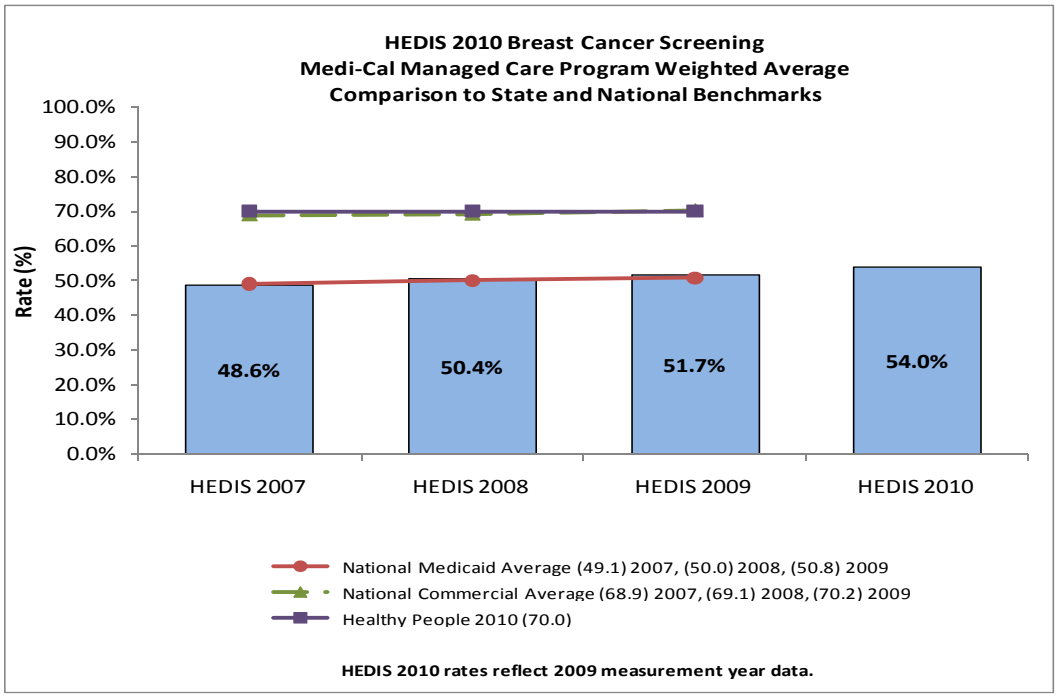
[40] Task Force on Community Preventive Services. Recommendations for Client- and Provider-Directed Interventions to Increase Breast, Cervical, and Colorectal Cancer Screening. *American Journal of Preventive Medicine.* 2008; 35(1 Supplement): S21-S25.
[41] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.
[42] American Cancer Society, Cancer Facts & Figures 2010. Available at: http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-026238.pdf. Accessed on: October 4, 2010.
[43] U.S. Preventive Services Task Force. Screening for Breast Cancer: United States Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine.* 2009; 151(10): 716-726, W-236.
[44] American Cancer Society. Cancer Facts & Figures 2009. Available at: http://www.cancer.org/downloads/STT/500809web.pdf. Accessed on: September 13, 2010.
[45] Shen Y, Yang Y, Inoue LY, et al. Role of Detection Method in Predicting Breast Cancer Survival: Analysis of Randomized Screening Trials. *Journal of the National Cancer Institute.* 2005; 97(16): 1195-1203.
[46] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.
[47] Ibid.
[48] Radice D, Redaelli A. Breast Cancer Management: Quality-of-Life and Cost Considerations. *Pharmacoeconomics*. 2003; 21(6): 383-396.

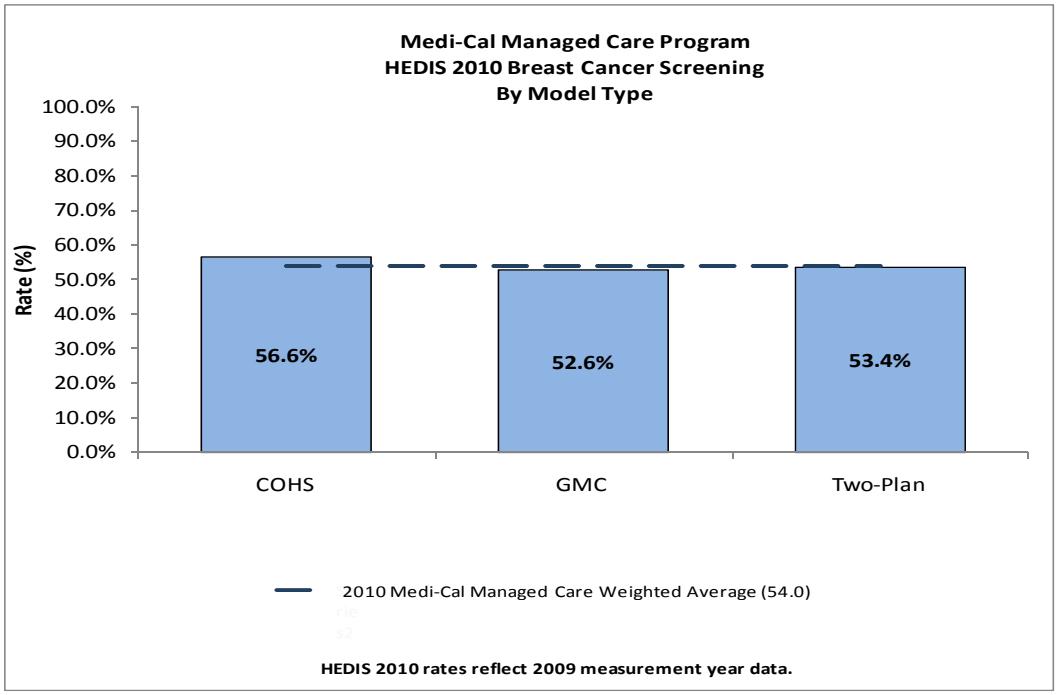
cancer costs the United States $7 billion per year; however, treatment for breast cancer detected in earlier stages costs significantly less than treatment for more advanced stages.[49]

In November 2009, the United States Preventive Services Task Force revised its biennial mammography screening recommendations to women 50 to 74 years of age.[50] NCQA may revise the measure definition for HEDIS 2012 based on this information.

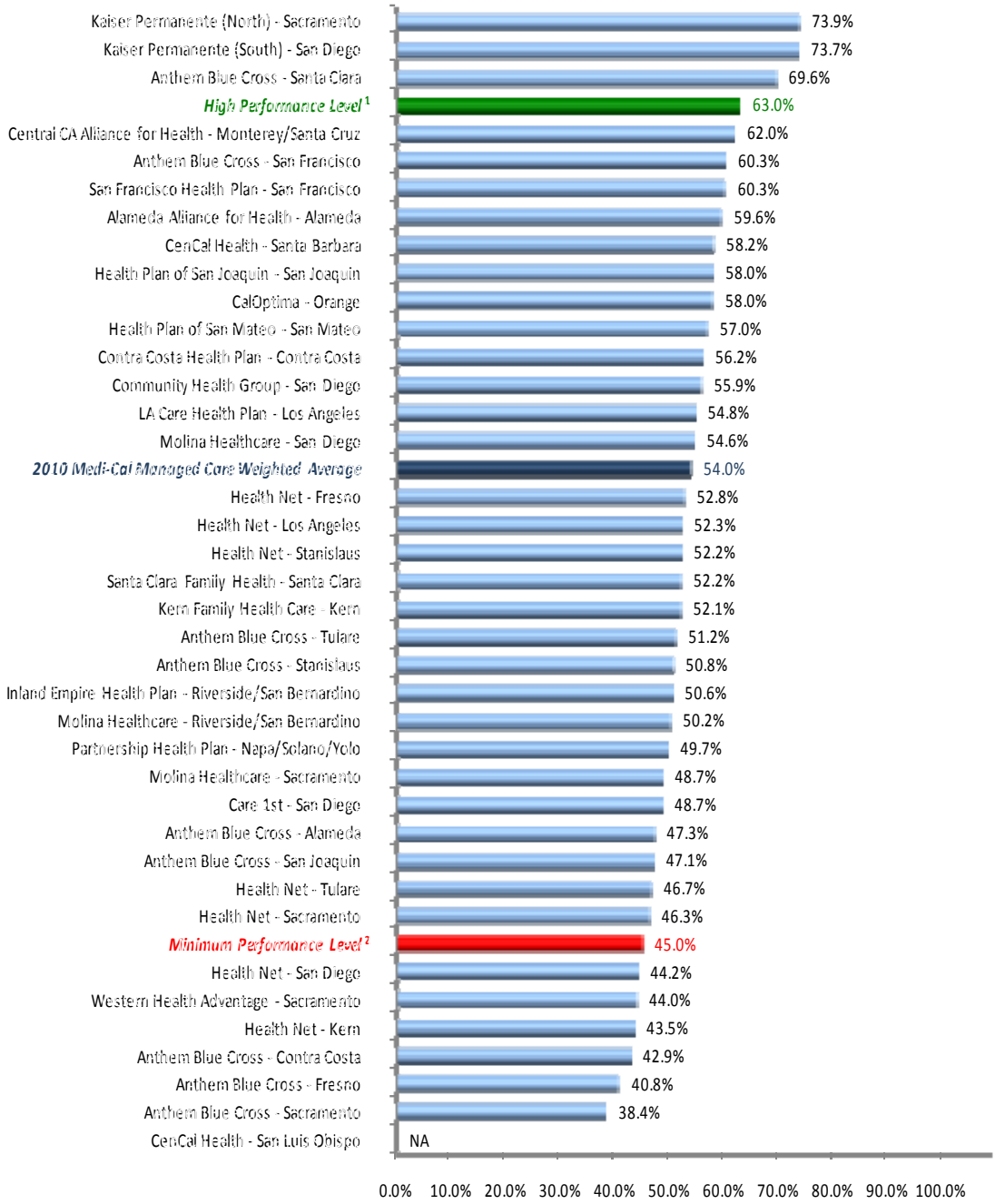
[49] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.
[50] Agency for Healthcare Research and Quality, U.S. Preventive Services Task Force. Screening for Breast Cancer, Release data, November 2009. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm. Accessed on: October 4, 2010.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Breast Cancer Screening



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's 2010 weighted average for the *Breast Cancer Screening* measure has gradually increased each year since 2007. The MCMC Program's weighted average has followed a consistent trend with the national Medicaid average. However, the weighted average consistently falls substantially below the 2009 national commercial average of 70.2 percent and the Healthy People 2010 goal of 70.0 percent.

High and Low Performers

Both Kaiser Permanente plans and Anthem Blue Cross—Santa Clara County performed above the HPL in 2010. Furthermore, these three plans have shown consistently high performance by achieving the HPL in 2008, 2009, and 2010.

Six plans performed below the MPL in 2010 compared to nine plans in 2009. Of these six plans, four plans, Anthem Blue Cross' Contra Costa and Sacramento counties, CenCal Health—San Luis Obispo County, and Western Health Advantage—Sacramento County, also fell below the MPL in 2009.

Fifteen plans had statistically significant improvement in their 2010 rates compared to their 2009 rates, while four plans showed a statistically significant decrease.

The COHS model type outperformed both the GMC and Two-Plan model types, as well at the MCMC 2010 Program weighted average.

Best Practices

Physician Reminders

Sharing a list of missed screening opportunities with PCPs and OB/GYNs is an effective practice that has shown to increase screening rates. Sending providers a list of patients who were identified as not having received a screening within the specified time frameenables them to contact members and encourage them to come in for important screenings. When PCPs and OB/GYNs use these lists to remind patients to have screenings, it is harder for women to evade or ignore promptings from their physicians.[51]

[51] National Committee for Quality Assurance. Breast Cancer Screening: Raising Member and Physician Awareness. *Quality Profiles*. 2008. Available at: http://www.qualityprofiles.org/quality_profiles/case_studies/Womens_Health/1_14.asp. Accessed on: May 6, 2010.

Patient Reminders

Members are more responsive to reminders when a clinician calls (i.e., physicians or their support staff).[52] However, other reminder methods, such as direct mailings (e.g., postcards and letters) and small media (e.g., brochures, pamphlets, flyers, and newsletters) have also shown to be effective. Reminders are most effective when they are eye-catching, timely, and personalized. One method that can be used to accomplish this is to send colorful birthday cards with enclosed reminders. Reminders also can be used to provide additional information on locations of screening facilities with business hours.

Improving Access and Awareness

It is important for a plan to determine if proper resources are in place to allow members to obtain screenings. Plans may contract with more OB/GYNs and/or increase the number of sites that perform screenings. At each stage, plans must keep members informed of the changes in procedures and additional resources.[53] Other methods to improve awareness include articles in member newsletters, educational materials for members, and readily available information on locations and business hours of screening facilities.

Physician Communication

If a physician is able to properly communicate with their patient about various topics such as the importance of getting routine breast cancer screenings, there is a higher chance the patient will be compliant.

Many health plans and medical groups are now giving formal training to practitioners in communication skills. This training can be completed either through in-house programs or communications programs offered by outside organizations. This type of training is usually optional; however, some organizations have made the classes a requirement. In other organizations, the training is only required for doctors who consistently receive low scores in the area of communication.[54]

The purpose of the training programs is to improve providers' effectiveness as both managers of health and educators of patients. It is also thought that trained physicians will allocate a greater

[52] Task Force on Community Preventive Services. Recommendations for Client- and Provider-Directed Interventions to Increase Breast, Cervical, and Colorectal Cancer Screening. *American Journal of Preventive Medicine.* 2008; 35 (1 Supplement): S21-S25.

[53] National Committee for Quality Assurance. Breast Cancer Screening – Hitting the Road with Screening Programs. *Quality Profiles*. 2010. Available at: http://www.qualityprofiles.org/quality_profiles/case_ studies/Womens_Health/1_15.asp. Accessed on: May 27, 2010.

[54] Agency for Healthcare Research and Quality. The CAHPS Improvement Guide. Available at: https://www.cahps.ahrq.gov/QIGuide/content/interventions/Training2AdvanceSkills.aspx. Accessed on: April 26, 2010.

percent of the clinic-visit time to patient education, which leads to greater patient knowledge, better compliance with treatment, and improved health outcomes.

The most effective and efficient way of offering physician-patient communication training is in the form of a workshop or seminar. With this method, many strategies can be covered for improved communication in a short period of time. Workshops also have the advantage of using case studies to illustrate the importance of communication and suggest approaches to improving the relationship between the physician and patient.[55]

Physician Tools and Resources

Providers often need reminders about screening guidelines. Three methods to improve HEDIS screening rates by reaching out to providers are to clarify and reinforce guidelines, reinforce the importance of screening, and create tools to facilitate screening.

NCQA further recommends the following tools to help facilitate screening:

- Patient registry of females who had screenings.
- Copies of reminder letters sent to patients who are due for screenings.
- List of patients, with contact information, who have not received screenings.[56]

[55] Agency for Healthcare Research and Quality. The CAHPS Improvement Guide. Available at: https://www.cahps.ahrq.gov/QIGuide/content/interventions/Training2AdvanceSkills.aspx. Accessed on: April 26, 2010.

[56] National Committee for Quality Assurance. Improving Chlamydia Screening: Strategies From Top Performing Health plans. 2007. Available at: http://www.ncqa.org/Portals/0/Publications/Resource %20 Library/ Improving_Chlamydia_Screening_08.pdf. Accessed on: May 28, 2010.

Cervical Cancer Screening

Measure Definition

The *Cervical Cancer Screening* measure reports the percentage of women 21 through 64 years of age who received one or more Pap tests within the prior three years.

Importance

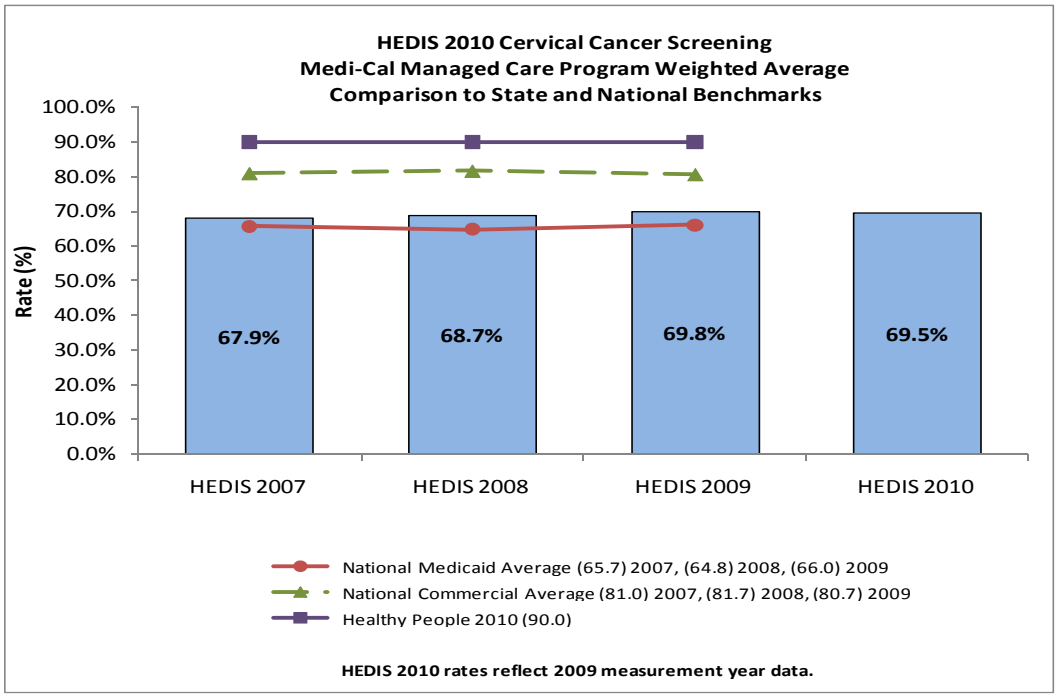
A well-proven method to prevent cervical cancer is to have testing (screening) to find pre-cancers before they can become invasive. The Pap test (or Pap smear) is the most common way to screen for cervical pre-cancers and cancers. If a pre-cancer is found, it can be treated to prevent progression to invasive cervical cancer. One of the risk factors associated with cervical cancer is not getting a regular Pap smear test.

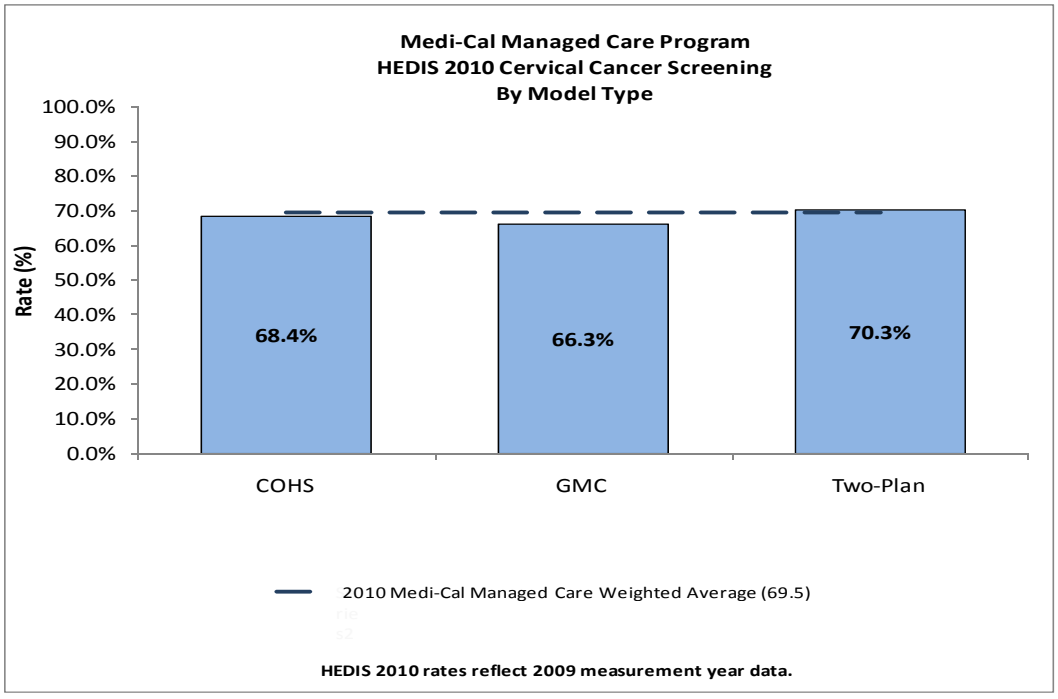
Early detection and appropriate treatment of cervical cancer result in a high treatment success rate. Since the risk of developing cervical cancer increases with age, it is important that women continue to have screenings as they age, even with prior negative tests. For 2010, the American Cancer Society estimated 12,200 new cases and 4,210 deaths resulting from cervical cancer.[57]

The five-year relative survival rate for early stages of invasive cervical cancer is 92 percent. Approximately six out of every 10 cases of cervical cancer occur in women who have never received a Pap smear test or have not been tested in five years. [58]

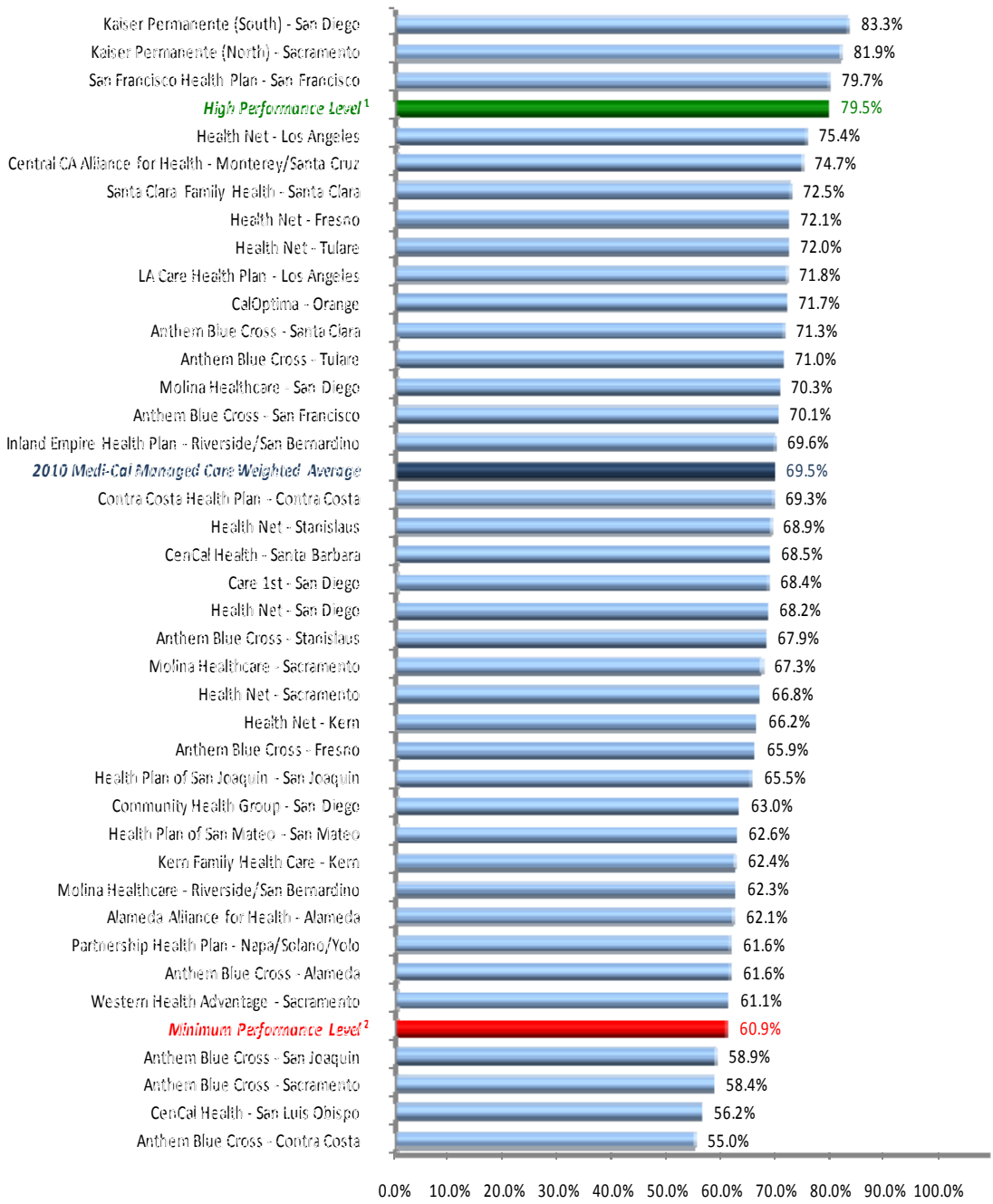
[57] American Cancer Society, Cancer Facts & Figures 2010. Available at: http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-026238.pdf. Accessed on: October 4, 2010.
[58] Ibid.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Cervical Cancer Screening



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's 2010 weighted average for the *Cervical Cancer Screening* measure decreased slightly from the 2009 weighted average. Despite the slight decrease from 2009 to 2010, the Program's weighted average has exceeded the national Medicaid average over the last three years. However, the Program's weighted average was substantially lower than the 2009 national commercial average of 80.7 percent and the Healthy People 2010 goal of 90.0 percent.

High and Low Performers

Both Kaiser Permanente plans and San Francisco Health Plan—San Francisco County performed above the HPL in 2010. Furthermore, these three plans have shown consistently high performance as the only three plans to perform above the HPL in 2009.

Four plans, Anthem Blue Cross in Contra Costa, Sacramento and San Joaquin counties and CenCal Health—San Luis Obispo County, performed below the MPL in 2010. Anthem Blue Cross—Contra Costa County also performed below the MPL in 2009.

Five plans showed statistically significant improvement in 2010 compared to their 2009 rates, while three plans showed a statistically significant decrease.

The Two-Plan model type outperformed the COHS and GMC model types and the MCMC Program's 2010 weighted average.

Best Practices

Many of the same best practices used for *Breast Cancer Screening* also may be used as best practices for *Cervical Cancer Screening*. These include:

- Physician reminders
- Patient reminders
- Improving access and awareness
- Physician communication training
- Physician screening tools and resources

Collection of Data

Some health plans have focused on improving their ability to capture the number of screening tests performed and collect data on and identify members who have been screened. Plans have been successful at this by revising laboratory coding and reporting processes, which include:

- Consolidating laboratory vendors and laboratory claims.
- Using LOINC codes.
- Requiring labs to report tests directly to health plans in addition to usual reports sent to providers.
- Developing capitated lab arrangements with most claims coming from central laboratory data vendors.[59]

[59] National Committee for Quality Assurance. Improving Chlamydia Screening: Strategies From Top Performing Health plans. 2007. Available at: http://www.ncqa.org/Portals/0/Publications/Resource %20 Library/ Improving_Chlamydia_Screening_08.pdf. Accessed on: May 28, 2010.

Childhood Immunization Status—Combination 3

Measure Definition

The *Childhood Immunization Status—Combination 3* measure calculates the percentage of children identified as having the following vaccinations: four diphtheria, tetanus, and pertussis (DTaP); three inactivated poliovirus (IPV); one measles, mumps, and rubella (MMR); two Haemophilus influenza type B (HiB); three hepatitis B; one varicella-zoster virus (chicken pox or VZV); and four pneumococcal conjugate vaccinations on or before the child's second birthday.

Importance

Disease prevention is the key to public health, and one of the most basic methods for the prevention of diseases is immunizations. Immunizations are the safest and most effective tools for protecting children from various potentially serious childhood diseases. Vaccines are proven to help children stay healthy and avoid the harmful effects of diseases such as diphtheria, tetanus, hepatitis, polio, measles, mumps, and rubella. While the rates of vaccine-preventable diseases are very low in the United States, the viruses and bacteria that cause these infectious diseases still exist. Without proper immunization, the potential to pass on vaccine-preventable diseases such as measles, mumps, and pertussis (whooping cough) to unprotected persons increases drastically.[60] Measles is one of the most prevalent infectious diseases in the world and frequently is imported into the United States. More than 90 percent of people who are not immunized will acquire the virus if exposed and as many as three out of every 1,000 cases in the United States will result in death.[61] Additionally, the Centers for Disease Control and Prevention (CDC) estimates that one-third of the lifelong hepatitis B virus infections in the United States resulted from infections acquired during infancy or during the first few years of life.[62]

The social and direct economic costs of ensuring each child receives the CDC Advisory Committee for Immunization Practices' (ACIP's) recommended schedule of vaccines provide an impressive return on investment. Childhood vaccines prevent 10.5 million diseases among all children born in the United States in a given year and are a cost-effective preventive measure. It is estimated that for every $1 spent on immunizations, up to $29 can be saved in direct and indirect

[60] Centers for Disease Control and Prevention. *Mumps Outbreaks.* Available at: http://www.cdc.gov/mumps/outbreaks.html#e. Accessed on: June 1, 2010.
[61] Centers for Disease Control and Prevention. *What Would Happen If We Stopped Vaccinations?* Available at: http://www.cdc.gov/vaccines/vac-gen/whatifstop.htm. Accessed on: June 1, 2010.
[62] National Committee for Quality Assurance. *The State of Health Care Quality in 2009*. Washington, D.C.: NCQA; 2009.

costs.[63] Based on an estimate of the 2001 U.S. birth cohort, routine childhood immunizations (as recommended by the ACIP) net an economic and societal cost savings of $9.9 billion and $43.3 billion, respectively.[64]

Despite the established guidelines and documented benefits and risks associated with childhood immunization, a gap in coverage still exists. Evidence has shown that the population at greatest risk for under-immunization is minority children from low-income families or children who live in inner-cities or rural areas.[65] In 2007, almost 25 percent of children in the United States ages 19 to 35 months did not receive recommended vaccinations.[66] For these reasons, leading health care organizations and professionals widely agree that the need to focus on increasing childhood immunization rates in the United States remains crucial.[67]

[63] Ibid.

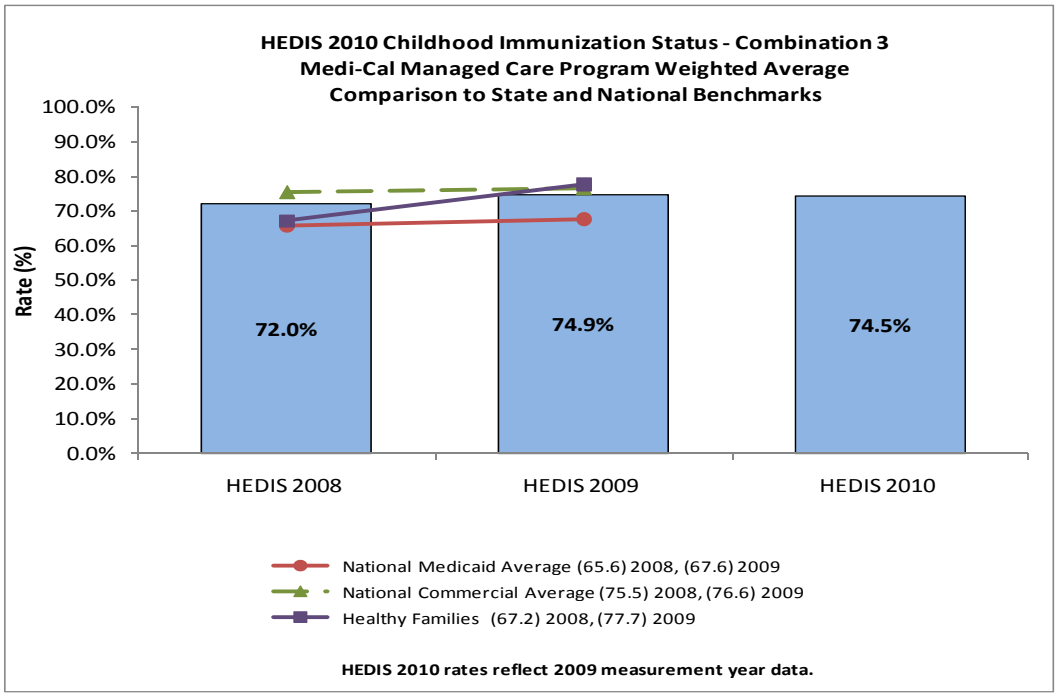
[64] Zhou F, Santoli J, Messonier ML, et al. Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the United States, 2001. *Archives of Pediatrics Adolescent Medicine.* 2005; 159(12): 1136-1144.

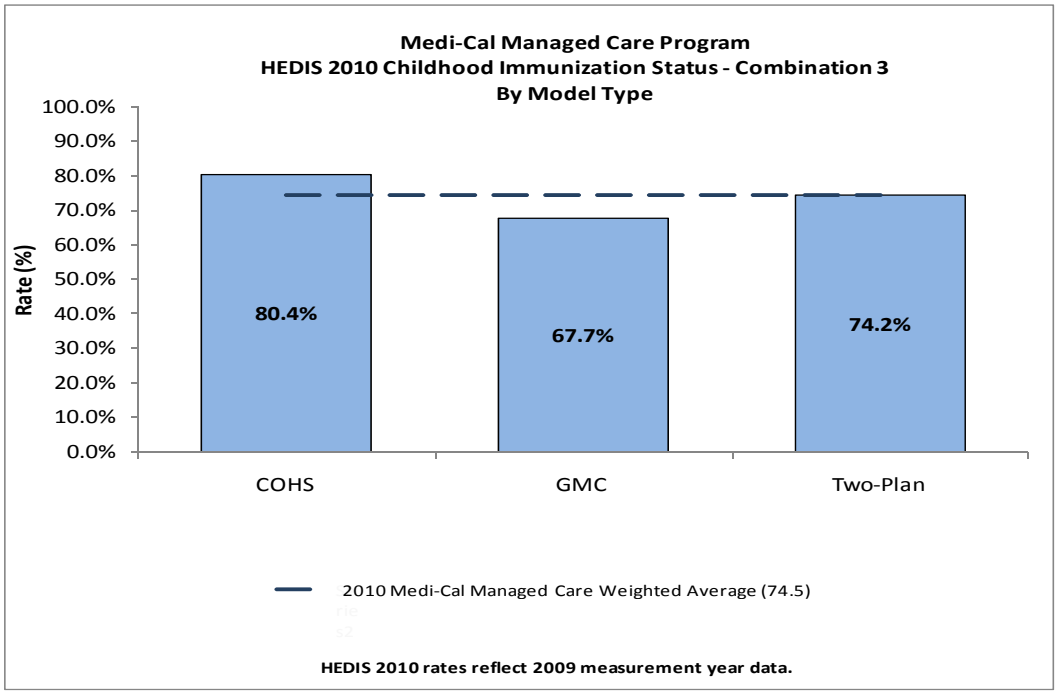
[65] American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine and Council on Community Pediatrics. Increasing Immunization Coverage. *Pediatrics.* 2003; 112(4): 993-996.

[66] Agency for Healthcare Research and Quality. "Childhood immunization status." *National Quality Measures Clearinghouse.* Available at http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?doc_id=14920&string=CIS. Accessed on: June 1, 2010.

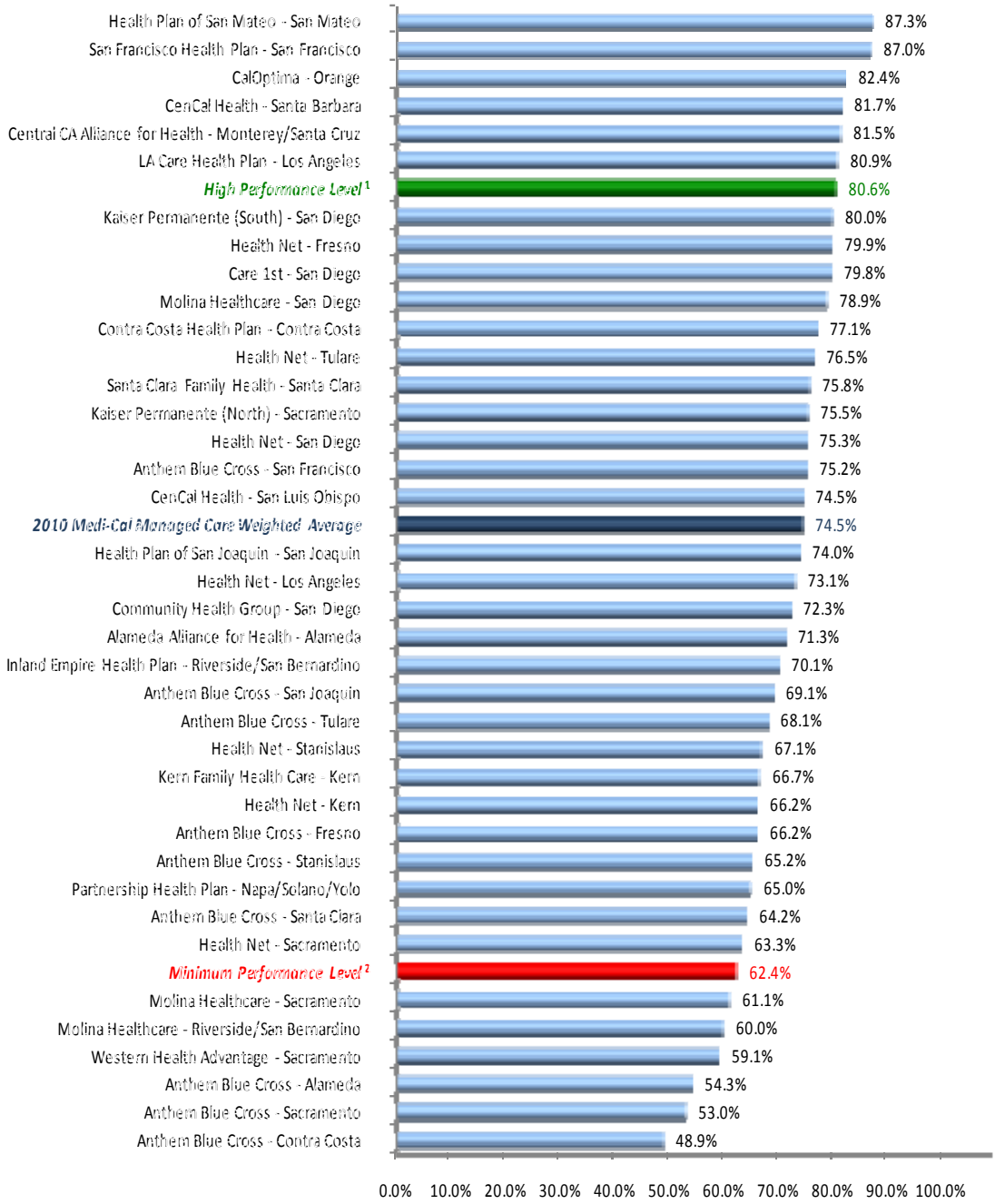
[67] Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases.* 11th ed. Washington, DC: Public Health Foundation; 2009. Available at: http://www.cdc.gov/vaccines/pubs/pinkbook/pink-chapters.htm. Accessed on: May 18, 2010.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Childhood Immunization Status—Combination 3



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Childhood Immunization Status—Combination 3* measure showed a slight decrease from 2009 to 2010. Despite this decrease, the Program's 2010 weighted average exceeded the 2009 national Medicaid average. DHCS began requiring the *Childhood Immunization Status—Combination 3* measure in 2008; therefore, trending prior to 2008 was not applicable.

High and Low Performers

Similar to the 2009 reporting year, six plans performed above the HPL in 2010. However, the number of plans that were below the MPL in 2009 compared to 2010 increased from three to six . Of the six plans that performed below the MPL in 2010, two plans, Anthem Blue Cross—Sacramento County and Western Health Advantage—Sacramento County, also performed below the MPL in 2009. This measure was part of the DHCS's auto-assignment program, with the DHCS using the *Combination 2* measure prior to adopting the *Combination 3* measure. The auto-assignment program may have played a role in the Program performing overall above the Medicaid national average.

Three plans showed statistically significant improvement from their 2009 to 2010 rates, while eight plans showed a statistically significant decrease.

The COHS and Two-Plan model types outperformed the GMC model type and the MCMC Program's 2010 weighted average.

Best Practices

Patient Reminders/Recalls: A Stepped Intervention

Stepped interventions have been found to improve childhood immunization rates.[68] The steps involve:

- Mailing language-appropriate reminder postcards to members before every visit.
- Following up by postcard and telephone to non-responders regarding missed appointments and/or immunizations.
- Offering case management and/or home visits for children missing or behind on immunizations.

This multi-level stepped approach has proven to be successful in achieving higher immunization rates for children who were at risk for delayed immunizations.

[68] Hambridge SJ, Phibbs SL, Chandramouli V, et al. A Stepped Intervention Increases Well-Child Care and Immunization Rates in a Disadvantaged Population. *Pediatrics*. 2009; 124(2): 455-464.

Parent Education

Educating parents through language appropriate materials about the benefits, safety, and risks associated with vaccine-preventable diseases and the impact immunizations have on the prevalence of these diseases has been shown to improve coverage. In addition, providing parents with information as to where they can find reliable and accurate immunization and vaccine information online can assist in minimizing the negative impact of false and inaccurate information.[69]

Provider Reminders

Studies have shown that provider reminders are helpful in increasing childhood immunization rates. Plans can give providers a list of patients who are due or past due for receiving routine immunizations to encourage provider follow-up. In addition, providers should be encouraged to use internal reminder systems, such as posting notices on patients' charts when certain vaccines are not on record or an immunization is due/past due. These reminders can prompt providers to offer immunizations to patients during routine or sick visits.[70]

Identify Alternative Venues and Expand Access to Immunizations

Identifying alternative settings where children can receive immunizations can be helpful in improving the delivery and rates of vaccinations. Additional venues could include public health department clinics; Women, Infants, and Children (WIC) program offices; school-based health clinics; child care centers; and where permissible, pharmacies. Coupled with identifying and collaborating with alternative venues, health plans need to capture the services provided at these alternative sites for HEDIS reporting purposes, either through traditional claims, medical record review, or as supplemental data. Additionally, multi-component interventions to expand access to immunizations in health care settings, such as reducing the distance from vaccination settings to patient homes, increasing or changing hours to include after-hours or weekend services, developing "drop-in" clinics or "express lane" vaccination services, have proven to be effective in increasing childhood immunization rates.[71]

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[69] American Academy of Pediatrics. Increasing Immunization Coverage. *Pediatrics*. 2010; 125(6): 1299-1304.

[70] Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 11th ed. Washington, DC: Public Health Foundation; 2009. Available at: http://www.cdc.gov/vaccines/pubs/pinkbook/pink-chapters.htm. Accessed on: May 18, 2010.

[71] Shefer A, Briss P, Rodewald L, et al. Improving Immunization Coverage Rates: An Evidence-based Review of the Literature. *Epidemiological Reviews*. 1999. Available at: http://epirev.oxfordjournals.org/cgi/reprint/21/1/96. Accessed on: May 18, 2010.

Conduct Regular Assessments

Conducting regular assessments of immunization rates has proven to increase vaccination coverage in a range of clinical settings and across populations. Ongoing health plan assessments are most effective when they combine chart reviews to determine coverage with providing the results to health care professionals and staff. Effective interventions also may include provider incentives or a comparison of provider performance to a goal or standard (i.e., benchmarking). This process is commonly referred to as assessment, feedback, incentives, and exchange of information (AFIX). Annual assessment of immunization levels is recommended so that reasons for low coverage can be identified and addressed.[72]

[72] Institute for Clinical Systems Improvement. Health Care Guideline: Immunizations. 2010. Available at: http://www.icsi.org/immunizations___guideline_/immunizations__guideline__38400.html. Accessed on: June 1, 2010.

Comprehensive Diabetes Care—HbA1c Testing

Measure Definition

The *Comprehensive Diabetes Care—HbA1c Testing* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who had one or more HbA1c test(s) conducted within the last year.

Importance

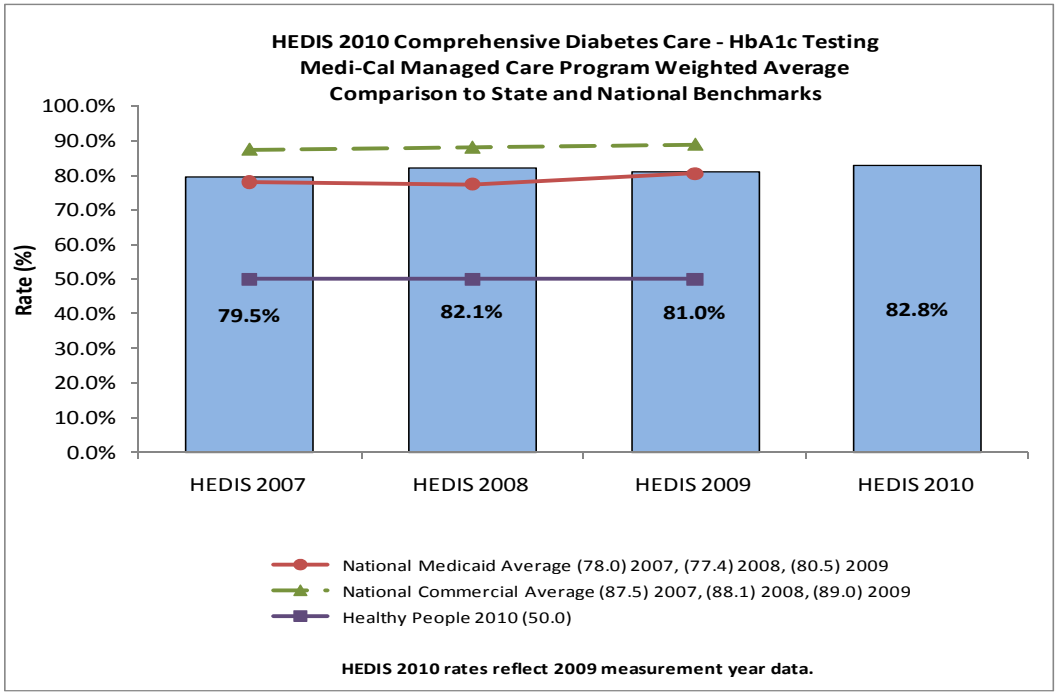
While diabetes can result in many serious complications, such as heart disease and kidney disease, control of diabetes significantly reduces the rate of such complications and improves quality of life. The annual cost of diabetes in the United States was an estimated $174 billion in 2007. Of this total, $116 billion was due to medical expenditures, while $58 billion was the result of lost productivity and other indirect costs.[73] However, appropriate and timely screening and treatment can significantly reduce the disease burden. [74]

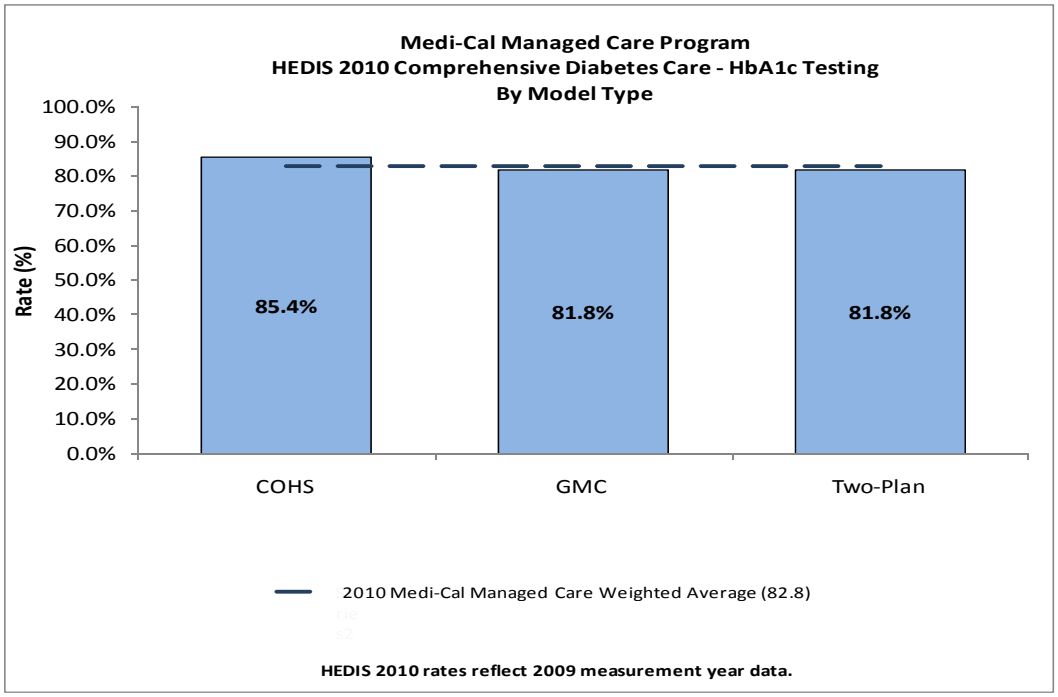
The HbA1c test (hemoglobin A1c test or glycosylated hemoglobin test) provides the average blood glucose level over a period of two to three months. Specifically, the test measures the percentage of hemoglobin in red blood cells that is glycosylated (or glycated).[75]

Diabetics who maintain near-normal HbA1c levels gain, on average, an extra five years of life, eight years of eyesight, and six years of freedom from kidney disease.[76]

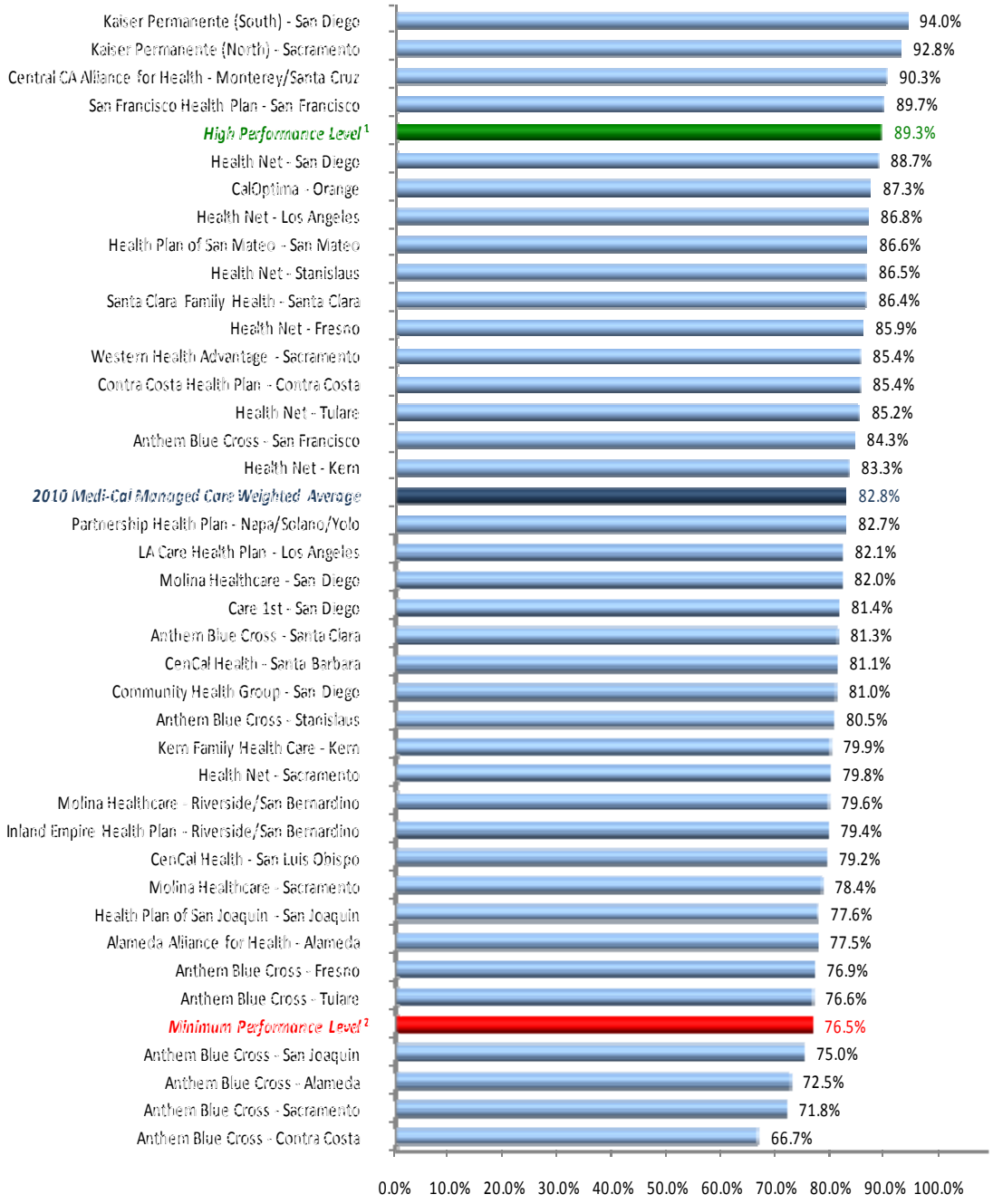
[73] American Diabetes Association. Direct and Indirect Costs of Diabetes in the United States. Available at: http://www.diabetes.org/diabetes-statistics/cost-of-diabetes-in-us.jsp. Accessed on: August 26, 2010.
[74] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.
[75] Ibid.
[76] Ibid.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Comprehensive Diabetes Care - HbA1c Testing



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—HbA1c Testing* measure reflects a general trend of increasing rates from 2007 to 2008 and 2009 to 2010. The Program's weighted average exceeded the national Medicaid average and the Healthy People 2010 goal from 2007 through 2010. However, the Program's weighted average has yet to exceed the national commercial average for any of the reporting years.

High and Low Performers

Four plans performed above the HPL of 89.3 percent for this measure in 2010. Of these fours plans, three plans continually have demonstrated high performance. Both of the Kaiser Permanente plans performed above the HPL in 2008, 2009, and 2010, and San Francisco Health Plan—San Francisco County exceeded the HPL in 2009 and 2010. All four plans that performed below the MPL in 2010 also performed below the MPL in 2009.

Four plans showed statistically significant improvement over their 2009 rates, with only one plan showing a statistically significant decrease from 2009 to 2010.

The COHS model type outperformed the GMC and Two-Plan model types and the MCMC Program's 2010 weighted average.

Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)

Measure Definition

The *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c test conducted during the measurement year showed a greater than 9 percent HbA1c level, indicating poor control.

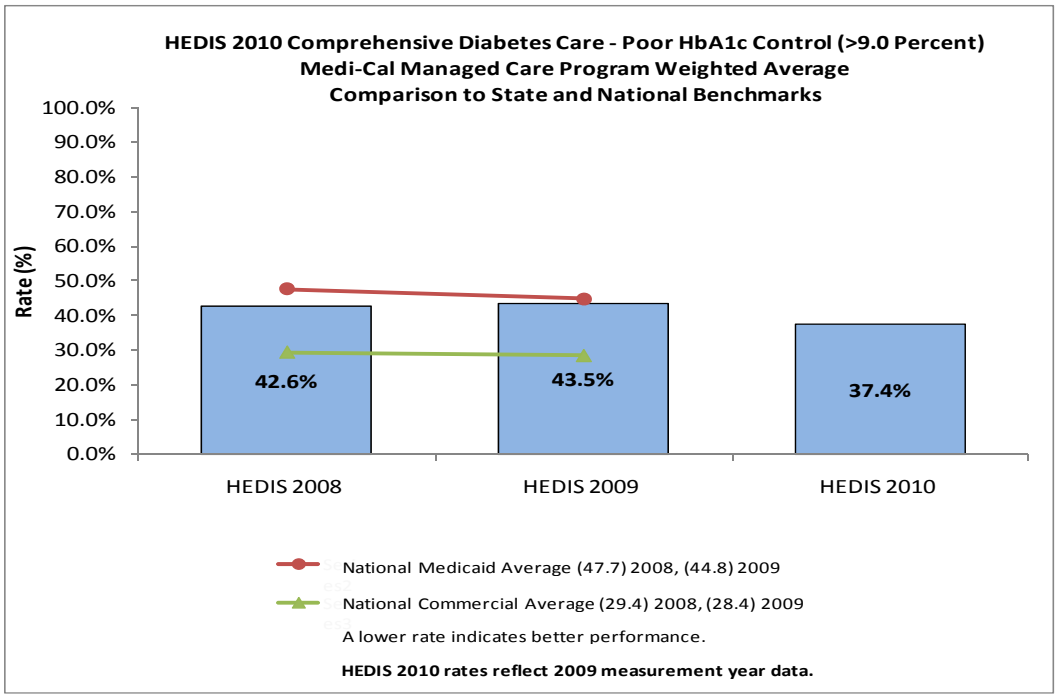
Importance

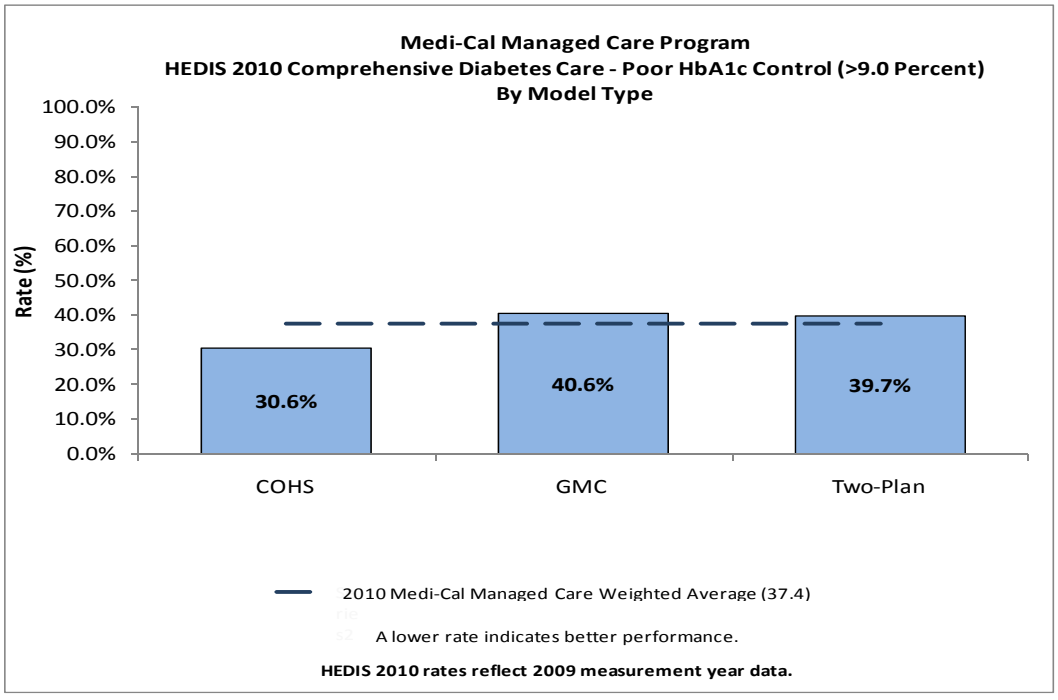
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Decreasing the HbA1c level lowers the risk of diabetes-related death. Controlling blood glucose levels in people with diabetes significantly reduces the risk for blindness, heart disease, end-stage renal disease (ESRD), stroke, nerve damage, and lower extremity amputation. The reduction of a patient's HbA1c level by 1 percent, decreases the risk of: [77]

- Heart failure by 16 percent.
- Heart attack by 14 percent.
- Stroke by 12 percent.
- Diabetes-related death by 21 percent.
- Death from all causes by 14 percent.
- Amputation by 43 percent.
- Small blood vessel disease by 37 percent.

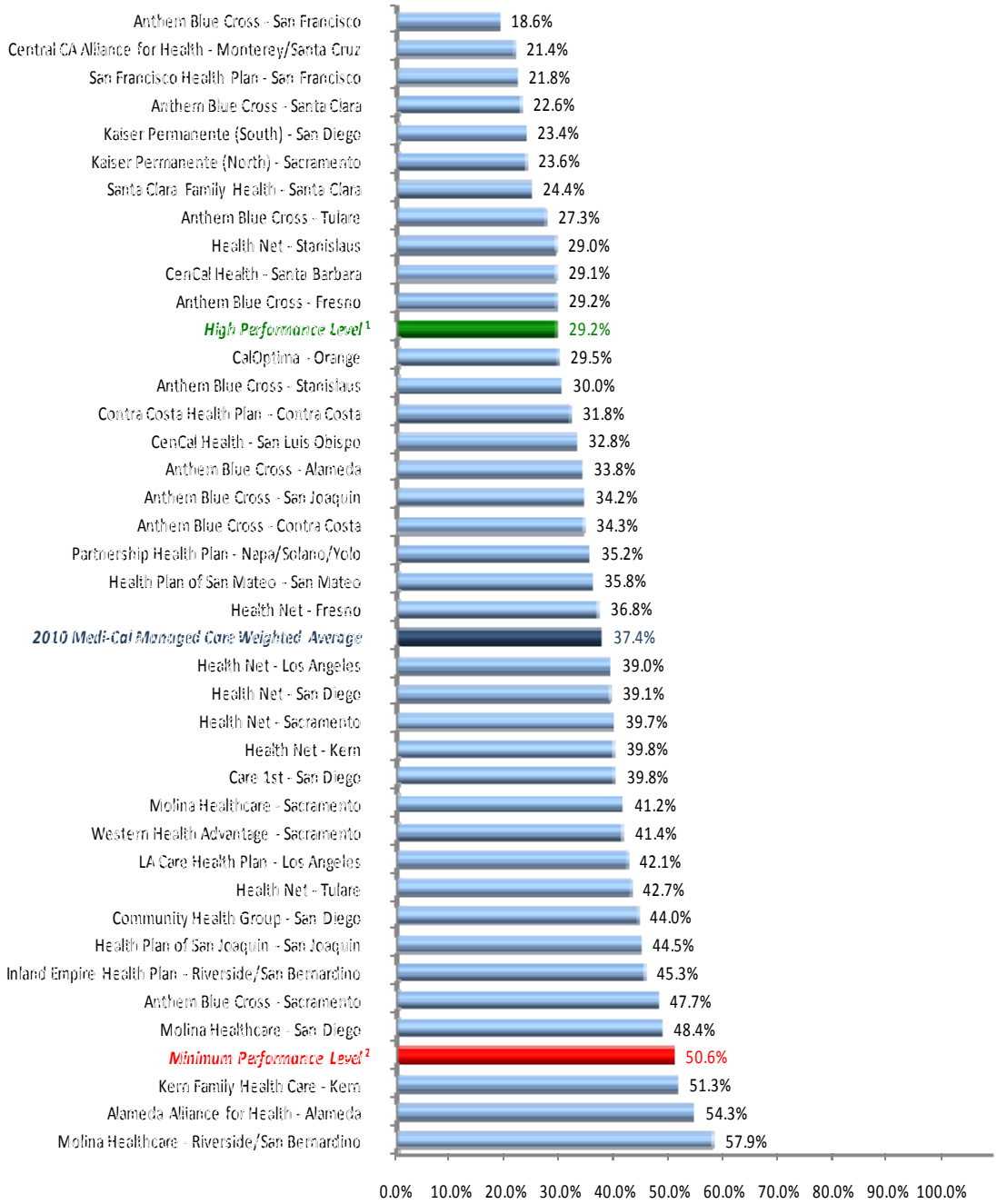
[77] Everybody. Diabetes and HbA1c Testing. Available at: http://www.everybody.co.nz/page-46cae434-1bb8-4f84-8d15-76be9785eae2.aspx. Accessed on: April 15, 2010.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Comprehensive Diabetes Care - Poor HbA1c Control (>9.0 Percent)[3]



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.
[3] A lower rate indicates better performance.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

For this measure, a lower rate indicates better performance. The MCMC Program's weighted average decreased from 2009 to 2010, indicating improved performance. In addition, the Program demonstrated better performance when compared to the 2009 national Medicaid average; however, the Program's 2010 weighted average was higher than the 2009 national commercial average, indicating lower performance.

High and Low Performers

Eleven plans exceeded the 2010 established HPL for this measure, an increase from 2009 when only five plans performed above the HPL. CenCal Health—Santa Barbara County, Health Net—Stanislaus County, both Kaiser Permanente plans, and San Francisco Health Plan—San Francisco County showed continued high performance exceeding the HPL in 2009. Furthermore, the number of plans that did not achieve the established MPL decreased from seven plans in 2009 to three plans in 2010.

In 2010, 14 plans showed statistically significant improvement over their 2009 rates (i.e., a significant decrease in the rate). Only two plans showed statistically significant declines in performance from their 2010 rates when compared to their 2009 rates (i.e., a significant increase in the rate).

The COHS model type outperformed both the Two-Plan and GMC model types and the MCMC Program's 2010 weighted average.

Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)

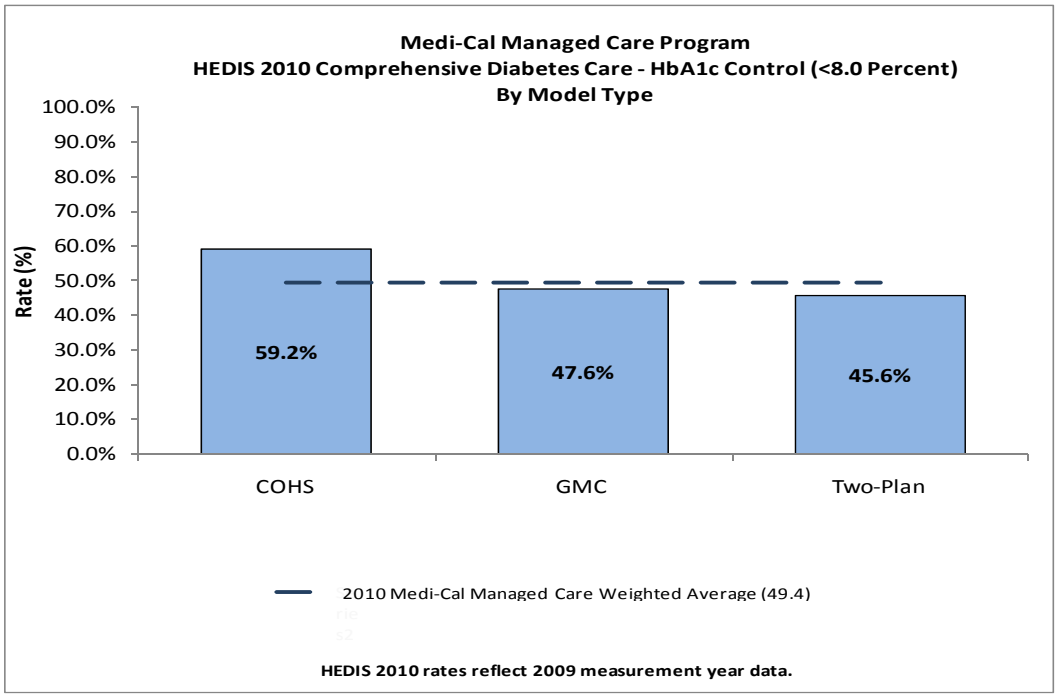
Measure Definition

The *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* measure reports the percentage of members 18 through 64 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c test conducted during the year showed an HbA1c level of less than 8 percent.

Importance

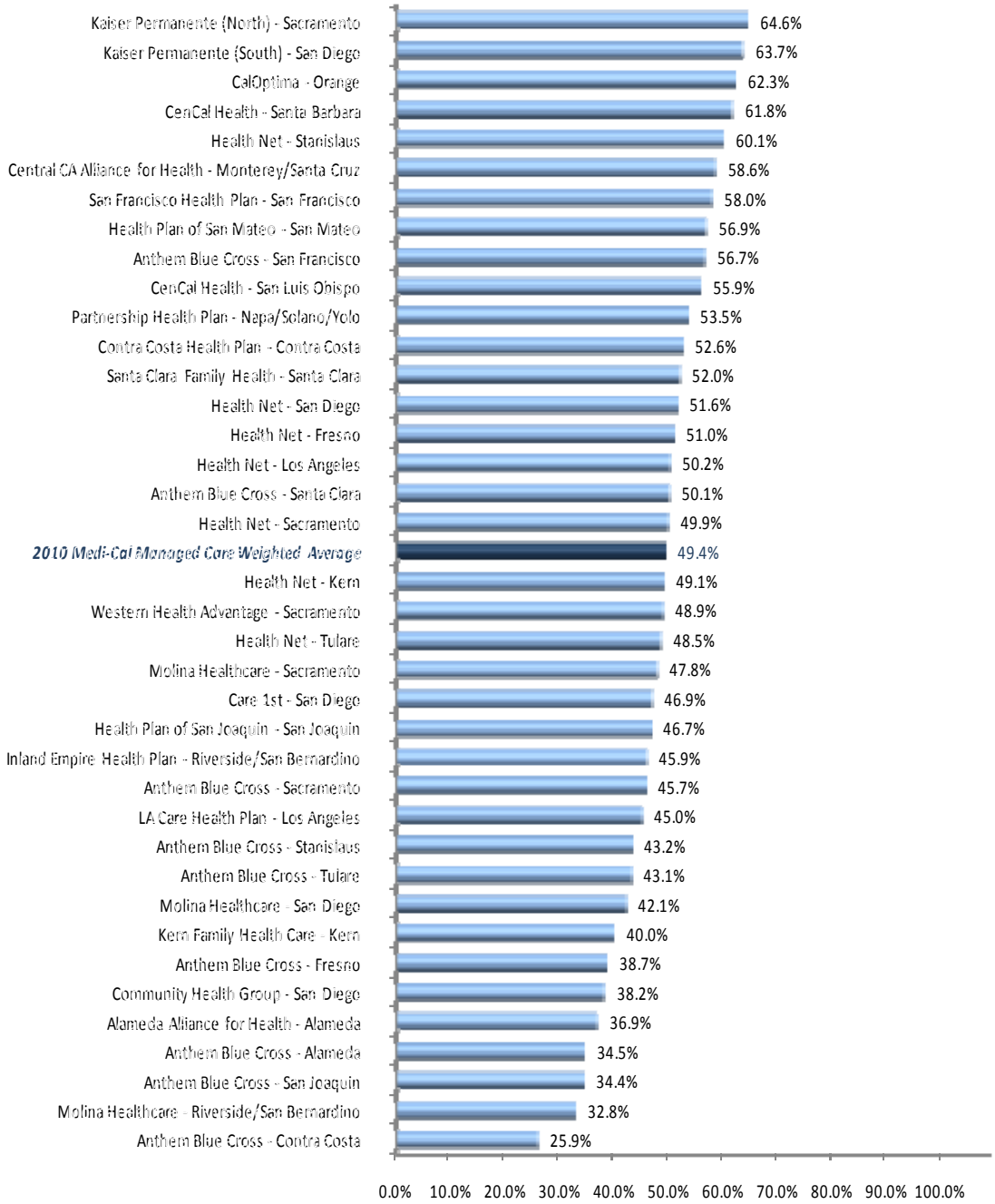
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Controlling the HbA1c level also lowers the risk of diabetes-related death. In addition, controlling blood glucose levels in people with diabetes significantly reduces the risk of blindness, ESRD, and lower extremity amputation.[78]

Performance Results



[78] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.

Medi-Cal Managed Care
HEDIS 2010 Comprehensive Diabetes Care - HbA1c Control (<8.0 Percent)



The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS requires the measure.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's 2010 weighted average was 49.4 percent. Since 2010 was the first year that the DHCS required that MCMC plans report this measure, no comparisons to prior years are displayed and comparisons to state and/or national benchmarks are not provided.

High and Low Performers

The DHCS did not apply an MPL or HPL to this measure in 2010 since this is the first year plans were required to report this measure. Eighteen plans reported a rate greater than the MCMC Program's 2010 weighted average.

The COHS model type outperformed the GMC and Two-Plan model types and the Program's 2010 weighted average.

Comprehensive Diabetes Care—LDL-C Screening

Measure Definition

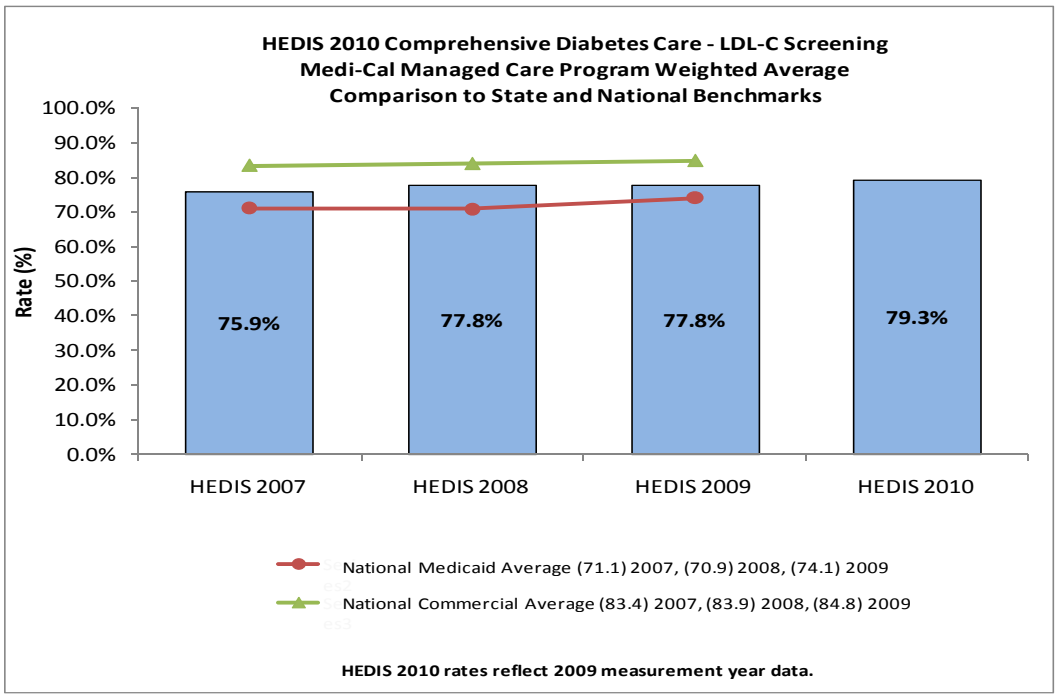
The *Comprehensive Diabetes Care—LDL-C Screening* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who had an LDL-C test during the measurement year.

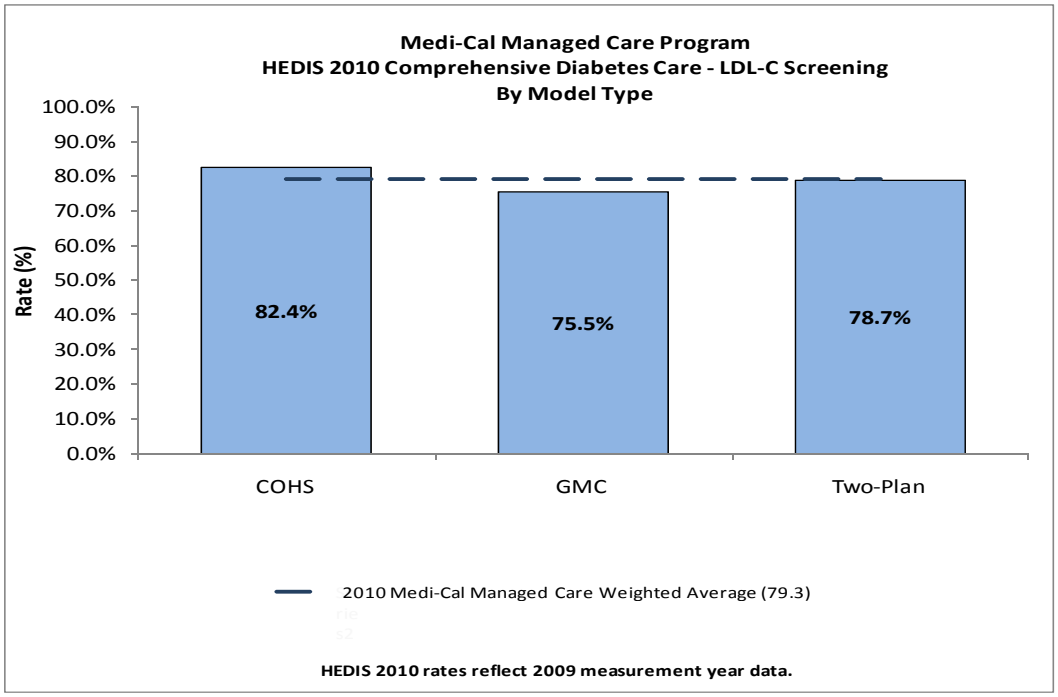
Importance

LDL is a type of lipoprotein that carries cholesterol in the blood. LDL is considered to be undesirable because it deposits excess cholesterol in the walls of blood vessels and contributes to atherosclerosis (hardening of the arteries) and heart disease. LDL-C screening is important for diabetics because high LDL-C levels are associated with increased risk for cardiovascular mortality, heart disease, heart attack, and stroke.[79]

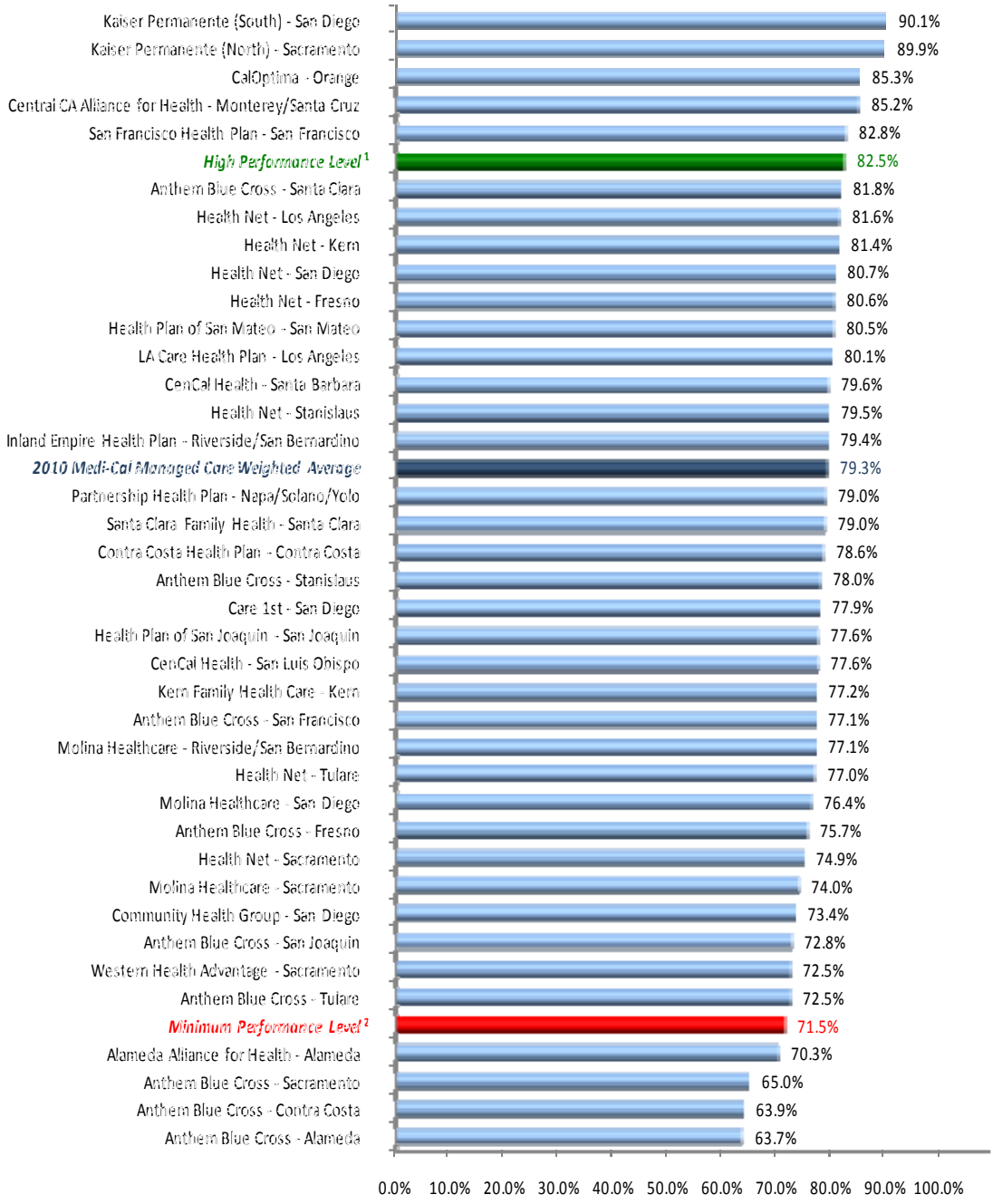
[79] American Heart Association. LDL and HDL Cholesterol What's Bad and What's Good? Available at: http://www.americanheart.org/presenter.jhtml?identifier=180. Accessed on: April 15, 2010.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Comprehensive Diabetes Care -
LDL-C Screening



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—LDL-C Screening* measure increased from 2009 to 2010. The Program's 2010 weighted average was above the national Medicaid average but below the national commercial average from 2007 to 2010.

High and Low Performers

Five plans performed above the HPL— CalOptima—Orange County, Central California Alliance for Health—Monterey/Santa Cruz counties, both of the Kaiser Permanente plans, and San Francisco Health Plan—San Francisco County. Both of the Kaiser Permanente plans also performed above the HPL in 2009. However, four plans, Alameda Alliance for Health—Alameda County and Anthem Blue Cross in Alameda, Contra Costa, and Sacramento counties performed the below the MPL in 2010.

Four plans had statistically significant increases from 2009 to 2010, and only one plan had a statistically significant decrease.

The COHS model type outperformed the GMC and Two-Plan model types and the MCMC Program's 2010 weighted average.

Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)

Measure Definition

The *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure calculates the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) whose most recent LDL-C test (performed during the measurement year) indicated an LDL-C level less than 100 mg/dL.

Importance

According to the American Diabetes Association, a desirable LDL-C level is less than 100 mg/dL.[80] Patients with diabetes have a two to three times greater risk of cardiovascular mortality compared to patients who are non-diabetics.[81] Therefore, maintaining a desirable LDL-C level is important because it can decrease the risk of cardiovascular complications in individuals with diabetes.

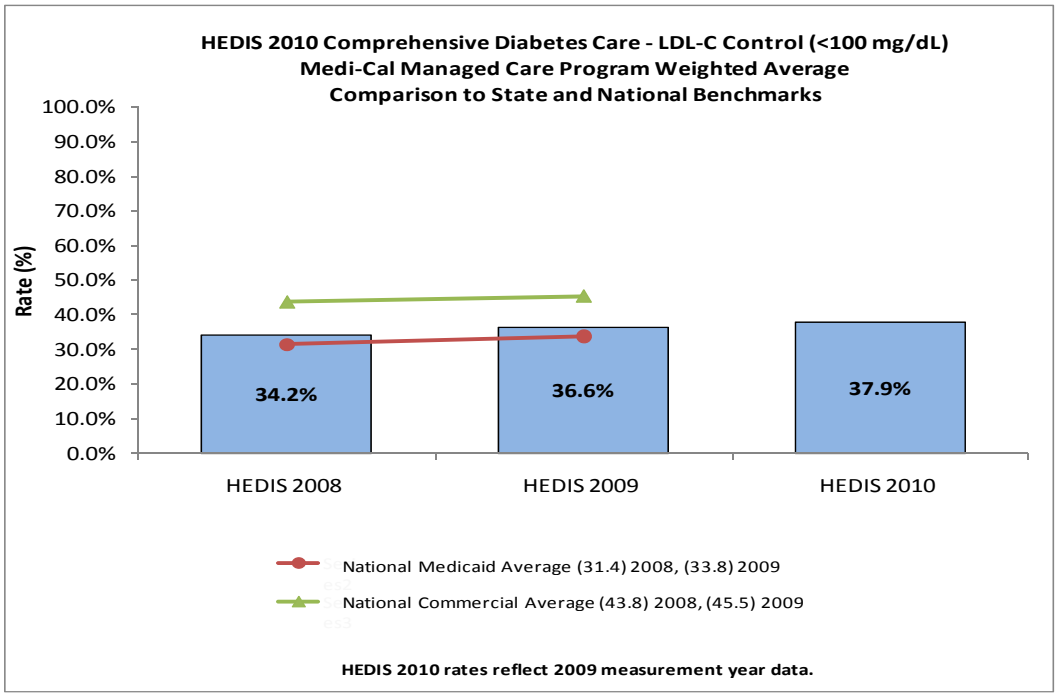
The reduction of cholesterol levels has also been shown to decrease:[82]

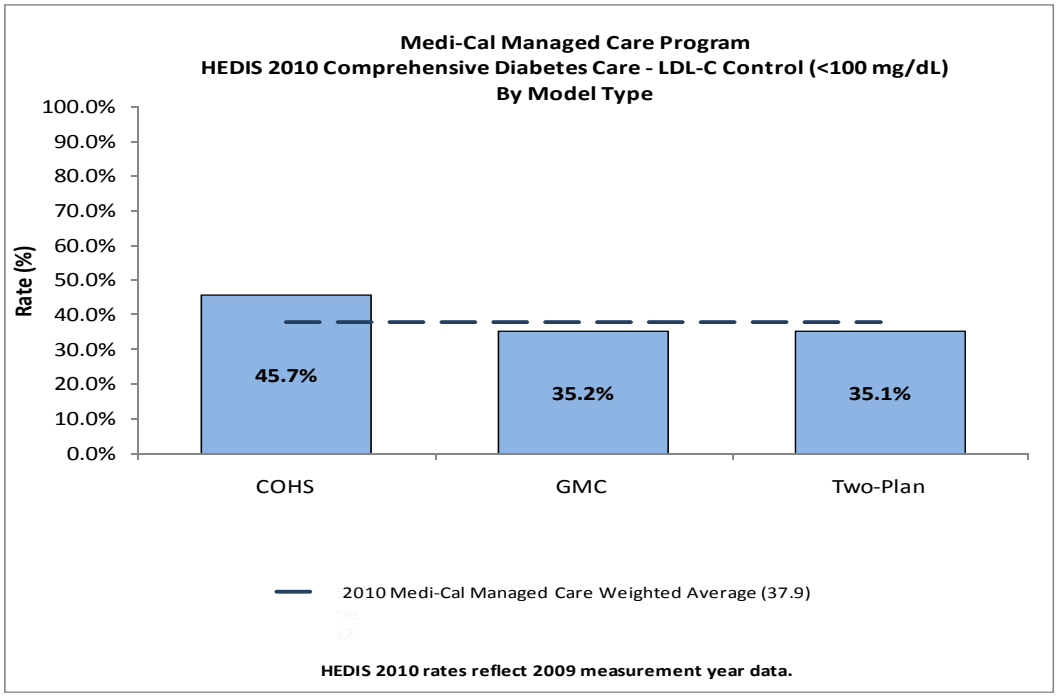
- Non-fatal heart attacks or death from coronary heart disease.
- Unstable angina.
- The need for bypass surgery or angioplasty.
- Death from all cardiovascular causes.
- Overall deaths from all causes.

A 30 percent reduction in LDL-C levels has been shown to reduce major vascular events by approximately 25 percent, regardless of the baseline LDL.[83]

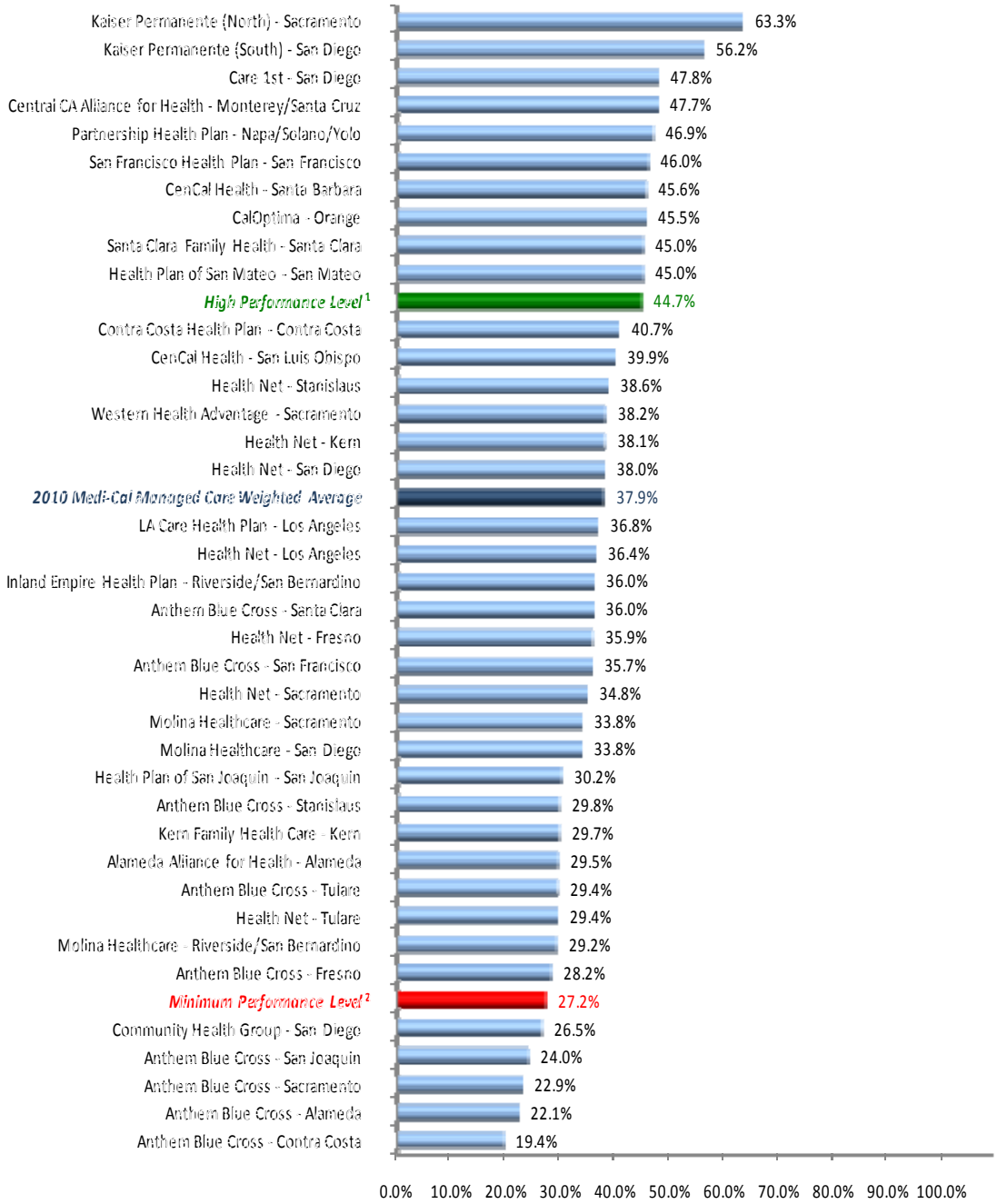
[80] American Diabetes Association. http://www.diabetes.org/heart-disease-stroke.jsp. Accessed October 4,2010.
[81] Goliath. LDL in Diabetes: How Low Should They Go? Little Evidence Supports Adding a Statin or Increasing the Dose Once Your Patient Achieves an LDL of <100 mg/dL. Available at: http://goliath.ecnext.com/coms2/gi_0199-7038473/LDL-levels-in-diabetes-how.html. Accessed on: April 15, 2010.
[82] National Lung, Heart, and Blood Institute. The Benefits of Cholesterol Lowering. Available at: http://www.nhlbisupport.com/chd1/why4.htm. Accessed on: April 15, 2010.
[83] Goliath. LDL in Diabetes: How Low Should They Go? Little Evidence Supports Adding a Statin or Increasing the Dose Once Your Patient Achieves an LDL of <100 mg/dL. Available at: http://goliath.ecnext.com/coms2/gi_0199-7038473/LDL-levels-in-diabetes-how.html. Accessed on: April 15, 2010.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Comprehensive Diabetes Care - LDL-C Control (<100 mg/dL)



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure has shown a gradual increase each year from 2008 to 2010. In addition, the Program's weighted average has been above the national Medicaid average since 2008; however, the MCMC Program's weighted average has continued to fall below the national commercial average since 2008.

The DHCS added this measure beginning in 2008; therefore, trending prior to 2008 was not applicable.

High and Low Performers

Ten plans performed above the established HPL for this measure in 2010. Six of these plans also exceeded the HPL in 2009, CenCal—Santa Barbara County, Health Plan of San Mateo—San Mateo County, both of the Kaiser Permanente plans, Partnership Health Plan—Napa/Solano/Yolo counties, and San Francisco Health Plan—San Francisco County. Five plans performed below the MPL, which included Anthem Blue Cross in Alameda, Contra Costa, Sacramento and San Joaquin counties and Community Health Group—San Diego County.

Four plans had statistically significant increases from 2009 to 2010, while four plans had statistically significant decreases.

The COHS model type outperformed the GMC and Two-Plan model types and the MCMC Program's 2010 weighted average.

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

Measure Definition

The *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who had an eye screening for diabetic retinal diseases (i.e., a retinal exam by an eye care professional) or a negative retinal exam in the year prior to the measurement year.

Importance

The three most common eye complications in diabetics are retinopathy, cataracts, and glaucoma.[84] Diabetic retinopathy causes 12,000 to 24,000 new cases of blindness each year and is the leading cause of new cases of blindness in adult diabetics 20 to 74 years of age.[85] Furthermore, diabetics have a 60 percent increased chance of having cataracts.[86] However, with timely and appropriate intervention, which may include laser treatment and vitrectomy, blindness can be reduced by up to 90 percent in patients with severe diabetic retinopathy.[87]

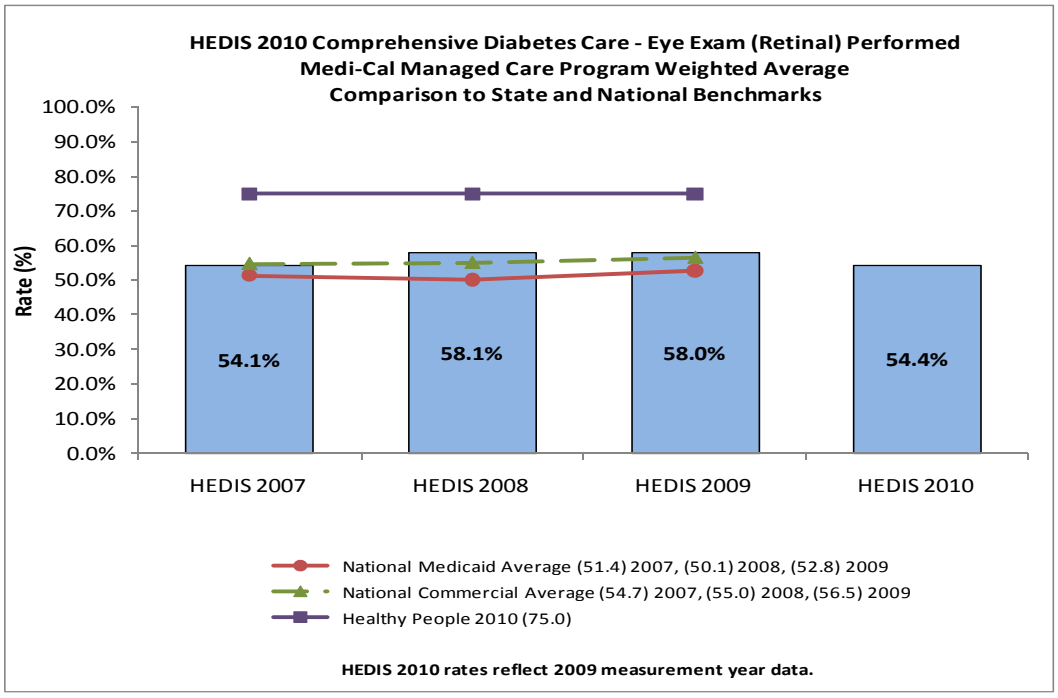
[84] WebMD. Eye Problems and Diabetes. Available at: http://diabetes.webmd.com/eye-problems. Accessed on: April 15, 2010.

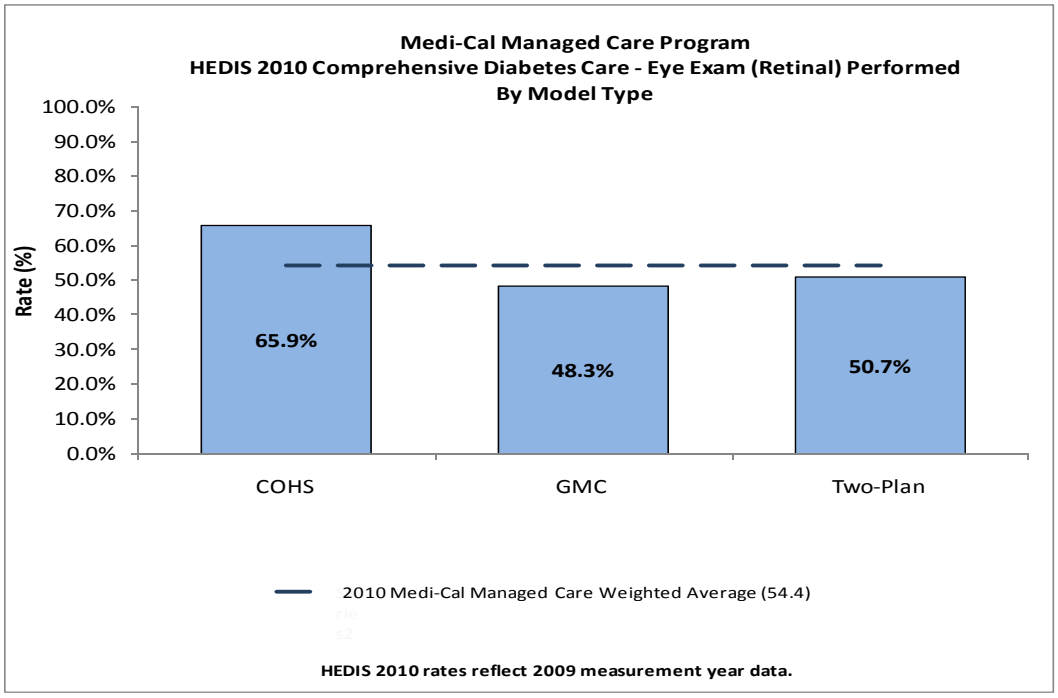
[85] American Diabetes Association. Diabetes and Retinopathy (Eye Complications). Available at: http://www.diabetes.org/diabetes-statistics/eye-complications.jsp. Accessed on: August 26, 2010.

[86] American Diabetes Association. Eye Complications. Available at: http://www.diabetes.org/living-with-diabetes/complications/eye-complications.html. Accessed on: April 15, 2010.

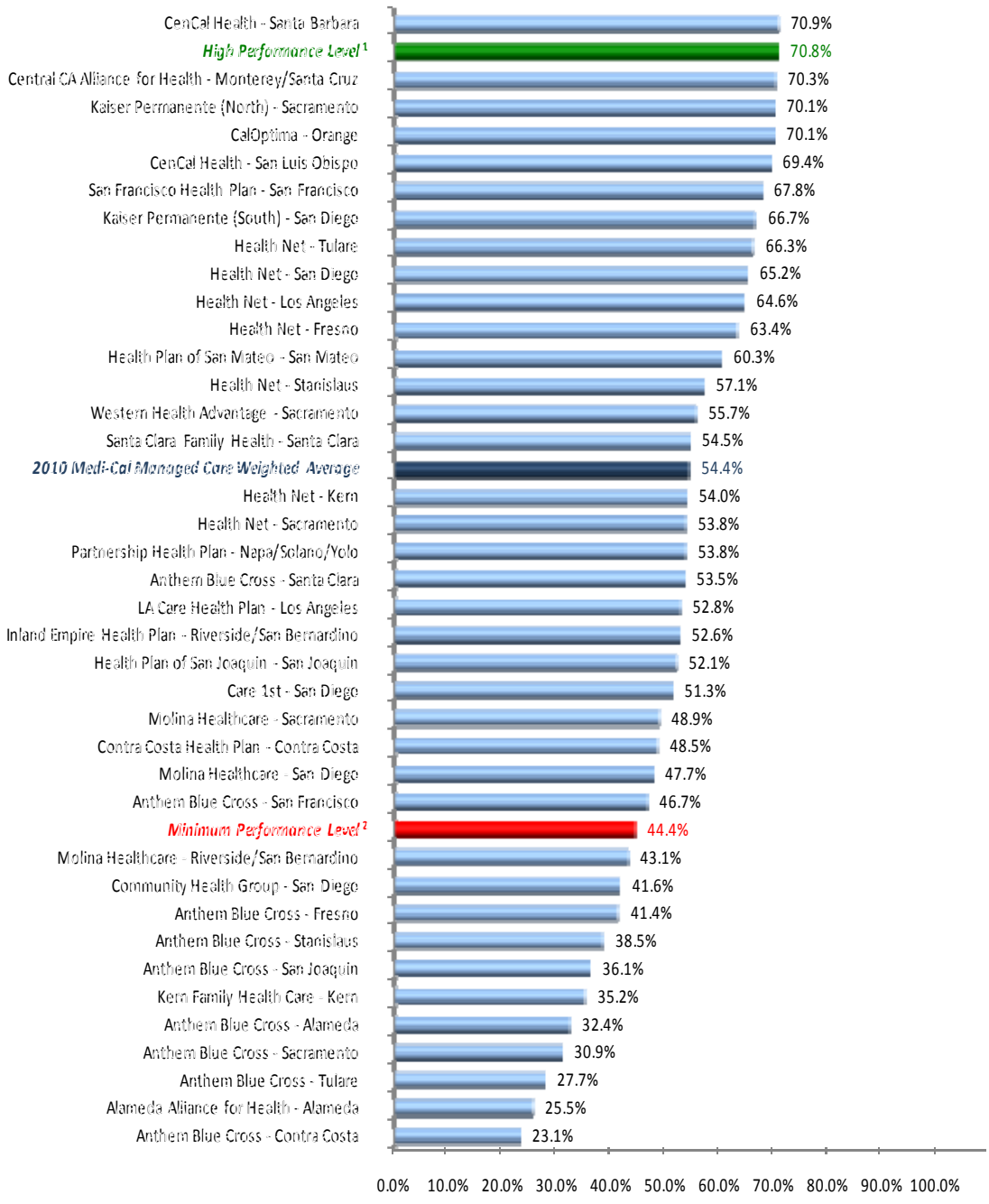
[87] National Institutes of Health. Fact Sheet: Diabetic Retinopathy. Available at: http://www.nih.gov/about/researchresultsforthepublic/DiabeticRetinopathy.pdf. Accessed on: August 26, 2010.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Comprehensive Diabetes Care -
Eye Exam (Retinal) Performed



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure has decreased each year from 2008 to 2010. Despite this decline, the MCMC Program's performance has remained above the national Medicaid average since 2007. However, 2010 is the first year the program has performed below the national commercial average.

High and Low Performers

Only one plan, CenCal Health—Santa Barbara County, performed above the established HPL, while 11 plans performed below the MPL. The number of plans below the MPL increased substantially from one in 2009 to 11 in 2010.

One plan had a statistically significant increase from 2009 to 2010; however, 18 plans had statistically significant decreases in rates from 2009 to 2010.

The COHS model type outperformed the GMC and Two-Plan model types and the MCMC Program's 2010 weighted average.

Comprehensive Diabetes Care—Medical Attention for Nephropathy

Measure Definition

The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure is intended to assess whether diabetic patients are being monitored for nephropathy (kidney disease). It reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who were screened for nephropathy or who received treatment for nephropathy. The rate includes patients who have been screened for nephropathy or who already have evidence of nephropathy.

Importance

Diabetes is a leading cause of kidney failure and ESRD, with 20 to 30 percent of diabetics developing evidence of nephropathy.[88] In the United States, diabetic nephropathy accounts for approximately 40 percent of all new cases of ESRD. While nephropathy is more common in patients with Type I diabetes, the higher prevalence of Type II diabetics accounts for a greater number of Type II diabetics on dialysis to treat kidney failure. In fact, over half of the diabetics on dialysis have Type II diabetes. For patients with Type II diabetes, Native Americans, Hispanics, and African Americans are at a greater risk of developing ESRD.[89,90] In 2008, 48,374 diabetics began ESRD treatment in the United States and Puerto Rico, and 202,290 diabetics were living on chronic dialysis or with a kidney transplant.[91]

In 2007, health care for patients in an ESRD program cost the United States $35.32 billion.[92] Diabetic nephropathy is a progressive kidney disease that takes years to develop. Kidney failure usually occurs 15 to 25 years after the onset of diabetes.

Nephropathy also is associated with increased risks for hypertension and high cholesterol. Blood sugar control reduces the risk of microalbuminuria (having small amounts of protein in the urine) by one-third and reduces the risk of microalbuminuria progressing by 50 percent. Tight control of blood sugar may even reverse microalbuminuria.[93]

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88 National Kidney and Urologic Diseases Information Clearinghouse. IgA Nephropathy. Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/iganephropathy/. Accessed on: April 15, 2010.

89 Ibid.

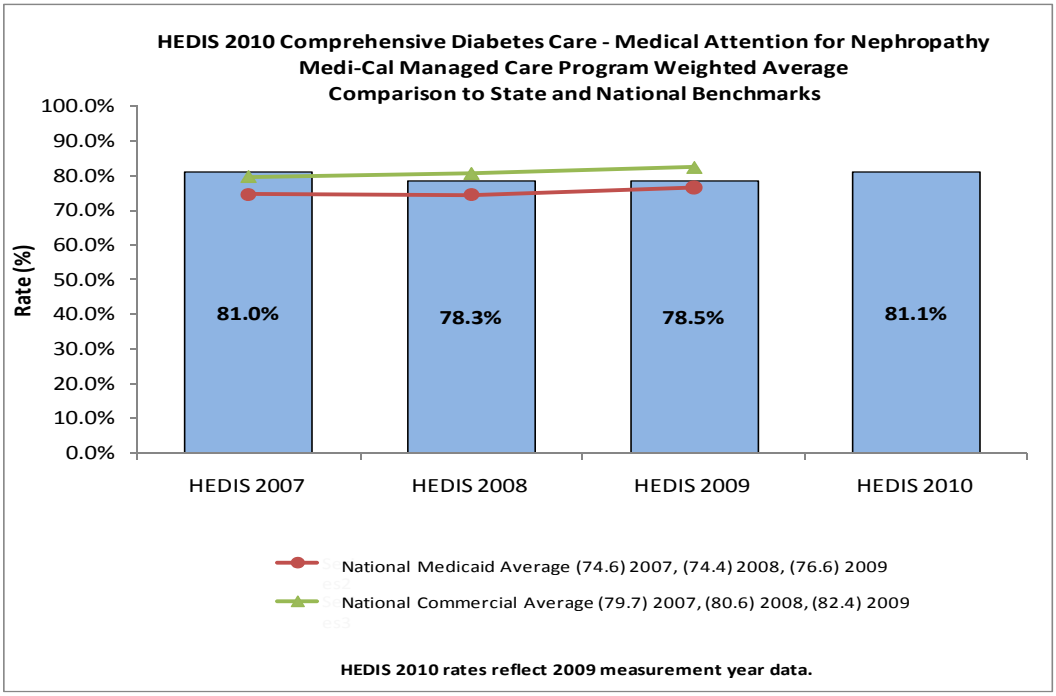
90 American Diabetes Association. Nephropathy in Diabetes. Available at: http://care.diabetesjournals.org/content/27/suppl_1/s79.full. Accessed on: April 15, 2010.

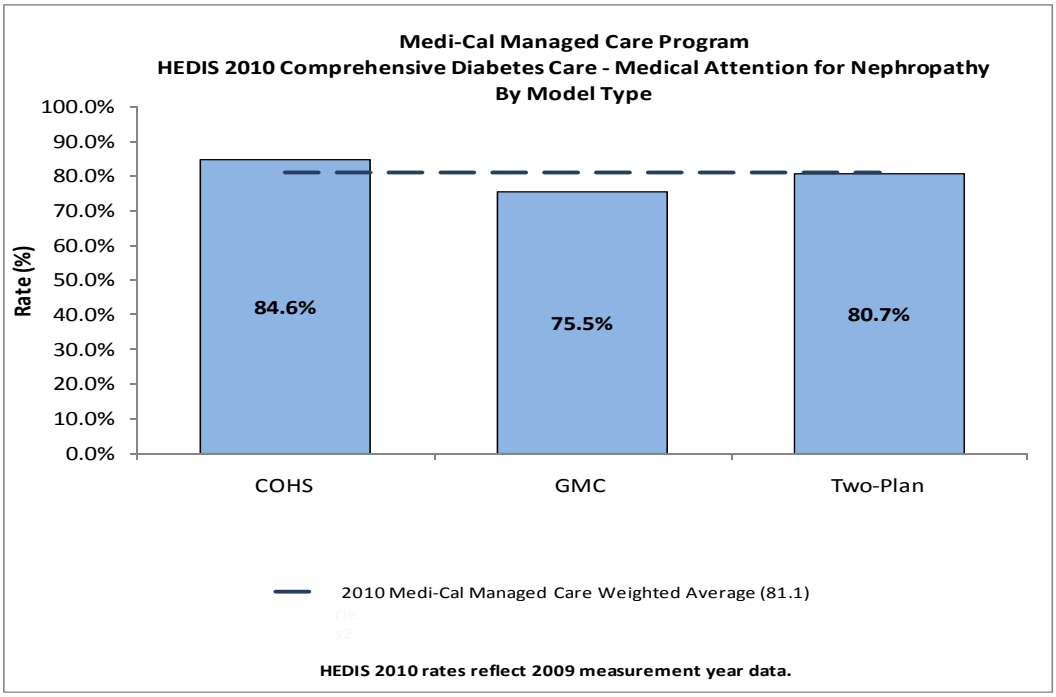
91 National Diabetes Information Clearinghouse. Available at: http://diabetes.niddk.nih.gov/dm/pubs/statistics/index.htm#Kidney. Accessed on: April 7, 2011.

92 National Kidney and Urologic Diseases Information Clearinghouse. Kidney Disease of Diabetes. Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/kdd/index.htm. Accessed on: April 7, 2011.

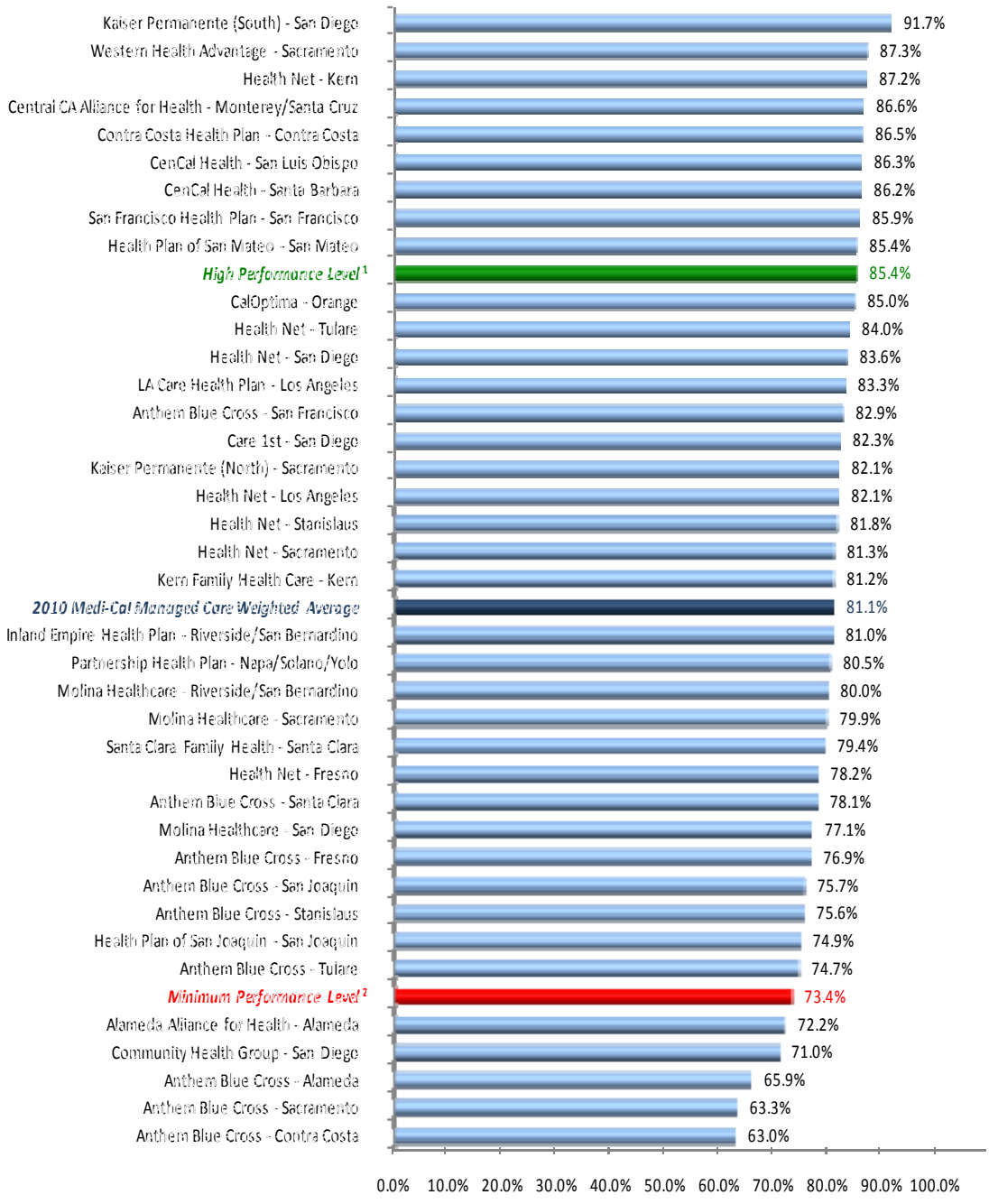
93 National Kidney and Urologic Diseases Information Clearinghouse. IgA Nephropathy. Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/iganephropathy/. Accessed on: April 15, 2010.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Comprehensive Diabetes Care -
Medical Attention for Nephropathy



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure has increased each year from 2008 to 2010. Since 2007, the Program's weighted average has remained above the national Medicaid average. The 2010 weighted average falls just below the 2009 national commercial average.

High and Low Performers

Eight plans exceeded the HPL, and five plans fell below the MPL in 2010. In 2009, only three plans achieved the HPL, and two plans were below the MPL. Kaiser Permanente (South)—San Diego County and San Francisco Health Plan—San Francisco County showed continued high performance exceeding the HPL in 2009 and 2010. On the other hand, Anthem Blue Cross in Alameda and Contra Costa counties fell below the MPL in both 2009 and 2010.

Four plans had statistically significant increases in rates from 2009 to 2010, while two plans had statistically significant decreases.

The COHS model type outperformed the GMC and Two-Plan model types and the MCMC Program's 2010 weighted average.

Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

Measure Definition

The *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure is intended to assess whether the blood pressure of diabetic patients is being monitored. It reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who had a blood pressure reading of <140/90 mm Hg.

Importance

High blood pressure (i.e., hypertension) is one of the leading complications of diabetes.[94] Two-thirds of diabetics have hypertension. Diabetics are at an increased risk for developing hypertension due to the effect diabetes has on a person's arteries, which can increase the risk of heart attack and stroke.[95,96] A person who has a combination of diabetes and hypertension is four times more likely to develop heart disease than someone who does not have either condition.[97] Diabetics also are two to four times more likely to have a stroke than non-diabetics.[98]

Blood pressure control in diabetics reduces the risk of heart disease by 33 percent and stroke by 50 percent. Additionally, blood pressure control reduces the risk of microvascular complications (e.g., eye, kidney, and nerve diseases) by approximately 33 percent. In early treatment of diabetes-related kidney disease, the decline in kidney function decreases by 30 to 70 percent when blood pressure is controlled. In addition, for every 10 mm Hg reduction in systolic blood pressure, the risk for any complication related to diabetes is decreased by 12 percent.[99]

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94 American Diabetes Association. High Blood Pressure (Hypertension). Available at: http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html. Accessed on: April 15, 2010.

95 WebMD. Diabetes and High Blood Pressure. Available at: http://www.webmd.com/hypertension-high-blood-pressure/guide/high-blood-pressure Accessed on: April 15, 2010.

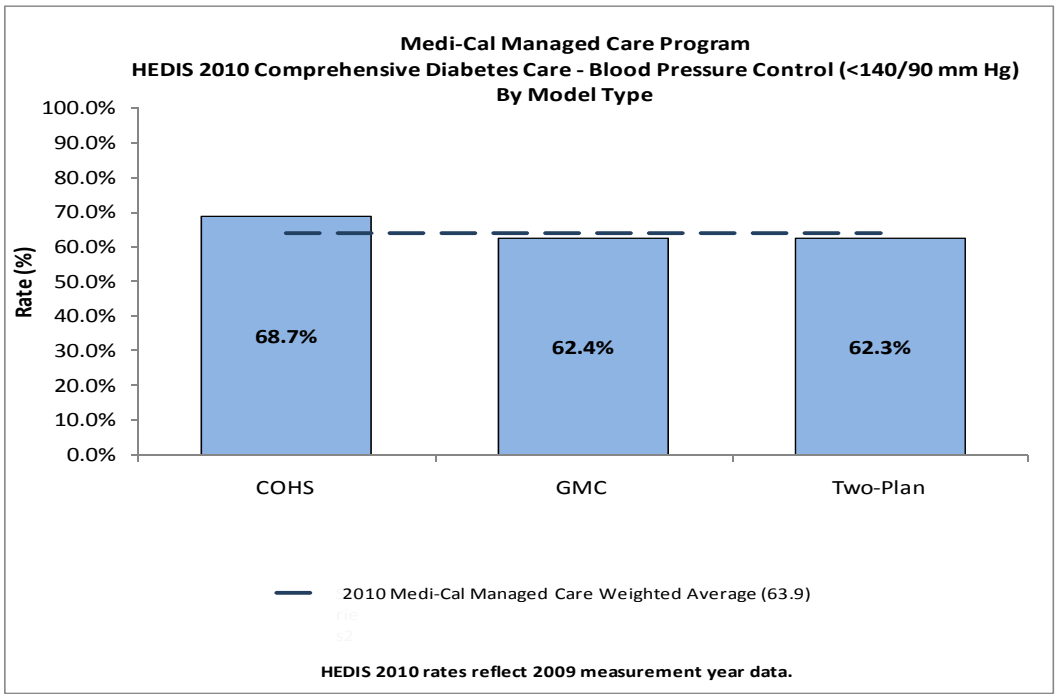
96 National Diabetes Information Clearinghouse. National Diabetes Statistics, 2007. Available at: http://diabetes.niddk.nih.gov/DM/PUBS/statistics. Accessed on: April 15, 2010.

97 American Diabetes Association. High Blood Pressure (Hypertension). Available at: http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html. Accessed on: April 15, 2010.

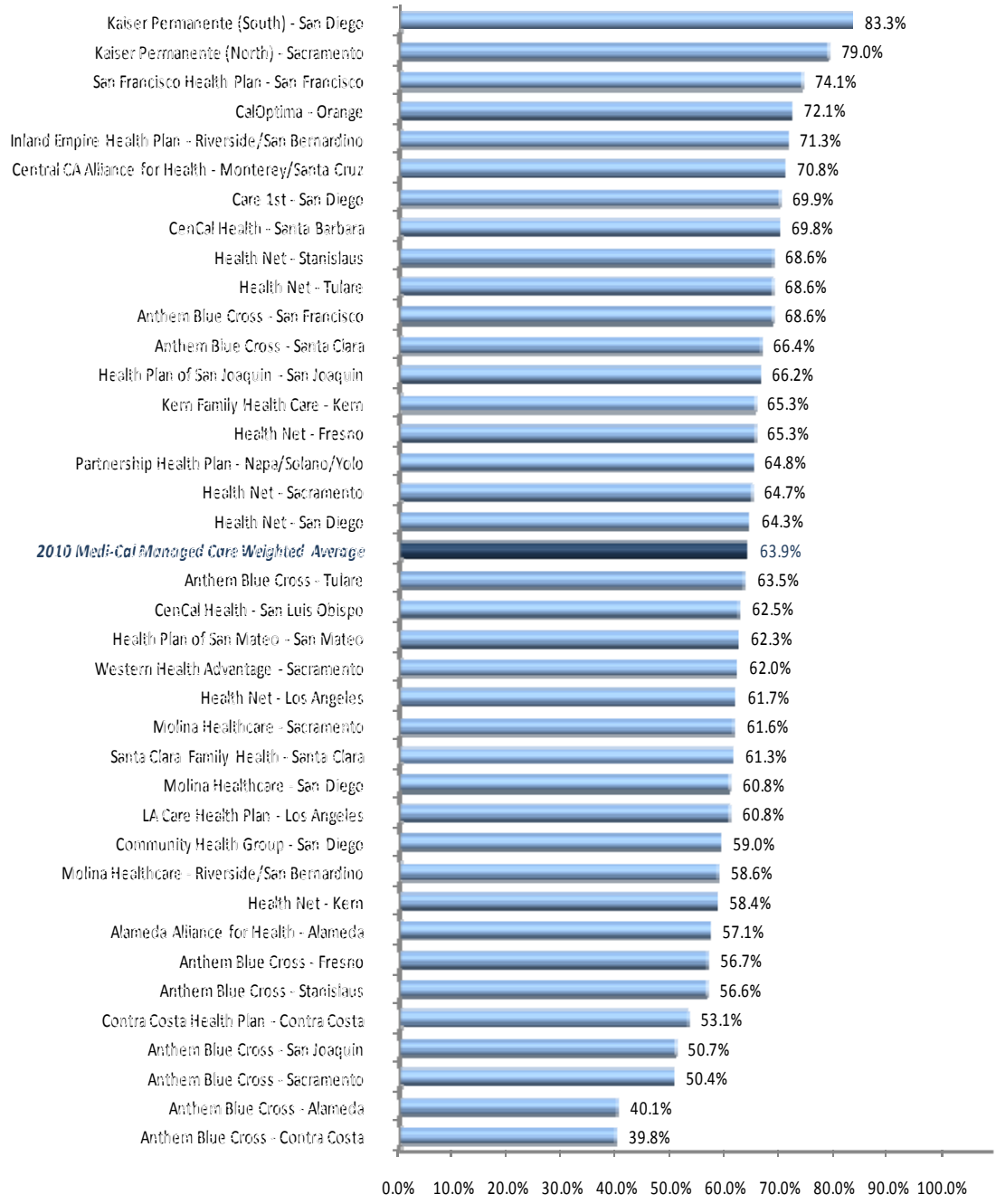
98 The Diabetes Monitor. What is High Blood Pressure? Available at: http://www.diabetesmonitor.com/b31.htm. Accessed on: April 15, 2010.

99 National Diabetes Information Clearinghouse. National Diabetes Statistics, 2007. Available at: http://diabetes.niddk.nih.gov/DM/PUBS/statistics. Accessed on: April 15, 2010.

Performance Results



Medi-Cal Managed Care
HEDIS 2010 Comprehensive Diabetes Care -
Blood Pressure Control (<140/90 mm Hg)



The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS requires the measure.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure was 63.9 percent in 2010. Since 2010 is the first year the DHCS required MCMC plans to report this measure, no comparisons to prior years are displayed and comparisons to state and/or national benchmarks are not provided.

High and Low Performers

The DHCS did not apply an MPL or HPL to this measure in 2010 since this is the first year plans were required to report scores for this measure. Therefore, as plans collected this data and reviewed their individual plan results in this first reporting year, they have an opportunity to consider how to improve performance in future years. Eighteen plans reported a rate greater than the MCMC Program's 2010 weighted average.

The COHS model type outperformed the GMC and Two-Plan model types and the MCMC Program's 2010 weighted average.

Comprehensive Diabetes Care—Best Practices

Quality improvement projects should aim to eliminate barriers associated with improving any combination of diabetes-related health care factors. Successful improvement projects have implemented interventions that manage other chronic disease measures and/or employed unique methods and tools developed specifically for a particular population of chronically ill members.

Support Groups

Support groups are programs which operate under the idea that patients can learn to take responsibility for day-to-day disease management. These group meetings may be face-to-face or via the Internet. Support group programs focus on teaching patients with chronic health problems to manage their own care (i.e., self-care), providing emotional support, and offering other types of support (e.g., getting groceries and medical transportation).

Using support groups can increase patients' knowledge about their condition, as well as assist in improving compliance with prescribed treatment. Additionally, patients who participate in support groups have been shown to have improved health status while to use fewer health care resources. Anecdotal evidence shows such programs also may have a positive correlation on long-term health outcomes. The following improvements have been seen with support groups:

- Increased communication with physicians.
- Improved self-reported health.
- Enhanced social/role activities.
- Reduced need for hospitalizations.

Evidence further suggests that other factors such as pain and psychological well-being have significant improvements in the long-term with the help of support groups. Support groups also have significant correlation with cost savings. A considerable amount of evidence shows patients who join support groups have fewer hospitalizations and overall days spent in a hospital.[100] These groups also allow patients to become more confident in caring for themselves.

Support groups have proven to be helpful for diabetics when it comes to controlling blood glucose levels, blood pressure, and blood lipids. Additionally, those in support groups tend to receive preventive care in a more timely manner.[101]

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[100] Lorig K, Sobel D, Stewart A, et al. Evidence Suggesting That a Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization: A Randomized Trial. 1999. Available at: http://www.des.emory.edu/mfp/Bandura1999MC.pdf. Accessed on: September 22, 2010.

[101] Agency for Healthcare Research and Quality. The CAHPS Improvement Guide. Available at: http://www.cahps.ahrq.gov/qiguide/. Accessed on: April 26, 2010.

Healthy Eating and Weight-Loss Programs

Healthy eating programs teach diabetics how to efficiently adjust and monitor their own diet. Research has shown healthy eating programs are effective in reducing the risk of developing high blood pressure and lowering blood pressure in those patients who currently already have high blood pressure.[102,103] Healthy eating also reduces the risks of heart disease, high cholesterol, and stroke.[104]

Weight loss programs offer a structured program in which diabetics can work together to lose weight and provide solutions for lifestyle changes (e.g., increased physical activity) that will result in weight loss. Many times weight loss programs are offered in collaboration with a healthy eating program. Research has shown that health can be improved in many ways by losing weight, including, but not limited to:[105,106]

- Lowered cholesterol.
- Reduced blood pressure.
- Prevention of angina and chest pain.
- Decreased risk of heart disease and stroke.
- Prevention of acquiring Type 2 diabetes.
- Improved blood sugar levels.

Reminder Systems for Preventive Care

Research has shown that reminder systems (e.g., letters and phone calls) are an effective method for contacting diabetics about needed preventive services and about non-compliance with prescribed treatment.[107] A study showed that reminder systems for the following services improved compliance by up to 20 percent: renal care, foot care, eye care, glycemic control, macrovascular care, and neurologic care.[108]

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102 Pederson K. Healthy Eating and Good Nutrition. *Home Remedies* Available at: http://www.home-remedies-for-you.com/articles/318/nutrition/healthy-eating-and-good-nutrition.html. Accessed on: April 14, 2010.

103 National Diabetes Information Clearinghouse. What I Need to Know About Eating and Diabetes. Available at: http://diabetes.niddk.nih.gov/dm/pubs/eating_ez/index.htm. Accessed on: April 14, 2010.

104 American Diabetes Association. High Blood Pressure (Hypertension). Available at: http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html. Accessed on: April 15, 2010.

105 National Diabetes Information Clearinghouse. What I Need to Know About Eating and Diabetes. Available at: http://diabetes.niddk.nih.gov/dm/pubs/eating_ez/index.htm. Accessed on: April 14, 2010.

106 About.com. The Health Benefits of Losing Weight. Available at: http://weightloss.about.com/library/blhealthbenefits.htm. Accessed on: April 14, 2010.

107 Health Services Advisory Group, Inc. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.

108 Nilasena DS, Lincoln MJ. A Computer-Generated Reminder System Improves Physician Compliance with Diabetes Preventive Care Guidelines. *Proceedings of the Annual Symposium on Computer Application in Medical Care.* 1995. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2579172/. Accessed on April 14, 2010.

Provider Education

Interventions related to provider education are more successful if they are repeated numerous times and distributed using varied modalities. Effective methods for provider education include:

- Informing providers of member incentives.
- Sending report cards to providers that document their care of diabetic members and include a list of diabetic members, summary of diabetic services that they received, and a chart tool.
- Recognizing top performing practitioners in diabetes care.
- Mailing diabetes clinical care guidelines to practitioners with an assessment tool.
- Posting diabetes clinical care guidelines to practitioners via a Web site.
- Distributing monthly newsletters to practitioners.[109]

Patient Outreach

Interventions related to patient education also are more successful if they are repeated numerous times and are distributed using varied modalities. Effective methods for patient education include:

- Identifying diabetic members in a new member welcome call assessment.
- Distributing health report cards to members with testing and result history.
- Providing incentives to members if they are compliant with all screening and testing requirements.
- Distributing quarterly newsletters with diabetes-related articles and updates.[110]

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109 Nilasena DS, Lincoln MJ. A Computer-Generated Reminder System Improves Physician Compliance with Diabetes Preventive Care Guidelines. *Proceedings of the Annual Symposium on Computer Application in Medical Care.* 1995. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2579172/. Accessed on: April 14, 2010.

110 Ibid.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Measure Definition

The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure calculates the percentage of women who delivered a live birth who received a prenatal care visit as a member of the plan in the first trimester or within 42 days of enrollment in the plan.

Importance

More than four million infants are born in the United States each year. Approximately 520,000 of these infants are born preterm, and another 338,000 have low birth weight. Low birth weight increases the risk for neurodevelopmental handicaps, congenital abnormalities, and respiratory illnesses compared to infants of normal birth weight. In 2009, Cailfornia's infant mortality rate was 5.2 deaths per 1,000 live births.[111] With comprehensive prenatal care, the incidence of low birth weight and infant mortality can be reduced. Compared to women who received prenatal care, women who did not receive prenatal care were three to four times more likely to die from complications of pregnancy and three times more likely to have an infant death.[112]

Effective prenatal care aids in the identification of high-risk pregnancies and provides educational opportunities to prevent subsequent poor birth outcomes.[113] Timely and frequent prenatal care visits allow health problems to be detected at an earlier stage. A lack of timely prenatal care may indicate weak therapeutic alliances, lack of peer support, and residential instability throughout the gestational period. Studies reveal that women in the United States who are at risk for inadequate use of prenatal care are more likely to be non-Caucasian, to not have graduated from high school, to be enrolled in Medicaid, to be unmarried, to smoke, to use illicit drugs, and/or to be under 20 years of age.[114] Socioeconomic factors that present barriers to consistent care are common in the Medicaid population. Due to this lack of care, poor birth outcomes are particularly high among Medicaid members.[115] In 2008, only 82 percent of Medicaid members received timely prenatal care, compared to approximately 92 percent for members in commercial health plans.[116]

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111 United Health Foundation. America's Health: State Health Rankings 2009. Available at: http://www.americashealthrankings.org/yearcompare/2008/2009/CA.aspx. Accessed on: October 5, 2010.

112 National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.

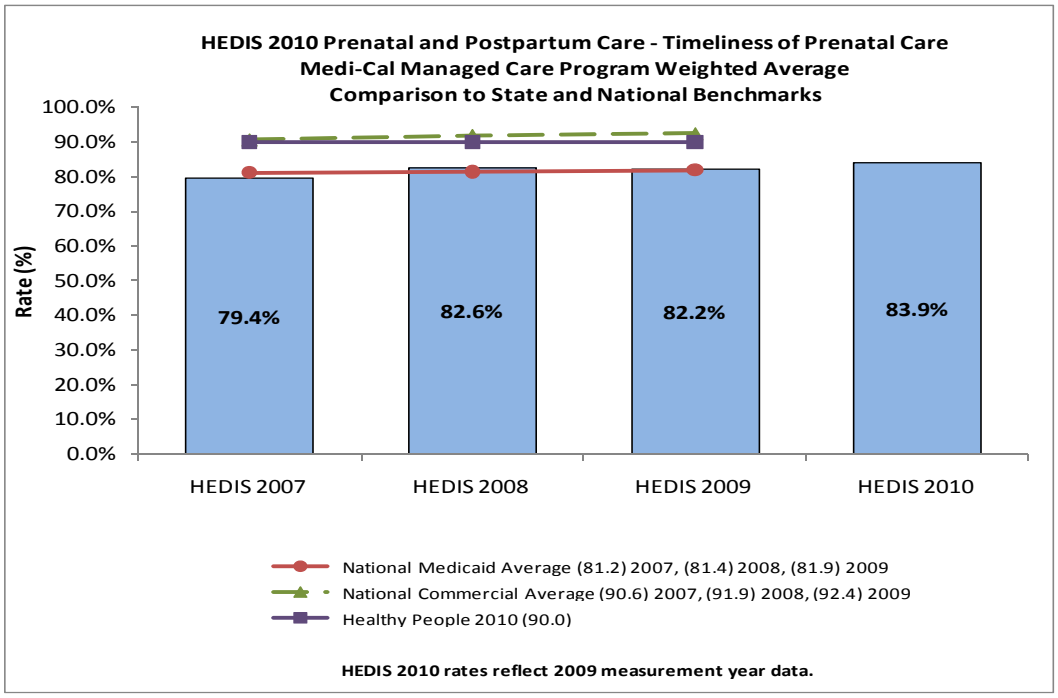
113 Ibid.

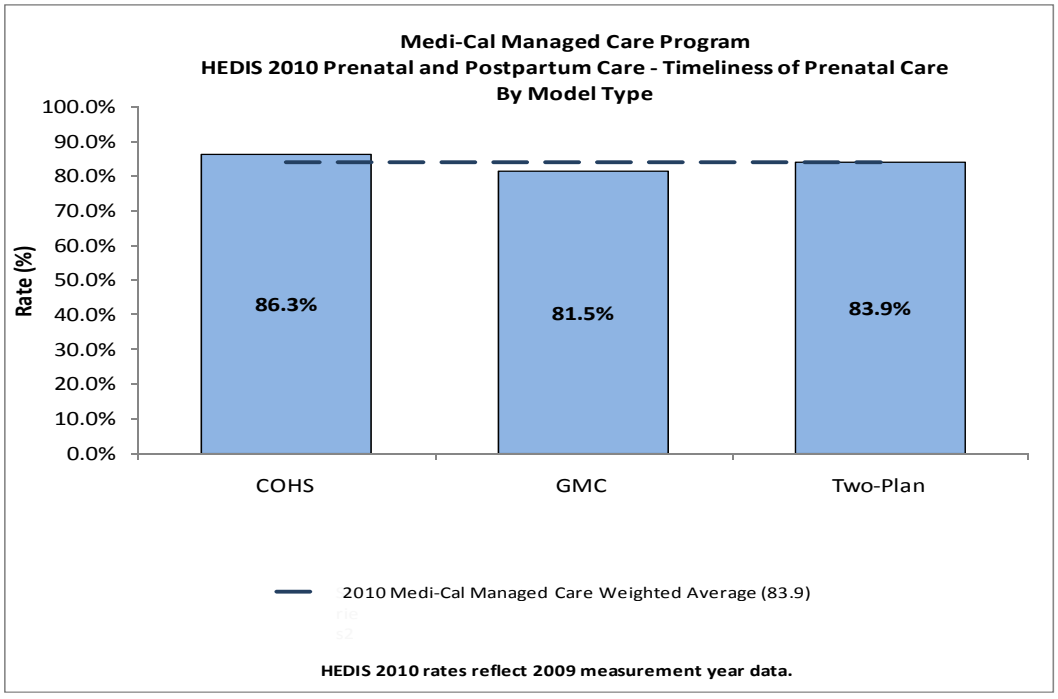
114 Tough S, Siever J, Johnson D. Retaining Women in a Prenatal care Randomized Controlled Trial in Canada: Implications for Program Planning. *BMC Public Health*. 2007; 7: 148.

115 Shulman, S. "Poor Preventive Care Achievement and Program Retention Among Low Birth Weight Infant Medicaid Enrollees". *Pediatrics*. 2006; 118(5): 1509-1515.

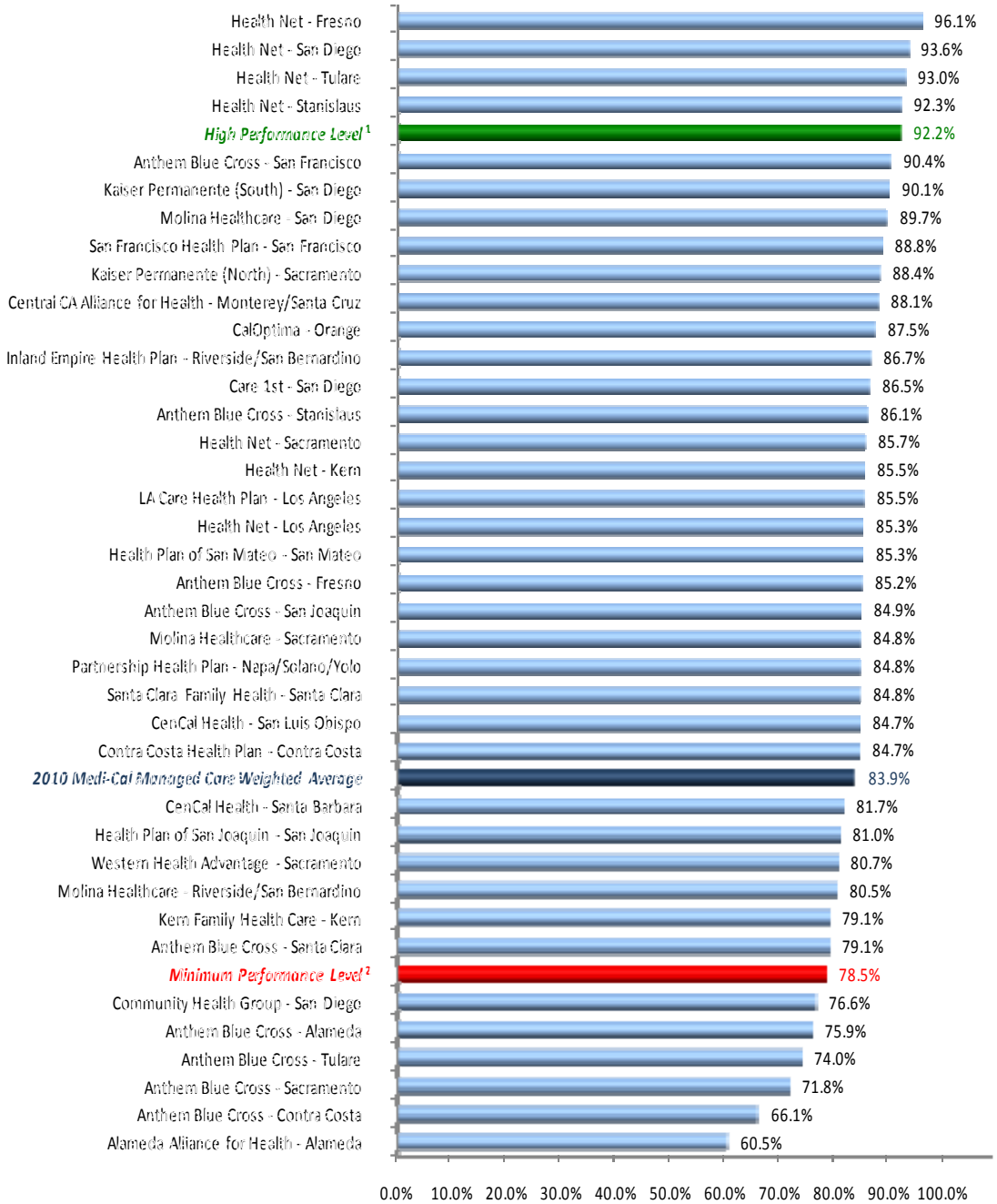
116 National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Prenatal and Postpartum Care –
Timeliness of Prenatal Care



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's 2010 weighted average for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure increased from 2009. Since 2007, the MCMC Program's weighted average has been consistent with the national Medicaid average, but has remained below the national commercial average and the Healthy People 2010 goal.

High and Low Performers

Despite this measure being part of the DHCS's auto-assignment program, only four plans, Health Net in Fresno, San Diego, Stanislaus, and Tulare counties performed above the HPL. Six plans fell below the MPL. Three plans, Alameda Alliance for Health—Alameda County, Anthem Blue Cross—Sacramento County, and Community Health Group—San Diego County, performed below the MPL in 2009 and 2010.

Nine plans demonstrated statistically significant improvement over their 2009 rates. Four plans had a statistically significant decrease in their 2010 rate compared to their 2009 rate.

The COHS model type outperformed both the GMC and Two-Plan model types and the MCMC Program's 2010 weighted average.

Best Practices

Education on Proper Coding

Health plans should educate and ensure that providers are accurately capturing prenatal and postpartum care visits through the use of CPT and CPT Category II codes. The use of these codes will help to facilitate the administrative capture of prenatal and postpartum visits and subsequently increase plans' rates. One study revealed that 94 percent of members received prenatal care in the first trimester based on medical record review; however, HEDIS rates based on administrative data reflected that only 75 percent of women received a timely prenatal care visit for the same time period evaluated. This difference in the rates suggests a lack of accurate and complete administrative data.[117] Working with providers to ensure that accurate and complete data are captured in medical records may help to increase rates.

Coordination of Care

Plans that coordinate care and validate practice guidelines between internists, family practitioners, and OB/GYNs can positively affect maternal health. Incorporating alternative types of providers into the care delivery process, such as nurses and midwives, has been associated with increased

[117] Green D, Koplan J, Cutler C. Prenatal Care In the First Trimester: Misleading Findings from HEDIS. *International Journal for Quality in Health Care.* 1999; 11(6): 465-473.

member satisfaction. Interventions that incorporate member tools for prenatal visits have been shown to improve rates.

Educational Outreach Programs

Plans may develop and implement educational outreach programs aimed at educating women who are pregnant or recently had a baby about the importance of timely prenatal care and postpartum care. Educational programs can be administered throughout the community in various settings. Plans can use media campaigns to further publicize the importance of receiving adequate care. Plans should ensure that educational materials meet the language, literacy levels, and cultural needs of its Medicaid members.[118]

Informational mailings also can be sent to members identified through administrative data as of childbearing age. These mailings can include information on women's health, including the importance of prenatal and postpartum health care visits.

Resource Lists

A barrier to prenatal and postpartum care can be that women simply do not know where to receive health care. An intervention that can help overcome this barrier is ensuring that a resource list with provider contact information is readily available to women. For example, plans can make a list of resources available to women at the time and place where pregnancy tests are performed, as well as through health plan mailings and the Web sites. In addition, plans can disseminate resource lists to providers, who can assist their patients in receiving necessary care in more convenient or accessible settings.[119]

Provide Transportation

One potential barrier to care is members' inability to consistently access transportation. Plans can work with stakeholder and policy makers to increase funding for transportation programs.[120] This best practice could result in an increase in prenatal and postpartum visit rates, particularly in rural areas with less public transportation. Another option is to provide members with bus tokens or taxi vouchers.

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[118] Center for Health Improvement. *Improving Access to and Use of Prenatal Care in San Joaquin County.* January 2004. Available at: http://www.co.san-joaquin.ca.us/FirstFive/base/documents/prenatalReport.pdf. Accessed on: May 5, 2010.

[119] Tough S, Siever J, Johnson D. Retaining Women in a Prenatal care Randomized Controlled Trial in Canada: Implications for Program Planning. *BMC Public Health.* 2007; 7: 148.

[120] Ibid.

Prenatal and Postpartum Care—Postpartum Care

Measure Definition

The *Prenatal and Postpartum Care—Postpartum Care* measure reports the percentage of women who delivered a live birth who received a postpartum visit on or between 21 days and 56 days after delivery.

Importance

While care strategies tend to emphasize the prenatal period, appropriate care during the postpartum period also is important. Socioeconomic factors that present barriers to consistent care are common in the Medicaid population. In 2008, almost 82 percent of members enrolled in commercial health plans received timely postpartum care; however, only 63 percent of Medicaid members received timely postpartum care.[121]

Postpartum care is an important determinant of health outcomes for women after giving birth. Since medical complications and death can occur after a woman has given birth, postpartum visits can address any adverse effects, such as persistent bleeding, inadequate iron levels, elevated blood pressure, pain, emotional changes, and infections.

Postpartum depression is one of the most prevalent complications that can occur after delivery. It is estimated that up to 70 percent of women experience postpartum sadness immediately after delivery (i.e., within the first week).[122] An estimated 10 percent of these women suffer from postpartum depression for which a postpartum care visit is needed.[123] This figure increases to 25 percent if the woman has a history of postpartum depression. If untreated, postpartum depression usually lasts around seven months.[124] Appropriate postpartum care can address these emotional issues.

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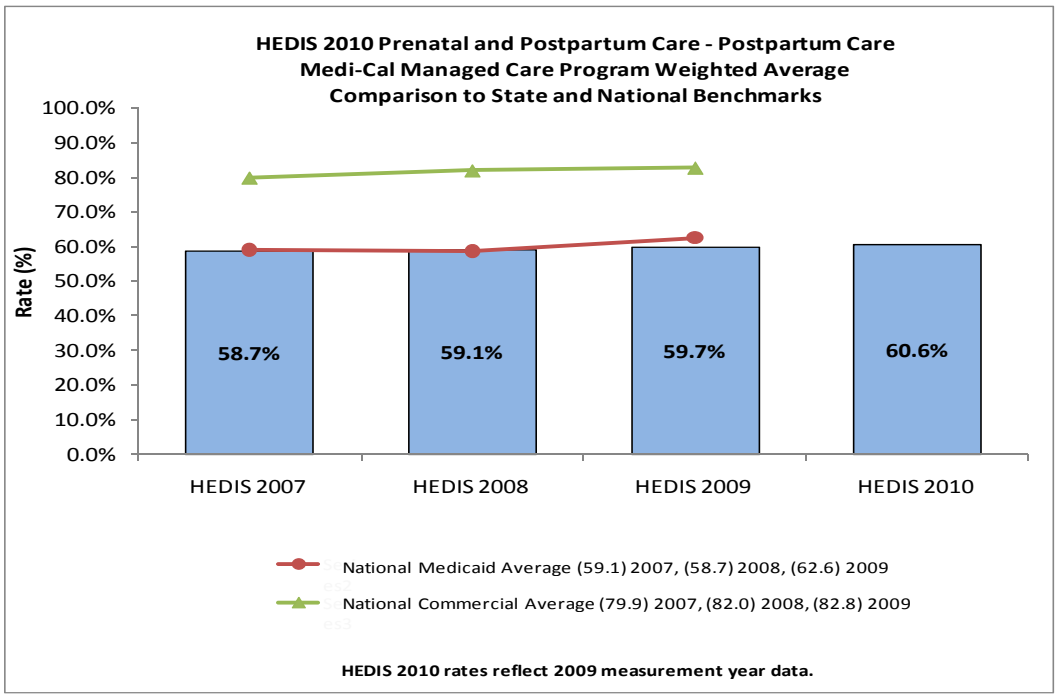
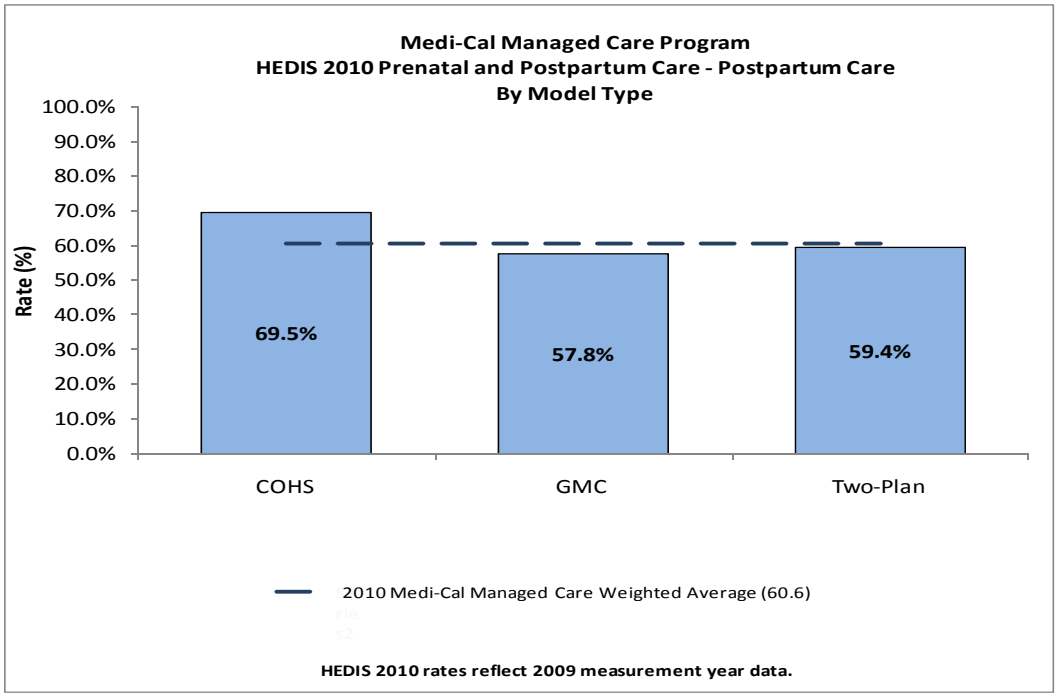
[121] National Committee for Quality Assurance. *The State of Health Care Quality in 2009*. Washington, D.C.: NCQA; 2009.
[122] Blenning C, Paladine H. An Approach to the Postpartum Office Visit. *American Family Physician.* 2005; 72(12): 2491-2496.
[123] Centers for Disease Control and Prevention. *PRAMS and Postpartum Depression.* Atlanta, GA: CDC; June 2004.
[124] Blenning C, Paladine H. An Approach to the Postpartum Office Visit. *American Family Physician.* 2005; 72(12): 2491-2496.

In addition to emotional issues, physical issues associated with pregnancy also should be closely monitored during the postpartum period. For example, 1 to 3 percent of vaginal deliveries result in postpartum endometriosis. Urinary incontinence is prevalent in up to 23 percent of pregnancies after the first year of delivery. Approximately 4 to 7 percent of pregnancies result in a thyroid disorder during the first year of pregnancy. Women at risk for any of these complications should be tested and treated during the postpartum period.[125]

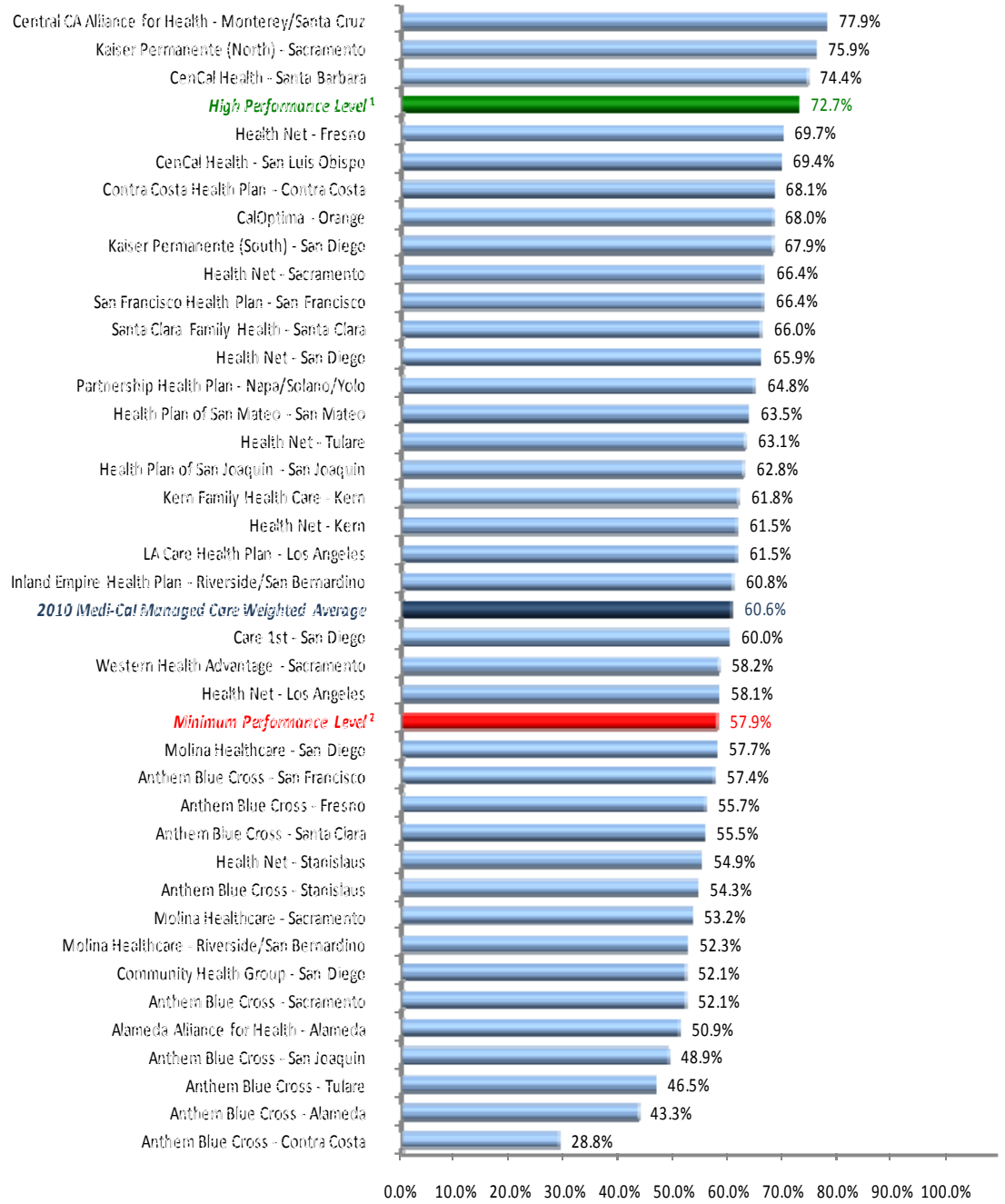
[125] Blenning C, Paladine H. An Approach to the Postpartum Office Visit. *American Family Physician.* 2005; 72(12): 2491 2496.

Performance Results





Medi-Cal Managed Care
HEDIS 2010 Prenatal and Postpartum Care – Postpartum Care



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Prenatal and Postpartum Care—Postpartum Care* measure has increased each year from 2007 to 2010. During this time period the MCMC Program's weighted average remained consistent with the national Medicaid average but fell below the national commercial average.

High and Low Performers

Three plans achieved the established HPL in 2010. Two of these three plans, CenCal Health—Santa Barbara County and Central California Alliance for Health—Monterey/Santa Cruz counties have shown consistently high performance exceeding the HPL in 2008, 2009, and 2010. In contrast, 15 plans performed below the 2010 established MPL, an increase from 2009, when only seven plans ranked below the MPL.

Seven plans showed statistically significant increases from their 2009 rates, while four plans showed statistically significant decreases.

The COHS model type outperformed the GMC and Two-Plan model type and exceeded the MCMC Program's 2010 weighted average.

Best Practices

Many of the same best practices used for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure also may also be used as best practices for the *Prenatal and Postpartum Care—Postpartum Care* measure. These include:

- Education on proper coding
- Coordination of care
- Educational outreach programs
- Resource lists
- Providing transportation

Use of Imaging Studies for Low Back Pain

Measure Definition

The *Use of Imaging Studies for Low Back Pain* measure assesses the percentage of members between 18 and 50 years of age who had a primary diagnosis of low back pain and who did not have an imaging study (X-ray, magnetic resonance imaging [MRI], computed topography [CT] scan) within 28 days of diagnosis.

Importance

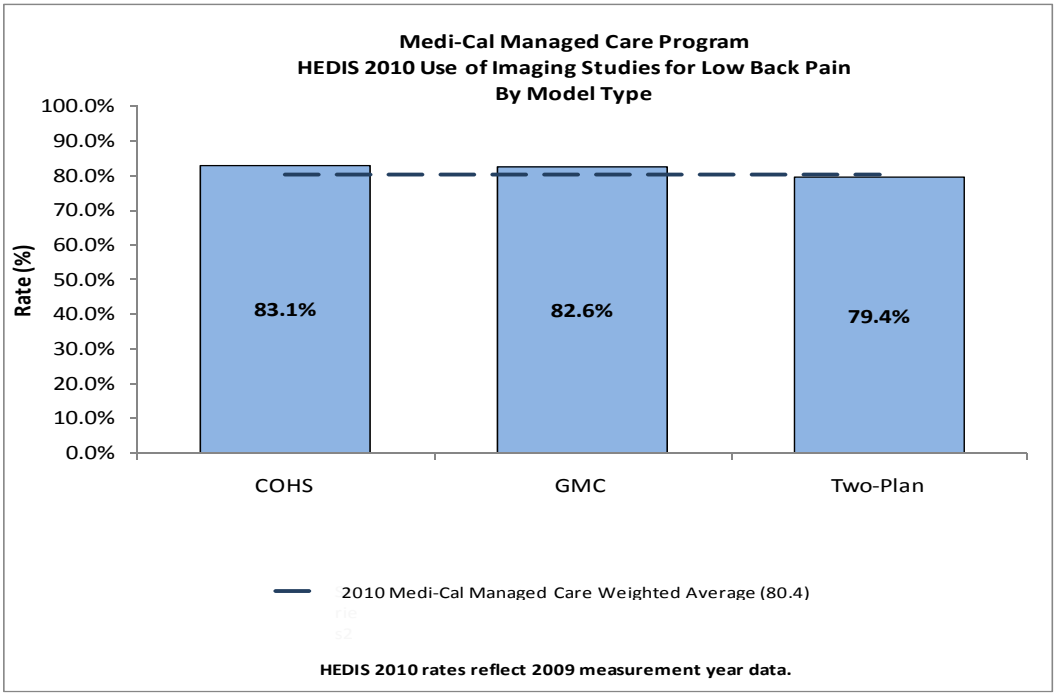
Low back pain is a common and expensive cause of lost productivity and work days in the United States. Each year, approximately half of American adults will experience low back pain.[126] For most patients, acute low back pain is non-specific. Only a small portion of patients with persistent pain will need to be evaluated further to investigate more serious health problems. A history and physical examination can provide clues to the rare but potentially serious causes of low back pain. While imaging may be appropriate for patients at risk for more serious conditions, the majority of patients experience low back pain that is non-specific and with no identifiable cause. According to the American College of Radiology, acute low back pain without complications is usually benign and self-limiting and does not necessitate early imaging studies, (e.g., X-ray, MRI, or CT scan).

However, despite this evidence, providers commonly overuse imaging studies in the evaluation of patients with acute low back pain. Less than 1 percent of radiographs reveal the cause of low back pain.[127] Abnormalities found when imaging those with and without back pain had similar prevalence. Other than patient satisfaction, most patients given standard care for their low back pain did not experience any differences in health outcomes compared to those given lower back radiographs.

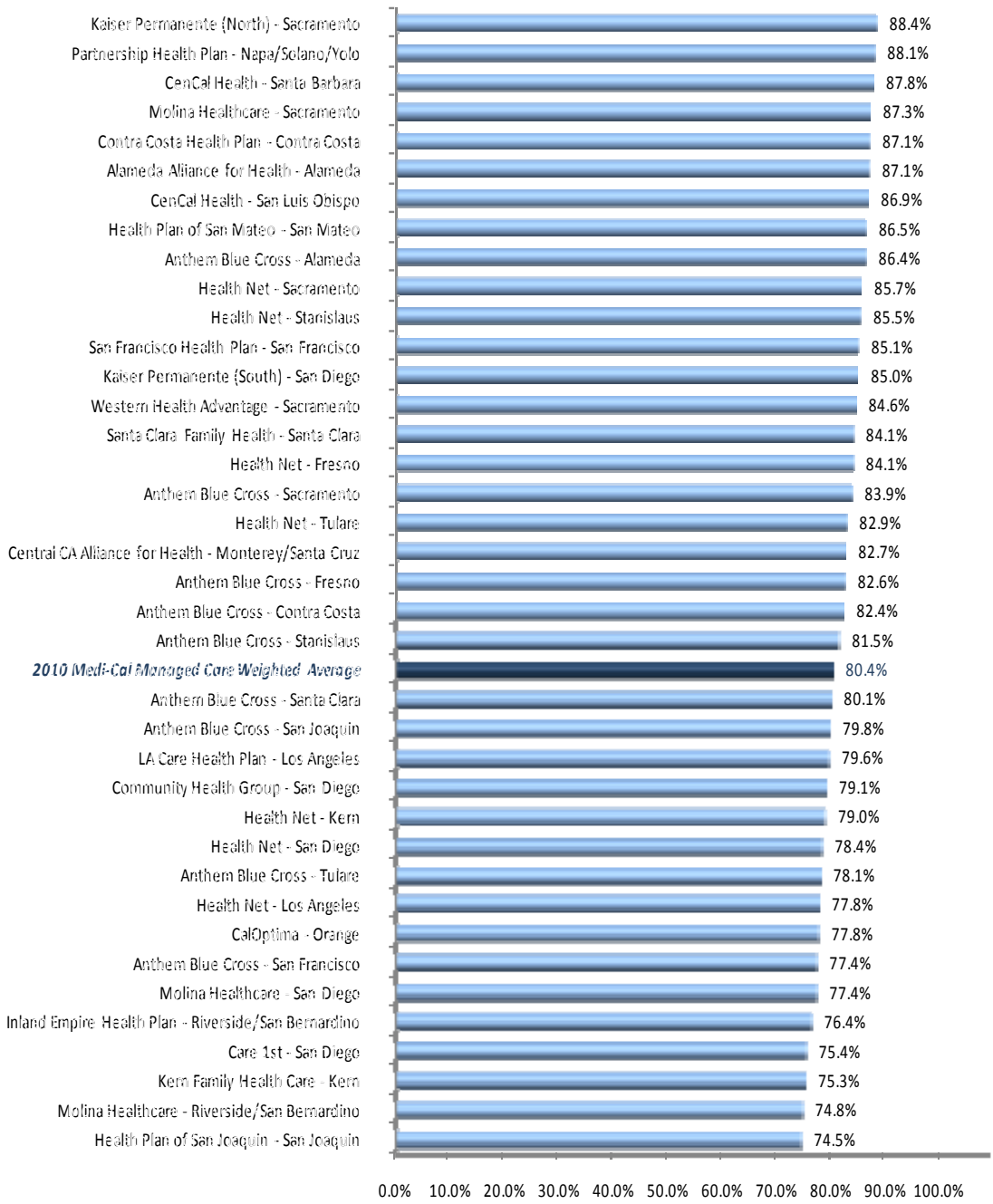
[126] Koes BW, van Tulder MW, Thomas S. Diagnosis and Treatment of Low Back Pain. *British Medical Journal.* 2006; 332: 1430-1434.

[127] Manek NJ, MacGregor AJ. Epidemiology of Back Disorders: Prevalence, Risk Factors, and Prognosis. *Current Opinion in Rheumatology.* 2005; 17:134-140.

Performance Results



Medi-Cal Managed Care
HEDIS 2010 Use of Imaging Studies for Low Back Pain



The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS requires the measure.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Use of Imaging Studies for Low Back Pain* measure was 80.4 percent in 2010. Since 2010 is the first year that the DHCS required MCMC plans to report this measure, no comparisons to prior years are displayed, and comparisons to state and/or national benchmarks are not provided.

High and Low Performers

The DHCS did not apply an MPL or HPL to this measure in 2010 since this is the first year plans were required to report this measure. Twenty-two plans reported a rate greater than the MCMC 2010 Program weighted average.

The COHS model type outperformed the GMC and Two-Plan model types. Both the COHS and GMC model types exceeded the MCMC Program's 2010 weighted average.

Best Practices

Focus on Identifying Red Flag Indicators

About 90 percent of all patients with low back pain will have non-specific low back pain. In clinical practice, as well as in the literature, non-specific low back pain is usually classified by the duration of the pain.[128] During the initial assessment of patients with low back pain, clinical guidelines recommend focusing on obtaining a complete medical history and physical examination. The history and physical examination will generally provide "red flag" indicators to rare but potentially serious causes of low back pain and identify if a patient is at risk for chronic disabling back pain. Examples of red flag indicators are age of onset; back pain unrelated to time or activity; thoracic pain; previous history of carcinoma, steroids, or human immunodeficiency virus (HIV); weight loss; widespread neurological symptoms; and structural spinal deformity.[129] When these red flag indicators are not present, the patient is considered as having non-specific low back pain. In clinical guidelines these findings have led to the recommendation the providers be restrictive in referral for imaging in patients with non-specific low back pain. Only in cases with red flag conditions should imaging be indicated.[130]

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128 Agency for Healthcare Research and Quality. *Clinical Practice Guideline, Acute Low Back Pain Problems in Adults: Assessment and Treatment*. 1994. Available at: http://chirobase.org/07Strategy/AHCPR/ahcprclinician.html. Accessed on: June 18, 2010.

129 Koes BW, van Tulder MW, Thomas S. Diagnosis and Treatment of Low Back Pain. *British Medical Journal.* 2006; 332: 1430-1434.

130 Agency for Healthcare Research and Quality. *Clinical Practice Guideline, Acute Low Back Pain Problems in Adults: Assessment and Treatment*. 1994. Available at: http://chirobase.org/07Strategy/AHCPR/ahcprclinician.html. Accessed on: June 18, 2010.

Meet Patient Expectations through Education

For most patients, receiving information from a provider about why an imaging test is not the appropriate means of care for back pain is generally sufficient. Providing patients with evidence-based information on low back pain with regard to the natural history of low back pain (i.e., its expected course), advising them to remain active, and providing them with information about effective self-care options and how to prevent future episodes can help ensure that patients' expectations are met.[131]

Provide Alternative Therapy

For those patients who do not improve with self-care options, clinicians should consider recommending nonpharmacologic therapy with proven benefits. For example, for patients with chronic or subacute low back pain, clinicians could suggest one of the following alternative therapies: intensive interdisciplinary rehabilitation, exercise therapy, acupuncture, massage therapy, spinal manipulation, yoga, cognitive-behavioral therapy, or progressive relaxation.

[131] Atlas SJ, Deyo RA. Evaluating and Managing Acute Low Back Pain in the Primary Care Setting. *Journal of General Internal Medicine*. 2001; 16: 120-131.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Measure Definition

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure calculates the percentage of enrolled members between 3 and 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of Body Mass Index (BMI) percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year.

Importance

The emergence of obesity in children and adolescents has been one of the most important developments in pediatrics, and its rapidly increasing prevalence is one of the most challenging dilemmas pediatricians face today in the United States.[132] In 1980, it was estimated that 6.9 percent of children 6 to 11 years of age and 5 percent of adolescents 12 to 19 years of age were obese. However, in the past 30 years the prevalence of obesity among children and adolescents has increased sharply. Results from the 2007-2008 National Health and Nutrition Examination Survey (NHANES) showed that obesity increased to 19.6 percent among children and to 18.1 percent among adolescents.[133] Also of great concern are children who are overweight and at risk for becoming obese. Overweight children and adolescents are more likely to become obese as adults. One study found that approximately 80 percent of children who were overweight at 10 to 15 years of age were obese at age 25.[134]

Additionally, a CDC study reported that almost 25 percent of children 9 to 13 years of age did not engage in any free-time physical activity.[135] For young people in grades 9 through 12, the level of physical activity decreases drastically. Almost two-thirds of young people in grades 9 through 12 do not engage in the recommended levels of physical activity, and only 54 percent participate in physical education class at least once a week. Evidence has also shown that daily participation in

[132] Agency for Healthcare Research and Quality. "Weight assessment and counseling for nutrition and physical activity for children and adolescents." *National Quality Measures Clearinghouse.* Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=14919. Accessed on: March 9, 2010.

[133] Ogden C, Carroll M. Prevalence of Obesity Among Children and Adolescents: United States, Trends 1963-1965 Through 2007-2008. 2010. Available at: http://www.cdc.gov/nchs/data/hestat/obesity_child_07_08/obesity_child_07_08.pdf. Accessed on: June 16, 2010.

[134] Agency for Healthcare Research and Quality. "Weight assessment and counseling for nutrition and physical activity for children and adolescents." *National Quality Measures Clearinghouse.* Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=14919. Accessed on: March 9, 2010.

[135] Physical Activity Levels Among Children 9-13 Years—United States, 2002. *Morbidity and Mortality Weekly Report*. 2003; 52(33): 785-788. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5233a1.htm. Accessed on: June 16, 2010.

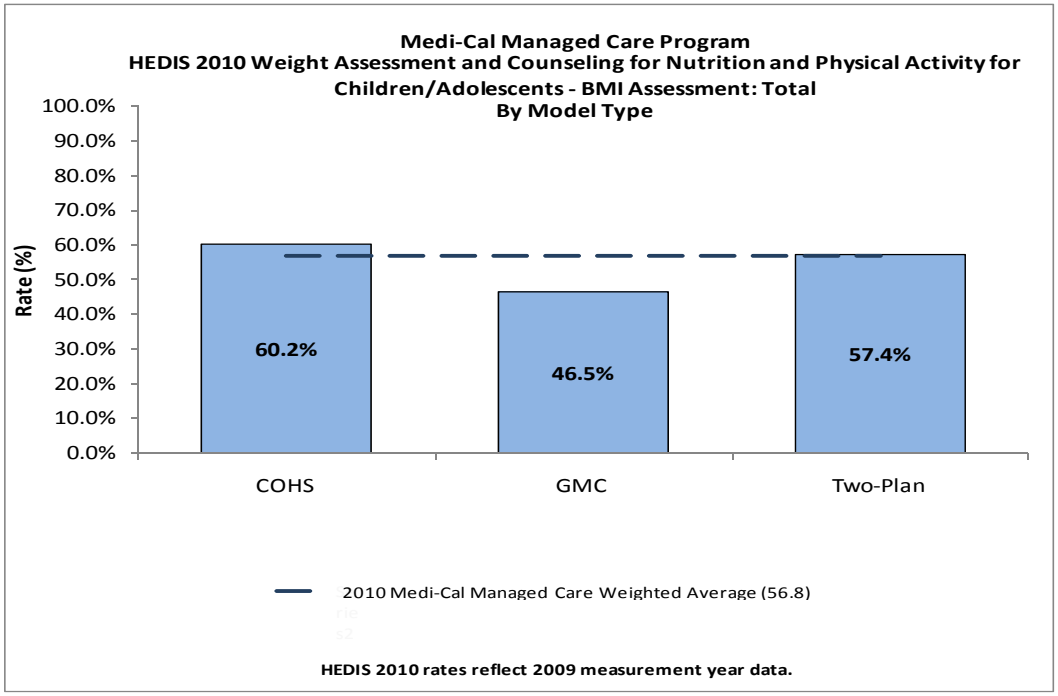
physical education classes among high school students has dropped from 42 percent in 1991 to 33 percent in 2005.[136]

For these reasons, it is essential that children and adolescents in the United States receive adequate weight assessment and counseling for nutrition and physical activity. The first step involves screening for overweight and obesity in the physicians' offices with the calculation of a BMI. The BMI is a useful screening tool for assessing and tracking the degree of obesity among children and adolescents. To address the lack of physical activity and nutritional education among children and adolescents in the United States, health care providers should promote regular physical activity and healthy eating, as well as assist parents to create an environment that supports these healthy habits.[137]

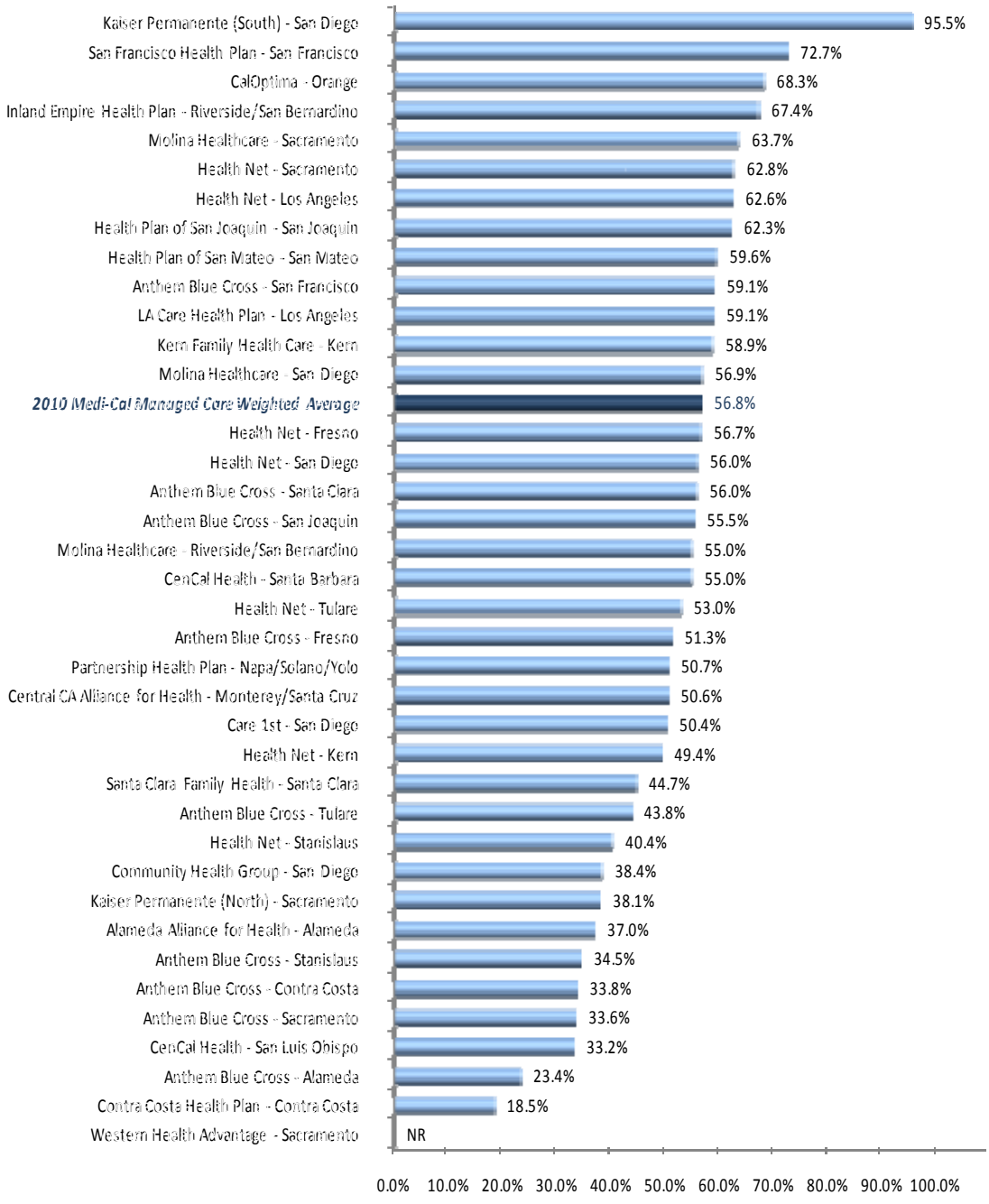
[136] Centers for Disease Control and Prevention. Youth Behavior Surveillance – United States, 2009. Surveillance Summaries. *Morbidity and Mortality Weekly Report*. 2010; 59(No. SS-5). Available at: http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf. Accessed on: June 16, 2010

[137] U.S. Department of Health and Human Services. *Physical Activity and Health: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 1996.

Performance Results—BMI Assessment



Medi-Cal Managed Care
HEDIS 2010 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total



The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS requires the measure.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

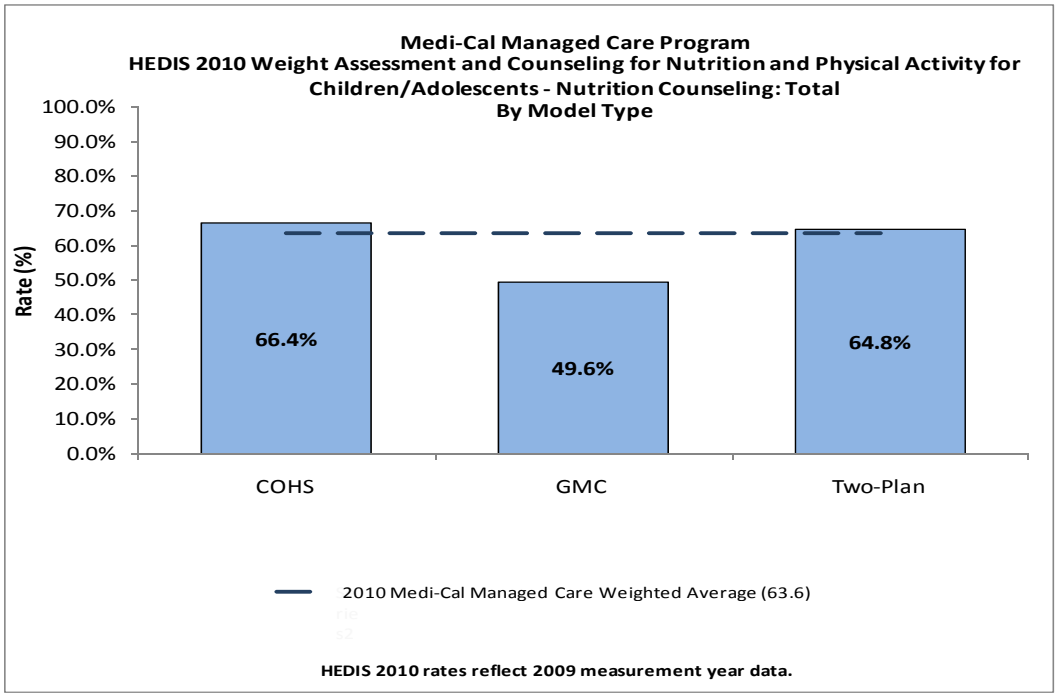
The MCMC Program's weighted average for the BMI Assessment indicator of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure was 56.8 percent in 2010. Since 2010 is the first year that the DHCS required MCMC plans to report this measure, no comparisons to prior years are displayed, and comparisons to state and/or national benchmarks are not provided.

High and Low Performers

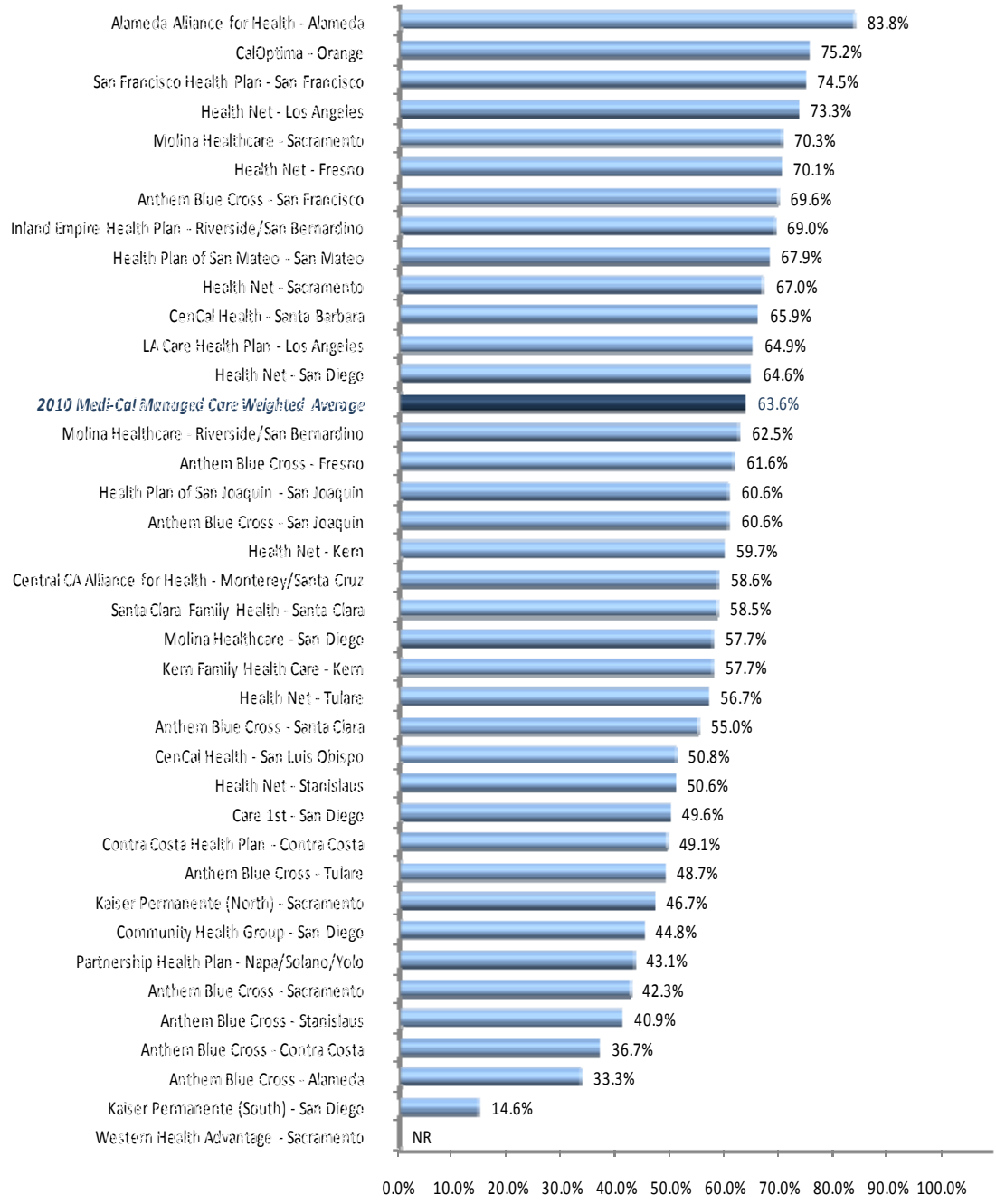
The DHCS did not apply an MPL or HPL to this measure in 2010 since this is the first year plans were required to report this measure. Thirteen plans reported a rate greater than the MCMC 2010 Program weighted average.

The COHS model type performed better than the GMC and Two-Plan model types.

Performance Results—Nutrition Counseling



Medi-Cal Managed Care
HEDIS 2010 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total



The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS requires the measure.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

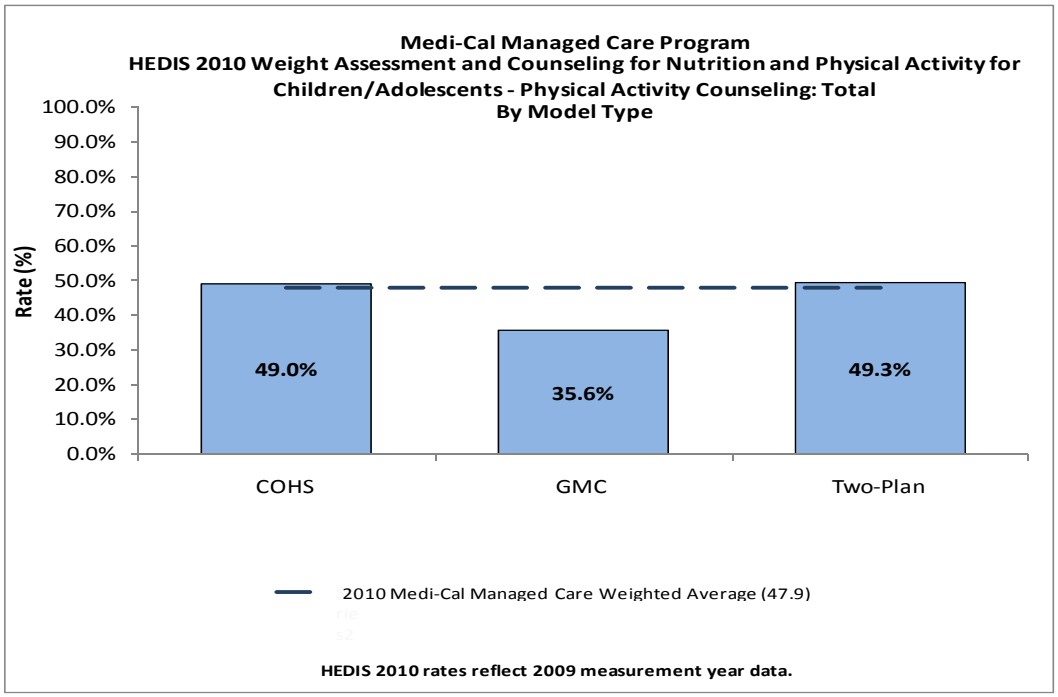
The MCMC Program's weighted average for the Nutritional Counseling indicator of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure was 63.6 percent for this measure in 2010. Since 2010 is the first year that the DHCS required MCMC plans to report this measure, no comparisons to prior years are displayed, and comparisons to state and/or national benchmarks are omitted.

High and Low Performers

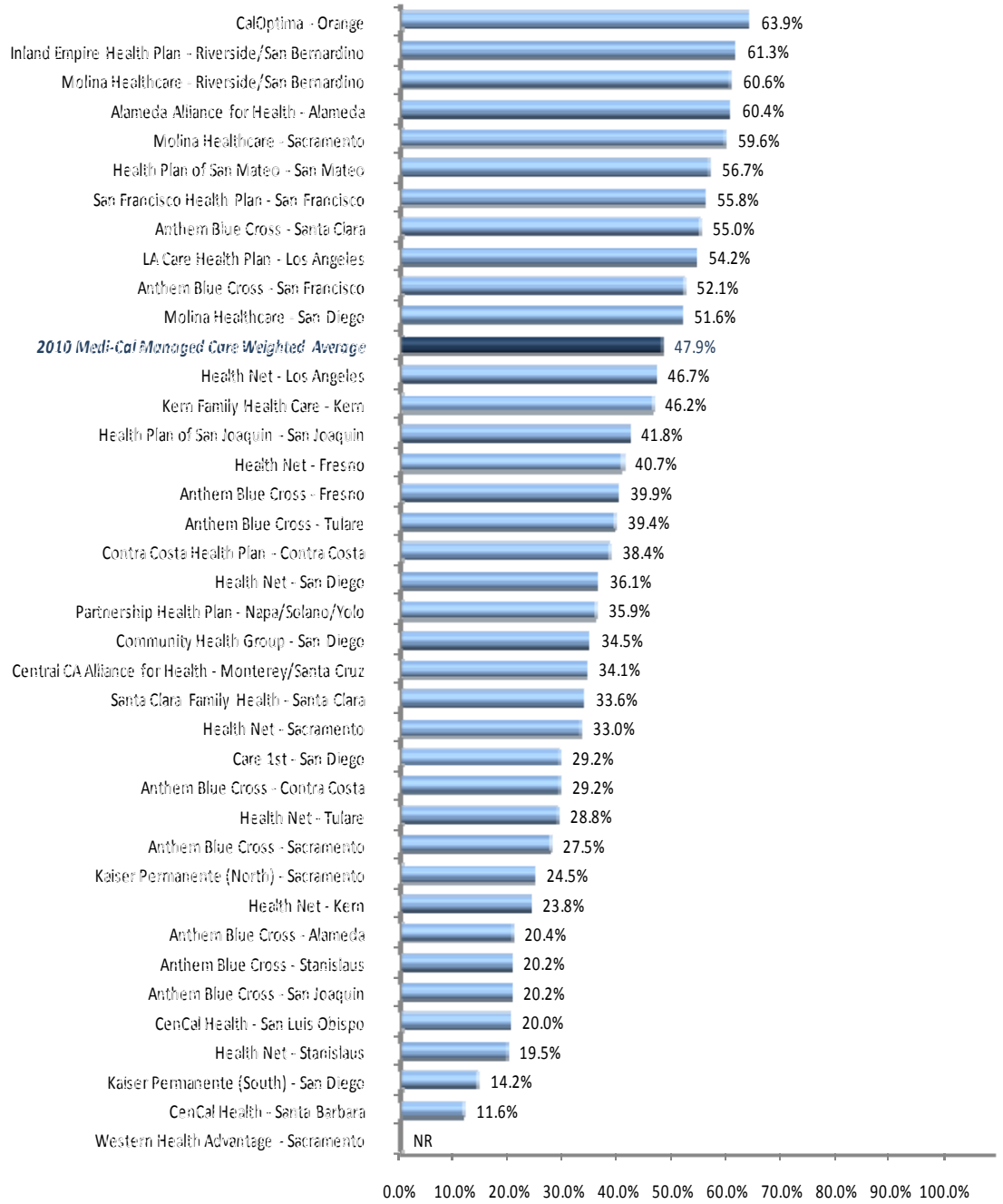
The DHCS did not apply an MPL or HPL to this measure in 2010 since this is the first year plans were required to report this measure. Thirteen plans reported a rate greater than the MCMC 2010 Program weighted average.

The COHS model type outperformed the GMC and Two-Plan model types.

Performance Results—Physical Activity Counseling



Medi-Cal Managed Care
HEDIS 2010 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total



The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS requires the measure.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Summary of Results

The MCMC Program's weighted average for the Physical Activity Counseling indicator of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure was 47.9 percent in 2010. Since 2010 is the first year that the DHCS required MCMC plans to report this measure, no comparisons to prior years are displayed, and comparisons to state and/or national benchmarks are not provided.

High and Low Performers

The DHCS did not apply an MPL or HPL to this measure in 2010 since this is the first year plans were required to report this measure. Eleven plans reported a rate greater than the MCMC 2010 Program weighted average.

The Two-Plan model type outperformed better than the COHS and GMC model types.

Best Practices

Educate Parents and Guardians

Educating parents and guardians on the importance of providing children and adolescents with a healthy diet and the significance of encouraging daily physical activity can be highly beneficial. Educational information and resources can include written or Web-based materials with information on the value of BMI assessment and information on community-based physical activity/weight management programs. Evidence also suggests that providing information and practical strategies related to good nutrition and meal preparation will lead to an increase in knowledge about healthy nutrition and an increase in health eating behaviors.[138]

Educate Health Care Professionals

Educating health care professionals and providing them with the tools, skills, and knowledge necessary to identify and screen children and adolescents for obesity in a primary care setting is crucial. Nearly 75 percent of American adolescents see a physician at least once a year.[139] Physician visits offer health care providers and other clinicians the opportunity to provide preventive services, such as BMI assessments, dietary counseling, and related weight management and nutrition services. Studies indicate that adolescents view their physicians as a trustworthy source of

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138 U.S. Department of Health and Human Services and U.S Department of Agriculture. *Dietary Guidelines for Americans, 2005*. Washington, D.C.: HHS; 2005. Available at: http://www.health.gov/dietaryguidelines/dga2005/report/. Accessed on: August 28, 2010.

139 Park MJ, Macdonald TM, Ozer EM, et al. Investing in Clinical Preventive Health Services for Adolescents. University of California, San Francisco, Policy Information and Analysis Center for Middle Childhood and Adolescence, and National Adolescent Health Information Center. 2001. Available at: http://nahic.ucsf.edu/downloads/CPHS.pdf. Accessed on: August 29, 2010.

health information and that parents want clinicians to provide these services.[140]

[140] Park MJ, Macdonald TM, Ozer EM, et al. Investing in Clinical Preventive Health Services for Adolescents. University of California, San Francisco, Policy Information and Analysis Center for Middle Childhood and Adolescence, and National Adolescent Health Information Center. 2001. Available at: http://nahic.ucsf.edu/downloads/CPHS.pdf. Accessed on August 29, 2010.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Measure Definition

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure calculates the percentage of members who were three, four, five, or six years old during the measurement year and who received one or more well-child visit with a PCP during the measurement year.

Importance

Regular check-ups are crucial to detect physical, developmental, behavioral, and emotional problems at an early stage, and well-child exams include many needed medical services important to the health and well-being of infants and children. Doctors may perform health exams and tests, such as vision, hearing, or lab services. Vaccinations often are performed concurrently, resulting in a reduction in disease, as well as savings in health costs over time. Furthermore, there is evidence that timely preventive care in children has a positive impact on overall health care utilization. Medicaid children who are up-to-date with well-child visits are approximately 48 percent less likely to have an avoidable hospitalization.[141]

The AMA and the American Academy of Pediatrics (AAP) recommend timely, comprehensive well-child visits for children. These periodic check-ups allow clinicians to assess a child's physical, behavioral, and developmental status and provide any necessary treatment, intervention, or referral to a specialist.[142] Children with poorer health status are more likely not to receive recommended well-child visits since these children tend to use more acute or specialty care.[143] Furthermore, there is evidence that timely preventive care in children has a positive impact on overall health care utilization. Researchers have found associations between increased well-child visits and reductions in avoidable hospitalizations, reductions in ED use, and improved child health.[144]

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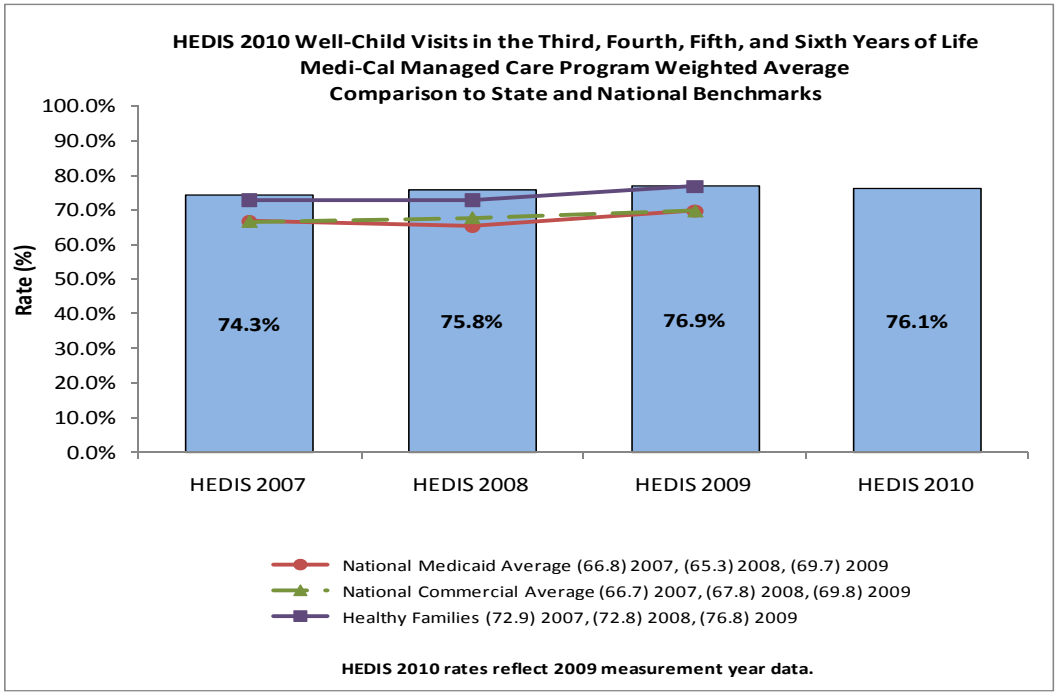
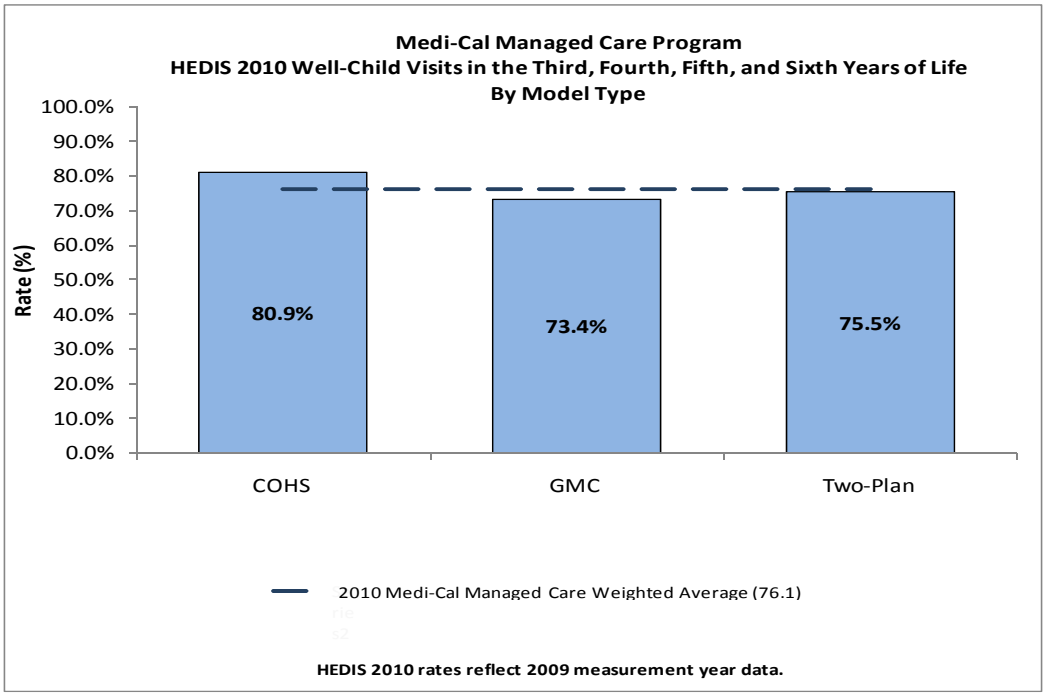
141 Hakim RB, Bye BV. Effectiveness of Compliance with Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries. *Pediatrics*. 2001; 108(1): 90-97.

142 Ibid.

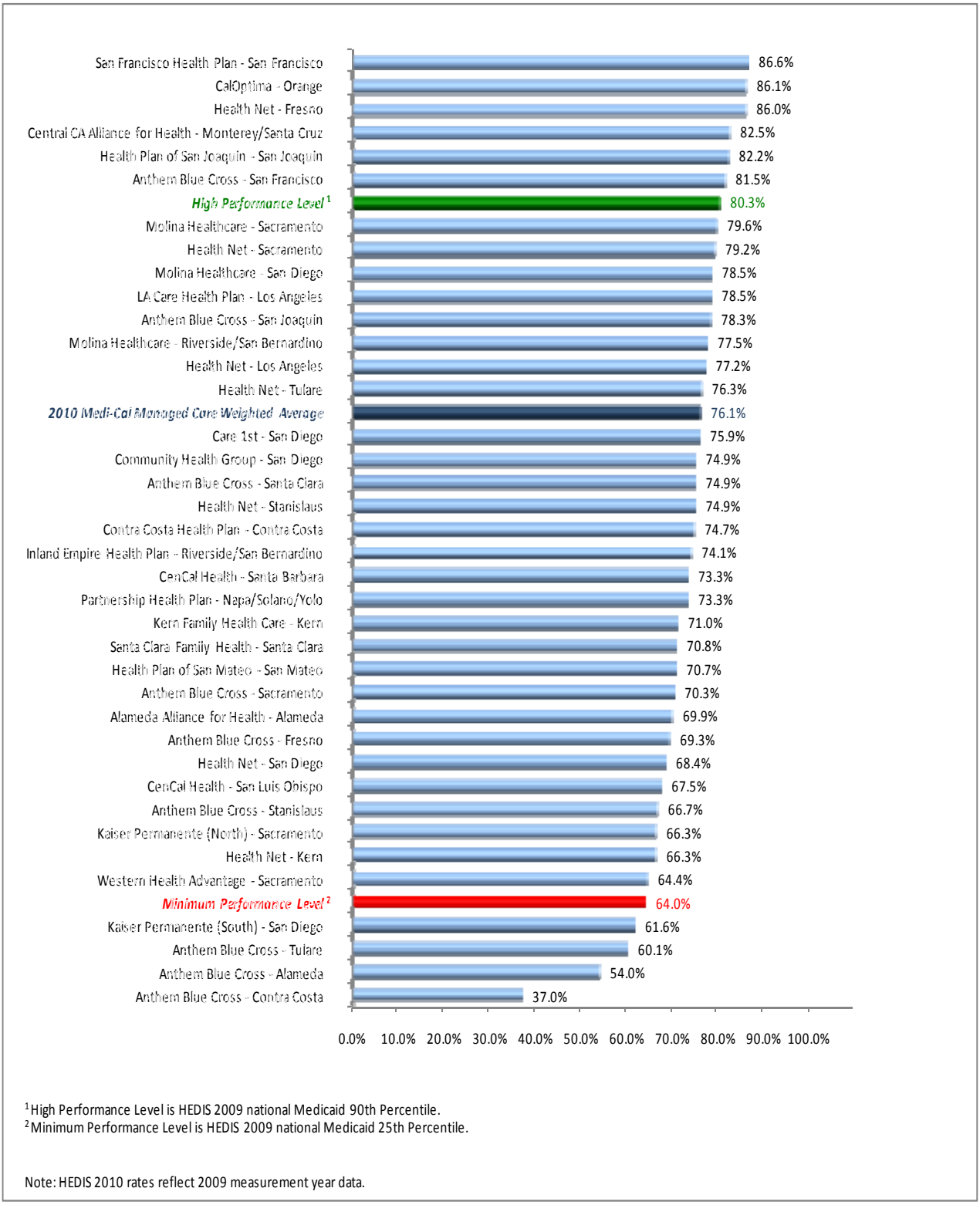
143 Yu SM, Bellamy HA, Kogan MD, et al. Factors That Influence Receipt of Recommended Preventive Pediatric Health and Dental Care. *Pediatrics*. 2002; 110(6): 73.

144 Selden TM. "Compliance with Well-Child Visit Recommendations: Evidence From the Medical Expenditure Panel Survey, 2000-2002." *Pediatrics*. 2006; 118(6): 1766-1778.


HEDIS 2010 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Medi-Cal Managed Care Program Weighted Average
Comparison to State and National Benchmarks
Rate (%)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
74.3%
75.8%
76.9%
76.1%
HEDIS 2007
HEDIS 2008
HEDIS 2009
HEDIS 2010
National Medicaid Average (66.8) 2007, (65.3) 2008, (69.7) 2009
National Commercial Average (66.7) 2007, (67.8) 2008, (69.8) 2009
Healthy Families (72.9) 2007, (72.8) 2008, (76.8) 2009
HEDIS 2010 rates reflect 2009 measurement year data.


Medi-Cal Managed Care Program
HEDIS 2010 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
By Model Type
Rate (%)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
80.9%
73.4%
75.5%
COHS
GMC
Two-Plan
2010 Medi-Cal Managed Care Weighted Average (76.1)
HEDIS 2010 rates reflect 2009 measurement year data.

Medi-Cal Managed Care
HEDIS 2010 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



[1] High Performance Level is HEDIS 2009 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2009 national Medicaid 25th Percentile.

Note: HEDIS 2010 rates reflect 2009 measurement year data.

Note: The figure above was updated to reflect a corrected rate for Kaiser Permanente (South) – San Diego. The plan identified an error in the reported rate, corrected the error, and obtained auditor approval. The weighted average was also recalculated using the corrected rate.

Summary of Results

The MCMC Program's weighted average for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure slightly decreased from 2009 to 2010. Despite this decrease, the MCMC Program's 2010 weighted average exceeded both the national Medicaid and commercial averages.

High and Low Performers

Six plans exceeded the established HPL, and four plans reported rates below the MPL in 2010. This is a slight increase from 2009, when only two plans reported rates below the MPL. This measure was part of the DHCS's auto-assignment program, which may have contributed to the consistent performance among plans.

Two plans showed statistically significant improvement over their 2009 rates, while three plans showed statistically significant decreases from 2009 to 2010.

The COHS model type outperformed the GMC and Two-Plan model types.

Best Practices

Plans have implemented several successful interventions to increase well-child visits. Successful in this context means a plan achieved sustained improvement of at least two years over the baseline year. The most effective interventions are those that target specific barriers and target both members and providers. Evidence-based best practices that plans and provider can implement to increase performance on well-child visits include the following.

Improve Access

Open access appointments can increase compliance by expanding provider availability.[145] Provider evening or weekend clinic hours can accommodate parents who cannot take time off from work. For example, one Saturday a month could be set aside for children and adolescents, with clinicians designated to perform well-child visits on that day. Visits on certain days could be made available on a walk-in, first-come, first-serve basis. Additionally, providers should encourage parents to schedule their next visit before leaving the clinic. Providing improved access to transportation also may increase well-child visit compliance.

[145] O'Connor ME, Matthews BS, Gao D. Effect of Open Access Scheduling on Missed Appointments, Immunizations, and Continuity of Care for Infant Well-Child Care Visits. *Archives of Pediatrics & Adolescent Medicine.* 2006; 160: 889-893.

Reminder Systems

Postcards are an easy and effective tool for increasing well-child visits. Plans or providers can send postcards to parents as a reminder to schedule their child's well-child visit. To be most effective, postcards should include contact information for either doctors' offices near the member's address or the member's assigned PCP. In addition, age-specific forms that detail what services should be provided and why they are important to the well-being of the child can help educate parents.

Physician Education

Quarterly provider reports that highlight children and adolescents in need of well-child visits are useful for promoting visit reminders and helping providers track their performance. Members who saw a doctor but did not have a well-child visit can be flagged as missed opportunities. To make this information pertinent to providers, their performance may be tied to a recognition program for providers who display outstanding performance. Another practice that can improve compliance is to educate providers on proper billing codes for well-child visits, which can improve data capture of well-child visits provided.

The DHCS contracts with three specialty plans and one prepaid health plan (PHP). These plans are required to report annual scores for two performance measures. DHCS chooses these performance measures in collaboration with each plan as appropriate for each plan's Medi-Cal managed care population. This section includes results from the specialty plans' and PHP 2010 performance measures, which reflect data from January 1, 2009, to December 31, 2009. As each specialty plan/PHP provides unique services relevant to its population, HSAG includes local and national benchmarks as available.

AHF Healthcare Centers

AHF Healthcare Centers is a Medi-Cal managed care specialty plan operating in Los Angeles County and providing services primarily to members living with HIV or acquired immunodeficiency syndrome (AIDS). Some of the plan's members are dual eligible (covered by both Medicare and Medi-Cal). The plan has been previously referred to as AIDS Healthcare Centers or Positive Healthcare.

AHF Healthcare Centers' 2010 performance measures were the HEDIS measures *Adults' Access to Preventive/Ambulatory Health Services* and *Colorectal Cancer Screening*.

Adults' Access to Preventive/Ambulatory Health Services

Measure Definition

The *Adults' Access to Preventive/Ambulatory Health Services* measure calculates the percentage of adults 20 years and older who had an ambulatory or preventive care visit during the measurement year. For this measure, rates are reported for three age groups: 20 to 44 years, 45 to 64 years, and 65 years and older.

Importance

Preventive care can significantly and positively affect many causes of disease and death. Ongoing monitoring and preventive care is particularly important for individuals with HIV or AIDS. A five-year study of adults in a national survey showed that those who had a primary care physician

as their regular source of care had one-third lower costs and were 19 percent less likely to die.[202] However, to realize these benefits, people must have access to effective services. A shortage of health care providers or facilities is a basic limitation that may impact access, but other factors such as lack of adequate health insurance, cultural and language differences, and lack of knowledge or education can also limit access. Lack of a usual source of medical care can also be a barrier to accessing health care. In 2006-2007, about 18 percent of U.S. adults 18 to 64 years of age did not have a usual source of health care.[203]

Performance Results

Table 6.1—HEDIS 2010 Rates for AHF Healthcare Centers

Adults' Access to Preventive/Ambulatory Health Services*			
	20-44 Years	45-64 Years	65+ Years
Rate	**98.0%**	**100.0%**	**NA**
HPL	88.4%	91.1%	93.7%
MPL	77.3%	83.9%	81.2%

Summary of Results

AHF Healthcare Centers exceeded the HPL for the two reportable age groups for this measure in 2010. In addition, the plan showed statistically significant improvement from 2009 to 2010 for the 45 to 64 years age group.

A rate of NA was assigned to the 65 years and older age group since the denominator was too small(less than 30) to report a valid rate.

Colorectal Cancer Screening

Measure Definition

The *Colorectal Cancer Screening* measure calculates the percentage of adults 50 to 75 years of age who had appropriate screening for colorectal cancer.

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[202] Starfield B, Shi L. The Medical Home, Access to Care, and Insurance: A Review of Evidence. *Pediatrics*. 2004; 113(5): 1493-1498. Available at: http://pediatrics.aappublications.org/cgi/content/full/113/5/S1/1493. Accessed on: June 23, 2010.

[203] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. *Health, United States, 2009*. Atlanta, GA: DHHS; 2010.

Importance

The American Cancer Society estimates that colon cancer will be the third-leading cancer site for new cases diagnosed in 2009 and will account for an estimated 9 percent of all cancer-related deaths in the United States in 2009 for both men and women.[204]

Colon cancer screening can result in the detection and removal of colorectal polyps before they become cancerous, as well as detect cancer at an early stage. Colon cancer screening reduces death by decreasing the incidence of colorectal cancers and by detecting a higher proportion of cancers at early, more treatable stages.[205] A 2006 study concluded that people infected with HIV are more likely to have colon cancer and should be routinely screened.[206]

Performance Results

Table 6.2—HEDIS 2010 Rates for AHF Healthcare Centers

	Colorectal Cancer Screening
Rate	**64.2%**
HPL	69.6%
MPL	52.1%

*The MPL and HPL for this measure is the 2009 national commercial 25th and 90th percentile, respectively, since no Medicaid benchmark exists for this measure.

Summary of Results

AHF Healthcare Centers performed above the MPL, but below the HPL for this measure in 2010. The DHCS based the MPL and HPL on the 2009 national commercial 25th and 90th percentiles, respectively, since no Medicaid benchmark exists for this measure.

Family Mosaic Project

The Family Mosaic Project (FMP), operated by the City and County of San Francisco Department of Public Health, is a specialty managed care plan in San Francisco County. FMP became operational with the Medi-Cal managed care program in February 1993.

FMP is part of the Child, Youth & Family System of Care operated by the City and County of San Francisco Department of Public Health, Community Behavioral Health Services. FMP provides Medi-Cal managed care children and adolescents at risk for out-of-home placement with intensive

[204] American Cancer Society. *Cancer Facts & Figures 2009*. Atlanta, GA: American Cancer Society; 2009.
[205] American Cancer Society. *Cancer Facts & Figures 2009*. Atlanta, GA: American Cancer Society; 2009.
[206] Bini EJ, Park J, Francois F, et al. Use of Flexible Sigmoidoscopy to Screen for Colorectal Cancer in HIV-Infected Patients 50 Years of Age and Older. *Archives of Internal Medicine*. 2006; 166(15):1626-1631.

case management and wrap-around services through a capitation agreement. To receive services in the Medi-Cal managed care program, a member must meet specific enrollment criteria, including being a San Francisco resident between 3 and 18 years of age, having serious mental health care needs, and being at imminent risk of out-of-home placement or already in an out-of-home placement. FMP submits appropriate clients to the DHCS for approval to be enrolled in FMP's Medi-Cal managed care program. Once a client is approved and under its contract with the DHCS, FMP receives a per-member, per-month capitated rate to provide mental health and related wraparound services to these members.

Due to the unique services FMP provides, standardized HEDIS measures were not appropriate. FMP, with consultation from HSAG, developed two performance measures for 2010 reporting.

Mental Health Utilization

Measure Definition

The percentage of members enrolled into Family Mosaic Project with one or more acute, mental health inpatient hospitalizations during the measurement year. For this measure, a lower rate indicates better performance.

Importance

A goal of FMP is to reduce the number of psychiatric hospitalizations by providing the mental health services and family supports needed to avert crises that land children and youth in the hospital. Maintaining members in an outpatient setting and avoiding acute, inpatient is one indicator that can be used to determine the effectiveness of FMP's case-management and wrap-around services.

Performance Results

Table 6.3—2010 Performance Measure Rates for FMP

	Inpatient Hospitalization–1 Admission*	Inpatient Hospitalizations–2 Admissions*	Inpatient Hospitalizations–3+ Admissions*
Rate	**1.4%**	**0.9%**	**0.0%**

*There are no MPLs or HPLs for these measures.

Summary of Results

This is the first year FMP reported rates for these measures in 2010. Additional analysis of performance measure results will be provided in subsequent years when more than one year of data are available for comparison.

Out-of-Home Placements

Measure Definition

The percentage of members enrolled into Family Mosaic Project who were discharged to an out-of-home placement (foster care, group home, residential treatment facilities) during the measurement period.

Importance

Research has shown adverse effects on the health and well-being of children and adolescents who were placed out-of-home in foster care, group home and residential treatment facilities, as well as community treatment facilities.[207] Out-of-home placements can be overly restrictive and contribute to behavioral health deterioration. Ensuring that members are maintained in a home-like setting is one goal of FMP.

Performance Results

Table 6.4—2010 Performance Measure Rate for FMP

	Out-of-Home Placements*
Rate	**13.6%**

*There is no MPL or HPL for this measure.

Summary of Results

The rate of out-of-home placements was 13.6 percent in 2010. Additional analysis of performance measure results will be provided in subsequent years when more than one year of data are available for comparison.

[207] Family Mosaic Project. Quality Improvement Project, Reducing the Rate of Out-of-Home Placements, 2010 submission.

Kaiser Prepaid Health Plan (PHP)

Kaiser Prepaid Health Plan for Marin and Sonoma counties, is a managed care plan contracted with the MCMC Program as KP Cal Marin/Sonoma ("Kaiser PHP-Marin and Sonoma counties"). The plan provides medical services similar to full-scope plans, but the DHCS applies specialty plan requirements to the PHP based on the plan's small population.

The plan became operational with the MCMC Program in 1992 in both Marin and Sonoma counties.

Kaiser PHP's performance measures were the HEDIS measures *Appropriate Testing for Children With Pharyngitis* and *Appropriate Treatment for Children With Upper Respiratory Infection.*

Appropriate Testing for Children With Pharyngitis

Measure Definition

The *Appropriate Testing for Children With Pharyngitis* measure reports the percentage of enrolled members 2 to 18 years of age during the measurement year who were diagnosed with pharyngitis, prescribed an antibiotic, and received a Group A strep test for the episode.

Importance

Pharyngitis (i.e., sore throat) occurs most commonly in children between 5 and 18 years of age. Pharyngitis is caused primarily by one of two types of infections: 1) a viral upper respiratory tract infection or 2) a group A strep bacterial infection (i.e., strep throat). Approximately 40 to 60 percent of pharyngitis cases are caused by a virus, and about 15 percent are associated with *Streptococcus* infection.[208] Determining the cause of pharyngitis is important since antibiotics are ineffective against viral infections, and viral infections are the cause for most episodes of pharyngitis.[209] However, in the Medicaid population, the average testing rate is only 61.4 percent compared to the commercial population rate of 75.6 percent.[210]

Furthermore, the overuse of antibiotics can increase the number of drug-resistant forms of bacteria, which can be very difficult to treat. In one study, four in 10 physicians reported that they would begin antibiotic treatment for children with pharyngitis before knowing the results of a test for strep throat and would continue with treatment even if the strep test was negative.

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[208] Pulmonology Channel. Pharyngitis. Available at: http://www.pulmonologychannel.com/pharyngitis/. Accessed on: August 26, 2010.

[209] Dowell SF, Schwartz B, Phillips WR, et al. Appropriate Use of Antibiotics for URIs in Children: Part II. Cough, Pharyngitis and the Common Cold. *American Family Physician.* 1998. Available at: http://www.aafp.org/afp/981015ap/dowell.html. Accessed on: April 13, 2010.

[210] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.

Furthermore, for 36 percent of patients who received antibiotics and received a strep throat test, the test result was negative (i.e., antibiotics were not the appropriate treatment).[211]

Since most episodes of pharyngitis are not strep throat, antibiotic therapy results in substantial overtreatment. Additionally, children also can have an adverse reaction to antibiotics: 2 percent will have a mild adverse reaction, 6 in 1,000 will have a severe adverse reaction, and 1 in 100,000 will have a fatal adverse reaction.[212] The widespread availability of accurate, inexpensive diagnostic tests for strep throat make testing children easy and cost-effective and offers an approach to avoid the overuse of antibiotics.[213] In fact, the testing of all children with pharyngitis is cheaper and safer than treating all children.[214]

Performance Results

Table 6.5—HEDIS 2010 Rates for Kaiser PHP

	Appropriate Testing for Children With Pharyngitis
Rate	**80.0%**
HPL	82.0%
MPL	53.6%

Summary of Results

Kaiser PHP performed above the MPL and just below the HPL for this measure in 2010.

Appropriate Treatment for Children With Upper Respiratory Infection

Measure Definition

The *Appropriate Treatment for Children With Upper Respiratory Infection* measure reports the percentage of enrolled members 3 months to 18 years of age who were given a diagnosis of URI and who were not dispensed an antibiotic prescription on or three days after the episode date.

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211 Dowell SF, Schwartz B, Phillips WR, et al. Appropriate Use of Antibiotics for URIs in Children: Part II. Cough, Pharyngitis and the Common Cold. *American Family Physician.* 1998. Available at: http://www.aafp.org/afp/981015ap/dowell.html. Accessed on: April 13, 2010.

212 Ibid.

213 Dowell SF, Schwartz B, Phillips WR, et al. Appropriate Use of Antibiotics for URIs in Children: Part II. Cough, Pharyngitis and the Common Cold. *American Family Physician.* 1998. Available at: http://www.aafp.org/afp/981015ap/ dowell.html. Accessed on: April 13, 2010.

214 National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.

Importance

Antibiotic overuse in children has become a common problem, aggravated by parental pressure for antibiotics.[215] As a result, many bacterial infections are becoming resistant to antibiotics, creating a lack of effective treatment for these infections and making it harder and harder to treat patients.

According to the National Center for Health Statistics (NCHS), approximately 75 percent of antibiotics prescribed in the ambulatory setting are for the treatment of five respiratory infections, one of which is URI.[216] The use of antimicrobial drugs is highest among children; therefore, the pediatric age group is the initial focus of inappropriate antibiotic use.[217] Since the origin of most URIs is viral, the prescribing of antibiotics for the treatment of a majority of URIs is inappropriate. The use of antibiotics is only appropriate for URIs of bacterial origin such as acute otitis media, bacterial sinusitis, mucopurulent rhinitis with prolonged symptoms (i.e., at least 10 days of continual symptoms), and group A streptococcal (strep) pharyngitis (but only cases with a confirmatory test for group A strep).[218] In addition, excessive and frequent use of unnecessary antibiotics leads to increased incidence of allergic drug reactions with significant associated morbidity and mortality.

Although a majority of physicians realize that antimicrobial therapy will not hasten the resolution of a cold, antimicrobial agents are often prescribed in an attempt to prevent bacterial complications. However, data indicate that this is not an effective strategy and that antibiotics do not change the course or outcomes of URI.[219]

Performance Results

Table 6.6—HEDIS 2010 Rates for Kaiser PHP

	Appropriate Treatment for Children With URI
Rate	**95.6%**
HPL	94.5%
MPL	81.1%

[215] McCaig LF, Besser RE, Hughes JM. Trends in Antimicrobial Prescribing Rates for Children and Adolescents. *The Journal of the American Medical Association*. 2002; 287(23): 3096-3102.

[216] Gonzales R, Malone DC, Maselli JH, et al. Excessive Antibiotic Use for Acute Respiratory Infections in the United States. *Clinical Infectious Disease*. 2001; 33(6): 757-762.

[217] Dowell SF, Schwartz B, Phillips WR, et al. Appropriate Use of Antibiotics for URIs in Children: Part II. Cough, Pharyngitis and the Common Cold. *American Family Physician*. 1998. Available at: http://www.aafp.org/afp/981015ap/dowell.html. Accessed on: April 13, 2010.

[218] The Centers for Medicare & Medicaid Services. *2010 Physician Quality Reporting Initiative Measure Specifications Manual for Claims and Registry Reporting of Individual Measures*. Version 4.1.

[219] Dowell SF, Schwartz B, Phillips WR, et al. Appropriate Use of Antibiotics for URIs in Children: Part II. Cough, Pharyngitis and the Common Cold. *American Family Physician*. 1998. Available at: http://www.aafp.org/afp/981015ap/dowell.html. Accessed on: April 13, 2010.

Summary of Results

Kaiser PHP performed above both the MPL and HPL for this measure in 2010.

SCAN Health Plan

Senior Care Action Network Health Plan ("SCAN Health Plan," or "SCAN") is a not-for-profit that contracts with the DHCS as a specialty plan. SCAN is a Medicare Advantage Special Needs Plan that provides a full range of health care services for elderly members who are dually eligible under both the Medicare and Medi-Cal Programs residing in Los Angeles, Riverside, and San Bernardino counties.

SCAN provides a full range of health care services for elderly members who are dually eligible. The plan provides comprehensive medical coverage, prescription benefits and support services specifically designed for seniors with a goal to enhance the ability of plan members to manage their health and remain independent. SCAN has been licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act in California since November 30, 1984, and became operational in Los Angeles County with the MCMC Program in 1985. The plan expanded into Riverside and San Bernardino counties in 1997.

SCAN's 2010 performance measures were the HEDIS measures *Glaucoma Screening in Older Adults* and *Persistence of Beta-Blocker Treatment After a Heart Attack*.

Glaucoma Screening in Older Adults

Measure Definition

The HEDIS *Glaucoma Screening in Older Adults* Medicare measure reports the percentage of members 65 years of age and older without a prior diagnosis of glaucoma who received an eye exam for glaucoma by an eye care professional.

Importance

Glaucoma is a group of diseases that results in irreversible damage to the optic nerve that carries information from the eye to the brain. Glaucoma, if untreated, leads to blindness. According to the Agency for Healthcare Research and Quality (AHRQ), more than 2 million Americans 40 years of age and older have glaucoma; however, many are unaware that they have the disease since vision loss is unnoticeable in early stages. Screening for glaucoma is important for early detection and treatment to prevent and delay damage.[220]

[220] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C: NCQA; 2009.

Performance Results

Table 6.7—HEDIS 2010 Rates for SCAN Health Plan

	Glaucoma Screening in Older Adults*
Rate	**75.2%**
HPL	76.6%
MPL	50.6%

*The MPL and HPL for this measure is the 2009 national Medicare 25th and 90th percentile, respectively, since no Medicaid benchmark exists for this measure.

Summary of Results

SCAN Health Plan performed above the established MPL, but below the HPL for this measure in 2010. The DHCS based the MPL and HPL on the 2009 Medicare 25th and 90th percentiles, since no Medicaid benchmark exists for this measure. In addition, the plan showed statistically significant improvement from 2009 to 2010.

Persistence of Beta-Blocker Treatment After a Heart Attack

Measure Definition

The *Persistence of Beta-Blocker Treatment After a Heart Attack* HEDIS measure reports the percentage of members 18 years of age and older who were hospitalized and discharged with a diagnosis of acute myocardial infarction (heart attack) and who received persistent beta-blocker treatment for six months after discharge.

Importance

Over 8 million adults have a history of myocardial infarctions, or heart attacks, and almost 1 million new and recurrent heart attacks occur in the United States annually, resulting in 450,000 deaths. The American Heart Association and the American College of Cardiology strongly recommend treatment using beta-blockers to reduce death during acute and long-term management of a heart attack.[221]

[221] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C: NCQA; 2009.

Performance Results

Table 6.8—HEDIS 2010 Rates for SCAN Health Plan

	Persistence of Beta-Blocker Treatment After a Heart Attack
Rate	**NA**
HPL	85.0%
MPL	67.7%

Summary of Results

A rate of NA was assigned to this measure since the denominator was too small (less than 30) to report a valid rate. Based on 2009 and 2010 performance measure results, HSAG recommends that the plan and the DHCS explore another measure that is meaningful for this plan's population and will provide the sufficient number of MCMC members to report a valid rate.

Table A.1—National HEDIS 2009 Medicaid Percentiles

Table A.1 National HEDIS 2009 Medicaid Percentiles					
Measure	**10th Percentile**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**90th Percentile**
Adolescent Well-Care Visits	32.8%	37.9%	45.1%	53.2%	59.4%
Appropriate Treatment for Children With Upper Respiratory Infection	78.1%	81.1%	85.6%	91.1%	94.5%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	17.7%	20.2%	23.7%	28.1%	33.4%
Breast Cancer Screening	38.6%	45.0%	50.5%	57.4%	63.0%
Cervical Cancer Screening	52.1%	60.9%	67.6%	73.2%	79.5%
Childhood Immunization Status—Combination 3	50.9%	62.4%	71.8%	76.4%	80.6%
Comprehensive Diabetes Care—HbA1c Testing	69.8%	76.5%	80.7%	86.2%	89.3%
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)*	29.2%	35.2%	42.6%	50.6%	61.0%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	27.8%	37.5%	45.6%	52.5%	60.1%
Comprehensive Diabetes Care—LDL-C Screening	62.7%	71.5%	76.1%	79.5%	82.5%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	21.3%	27.2%	35.1%	40.6%	44.7%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	33.3%	44.4%	55.4%	62.3%	70.8%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	64.5%	73.4%	78.1%	82.2%	85.4%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	37.5%	52.3%	61.1%	66.4%	71.2%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	67.9%	78.5%	85.6%	89.4%	92.2%
Prenatal and Postpartum Care—Postpartum Care	50.3%	57.9%	63.9%	68.4%	72.7%
Use of Imaging Studies for Low Back Pain	69.6%	72.7%	76.2%	79.7%	81.6%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	0.1%	2.6%	16.9%	34.1%	47.4%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	0.3%	7.7%	40.5%	53.0%	64.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	0.0%	0.1%	29.8%	39.7%	51.6%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	57.5%	64.0%	70.4%	75.9%	80.3%

*For this measure, a lower rate indicates better performance.

Source: NCQA. Medicaid HEDIS 2009 Audit Means, Percentiles, and Ratios.

Tables B.1 through B.41 provide three-year trending information for each plan across the reported measures. The following audit findings are provided within the table:

– = A year that data was not collected.

NR = A *Not Report* audit finding. The rate could not be publically reported because it was either materially biased or the plan chose not to report the result.

NA = A *Not Applicable* audit finding because the plan's denominator was too small.

Within Tables B.1 through B.41, HSAG calculated statistical significance testing between the 2009 and 2010 rates for each measure using a chi-square test and displayed this information within the "2009–2010 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2010 were significantly higher than they were in 2009.

↓ = Rates in 2010 were significantly lower than they were in 2009.

↔ = Rates in 2010 were not significantly different than they were in 2009.

Different symbols (▲ ▼) are used to indicate a performance change for *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2010 rate from the 2009 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2010 rate from the 2009 rate.

Not comparable = A 2009–2010 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Table B.1 Alameda Alliance for Health—Alameda HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	45.3%	44.8%	38.7%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	94.9%	90.6%	94.9%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	25.9%	23.3%	29.8%	↔
Breast Cancer Screening	50.2%	45.2%	59.6%	↑
Cervical Cancer Screening	72.5%	69.6%	62.1%	↓
Childhood Immunization Status—Combination 3	70.6%	79.0%	71.3%	↓
Comprehensive Diabetes Care—HbA1c Testing	73.5%	74.6%	77.5%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	48.9%	54.4%	54.3%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	36.9%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	71.3%	76.1%	70.3%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	24.8%	35.4%	29.5%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	NR	31.4%	25.5%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.2%	81.0%	72.2%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	57.1%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	74.0%	69.2%	60.5%	↓
Prenatal and Postpartum Care—Postpartum Care	57.7%	60.3%	50.9%	↓
Use of Imaging Studies for Low Back Pain	—	—	87.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	37.0%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	83.8%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	60.4%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.5%	71.3%	69.9%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.2 Anthem Blue Cross—Alameda HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	34.0%	34.0%	26.5%	↓
Appropriate Treatment for Children With Upper Respiratory Infection	93.4%	93.6%	92.5%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	36.9%	33.8%	32.0%	↔
Breast Cancer Screening	38.3%	41.1%	47.3%	↑
Cervical Cancer Screening	63.7%	60.0%	61.6%	↔
Childhood Immunization Status—Combination 3	52.5%	64.1%	54.3%	↓
Comprehensive Diabetes Care—HbA1c Testing	71.2%	69.1%	72.5%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	64.7%	62.9%	33.8%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	34.5%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	67.4%	64.8%	63.7%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	17.2%	24.6%	22.1%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.8%	45.6%	32.4%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	58.1%	62.4%	65.9%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	40.1%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	70.4%	76.8%	75.9%	↔
Prenatal and Postpartum Care—Postpartum Care	48.8%	49.7%	43.3%	↔
Use of Imaging Studies for Low Back Pain	—	—	86.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	23.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	33.3%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	20.4%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.5%	58.2%	54.0%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.3 Anthem Blue Cross—Contra Costa HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	28.2%	29.2%	21.2%	↓
Appropriate Treatment for Children With Upper Respiratory Infection	88.8%	88.7%	91.2%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	NA	36.6%	42.9%	↔
Breast Cancer Screening	35.9%	38.6%	42.9%	↔
Cervical Cancer Screening	54.5%	55.5%	55.0%	↔
Childhood Immunization Status—Combination 3	48.8%	62.8%	48.9%	↓
Comprehensive Diabetes Care—HbA1c Testing	72.5%	71.1%	66.7%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	60.0%	71.1%	34.3%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	25.9%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	56.3%	65.6%	63.9%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	21.3%	30.0%	19.4%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.8%	43.3%	23.1%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	63.8%	65.6%	63.0%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	39.8%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	72.1%	79.3%	66.1%	↓
Prenatal and Postpartum Care—Postpartum Care	51.9%	47.1%	28.8%	↓
Use of Imaging Studies for Low Back Pain	—	—	82.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	33.8%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	36.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	29.2%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	58.6%	55.7%	37.0%	↓

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.4 Anthem Blue Cross—Fresno HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	44.2%	38.2%	40.9%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	86.2%	87.3%	87.1%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	35.2%	34.8%	32.3%	↔
Breast Cancer Screening	45.7%	45.1%	40.8%	↓
Cervical Cancer Screening	70.6%	73.9%	65.9%	↓
Childhood Immunization Status—Combination 3	65.5%	73.6%	66.2%	↓
Comprehensive Diabetes Care—HbA1c Testing	81.1%	85.2%	76.9%	↓
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	59.6%	46.0%	29.2%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	38.7%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	73.5%	77.9%	75.7%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	20.8%	27.9%	28.2%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.1%	57.4%	41.4%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.5%	79.8%	76.9%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	56.7%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.2%	85.7%	85.2%	↔
Prenatal and Postpartum Care—Postpartum Care	67.1%	58.5%	55.7%	↔
Use of Imaging Studies for Low Back Pain	—	—	82.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	51.3%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	61.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	39.9%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.9%	73.8%	69.3%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.5 Anthem Blue Cross—Sacramento HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	36.6%	34.3%	36.5%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	91.5%	92.2%	93.8%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	27.7%	25.2%	30.9%	↔
Breast Cancer Screening	45.5%	43.2%	38.4%	↓
Cervical Cancer Screening	67.3%	64.5%	58.4%	↔
Childhood Immunization Status—Combination 3	63.9%	56.3%	53.0%	↔
Comprehensive Diabetes Care—HbA1c Testing	71.2%	72.5%	71.8%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	47.0%	59.4%	47.7%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	45.7%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	66.6%	67.5%	65.0%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	21.1%	22.6%	22.9%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.9%	43.1%	30.9%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	67.3%	72.4%	63.3%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	50.4%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	81.5%	74.7%	71.8%	↔
Prenatal and Postpartum Care—Postpartum Care	51.2%	55.3%	52.1%	↔
Use of Imaging Studies for Low Back Pain	—	—	83.9%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	33.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	42.3%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	27.5%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.5%	71.9%	70.3%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.6 Anthem Blue Cross—San Francisco HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	53.2%	53.6%	53.8%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	94.7%	95.4%	95.3%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	46.6%	42.5%	52.1%	↔
Breast Cancer Screening	57.3%	59.5%	60.3%	↔
Cervical Cancer Screening	69.2%	71.9%	70.1%	↔
Childhood Immunization Status—Combination 3	79.5%	75.9%	75.2%	↔
Comprehensive Diabetes Care—HbA1c Testing	80.8%	81.4%	84.3%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	35.5%	42.7%	18.6%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	56.7%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	78.3%	70.4%	77.1%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.5%	26.6%	35.7%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	56.7%	61.3%	46.7%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.9%	80.4%	82.9%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	68.6%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.4%	82.6%	90.4%	↑
Prenatal and Postpartum Care—Postpartum Care	63.0%	54.4%	57.4%	↔
Use of Imaging Studies for Low Back Pain	—	—	77.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	59.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	69.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	52.1%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	85.2%	78.7%	81.5%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.7 Anthem Blue Cross—San Joaquin HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	41.2%	41.7%	41.4%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	86.3%	82.1%	84.7%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	18.8%	18.4%	21.5%	↔
Breast Cancer Screening	45.6%	45.1%	47.1%	↔
Cervical Cancer Screening	60.6%	61.6%	58.9%	↔
Childhood Immunization Status—Combination 3	68.1%	68.3%	69.1%	↔
Comprehensive Diabetes Care—HbA1c Testing	74.9%	71.9%	75.0%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	53.6%	68.3%	34.2%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	34.4%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	69.5%	73.0%	72.8%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.0%	19.7%	24.0%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.5%	50.0%	36.1%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.6%	73.8%	75.7%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	50.7%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	78.7%	77.7%	84.9%	↑
Prenatal and Postpartum Care—Postpartum Care	47.6%	52.4%	48.9%	↔
Use of Imaging Studies for Low Back Pain	—	—	79.8%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	55.5%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	60.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	20.2%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.7%	75.7%	78.3%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.8 Anthem Blue Cross—Santa Clara HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	41.0%	39.7%	48.7%	↑
Appropriate Treatment for Children With Upper Respiratory Infection	89.8%	90.5%	91.5%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	21.7%	24.1%	26.7%	↔
Breast Cancer Screening	64.7%	64.5%	69.6%	↑
Cervical Cancer Screening	70.1%	72.4%	71.3%	↔
Childhood Immunization Status—Combination 3	63.6%	48.1%	64.2%	↑
Comprehensive Diabetes Care—HbA1c Testing	80.3%	81.6%	81.3%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	50.7%	62.0%	22.6%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	50.1%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	77.5%	80.4%	81.8%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	27.3%	37.0%	36.0%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.3%	67.4%	53.5%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	71.3%	80.7%	78.1%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	66.4%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.1%	73.4%	79.1%	↔
Prenatal and Postpartum Care—Postpartum Care	50.2%	56.0%	55.5%	↔
Use of Imaging Studies for Low Back Pain	—	—	80.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	56.0%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	55.0%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	55.0%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.5%	69.1%	74.9%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.9 Anthem Blue Cross—Stanislaus HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	32.2%	22.1%	34.3%	↑
Appropriate Treatment for Children With Upper Respiratory Infection	89.8%	91.6%	92.0%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	20.0%	22.5%	22.0%	↔
Breast Cancer Screening	45.2%	48.1%	50.8%	↔
Cervical Cancer Screening	61.6%	64.8%	67.9%	↔
Childhood Immunization Status—Combination 3	62.7%	67.4%	65.2%	↔
Comprehensive Diabetes Care—HbA1c Testing	82.3%	77.9%	80.5%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	35.2%	47.0%	30.0%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	43.2%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	75.7%	77.2%	78.0%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.5%	35.1%	29.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.2%	48.7%	38.5%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	70.6%	73.6%	75.6%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	56.6%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.0%	83.1%	86.1%	↔
Prenatal and Postpartum Care—Postpartum Care	56.3%	53.8%	54.3%	↔
Use of Imaging Studies for Low Back Pain	—	—	81.5%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	34.5%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	40.9%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	20.2%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.0%	62.3%	66.7%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.10 Anthem Blue Cross—Tulare HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	40.0%	38.7%	29.9%	↓
Appropriate Treatment for Children With Upper Respiratory Infection	84.6%	83.9%	83.7%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	21.1%	24.4%	23.6%	↔
Breast Cancer Screening	53.4%	50.5%	51.2%	↔
Cervical Cancer Screening	75.0%	74.7%	71.0%	↔
Childhood Immunization Status—Combination 3	73.6%	72.5%	68.1%	↔
Comprehensive Diabetes Care—HbA1c Testing	82.2%	73.9%	76.6%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	42.5%	51.1%	27.3%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	43.1%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	77.8%	65.3%	72.5%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.8%	25.4%	29.4%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.0%	46.1%	27.7%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.7%	72.6%	74.7%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	63.5%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.8%	82.7%	74.0%	↓
Prenatal and Postpartum Care—Postpartum Care	68.3%	63.6%	46.5%	↓
Use of Imaging Studies for Low Back Pain	—	—	78.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	43.8%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	48.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	39.4%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.3%	70.8%	60.1%	↓

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.11 CalOptima—Orange HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	56.3%	56.3%	55.7%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	83.2%	84.9%	89.1%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	20.9%	24.1%	21.8%	↔
Breast Cancer Screening	55.2%	56.2%	58.0%	↑
Cervical Cancer Screening	70.1%	74.3%	71.7%	↔
Childhood Immunization Status—Combination 3	76.9%	79.1%	82.4%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.5%	83.2%	87.3%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	38.1%	40.3%	29.5%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	62.3%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	82.8%	81.2%	85.3%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.2%	36.1%	45.5%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.4%	66.0%	70.1%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.7%	82.2%	85.0%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	72.1%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.0%	76.7%	87.5%	↑
Prenatal and Postpartum Care—Postpartum Care	64.9%	58.3%	68.0%	↑
Use of Imaging Studies for Low Back Pain	—	—	77.8%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	68.3%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	75.2%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	63.9%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	83.9%	84.9%	86.1%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.12 Care 1st—San Diego HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	40.6%	40.9%	42.6%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	86.8%	91.3%	91.6%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	NA	NA	23.3%	Not Comparable
Breast Cancer Screening	NA	34.4%	48.7%	↔
Cervical Cancer Screening	58.9%	60.6%	68.4%	↑
Childhood Immunization Status—Combination 3	61.5%	76.4%	79.8%	↔
Comprehensive Diabetes Care—HbA1c Testing	NA	85.5%	81.4%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	NA	38.7%	39.8%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	46.9%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	NA	72.6%	77.9%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	NA	40.3%	47.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	NA	48.4%	51.3%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	NA	87.1%	82.3%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	69.9%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.2%	81.7%	86.5%	↔
Prenatal and Postpartum Care—Postpartum Care	63.2%	62.7%	60.0%	↔
Use of Imaging Studies for Low Back Pain	—	—	75.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	50.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	49.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	29.2%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.3%	68.4%	75.9%	↑

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.13 CenCal Health—San Luis Obispo HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	—	40.0%	36.3%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	—	89.2%	92.0%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	NA	55.7%	Not Comparable
Breast Cancer Screening	—	NA	NA	Not Comparable
Cervical Cancer Screening	—	63.2%	56.2%	↔
Childhood Immunization Status—Combination 3	—	NA	74.5%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	NA	79.2%	Not Comparable
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	—	NA	32.8%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	55.9%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	NA	77.6%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	NA	39.9%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	NA	69.4%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	NA	86.3%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	62.5%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	93.7%	84.7%	↓
Prenatal and Postpartum Care—Postpartum Care	—	73.1%	69.4%	↔
Use of Imaging Studies for Low Back Pain	—	—	86.9%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	33.2%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	50.8%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	20.0%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	68.8%	67.5%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.14 CenCal Health—Santa Barbara HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	35.9%	42.4%	41.0%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	78.2%	84.4%	90.4%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	46.7%	45.4%	60.3%	↑
Breast Cancer Screening	56.7%	57.4%	58.2%	↔
Cervical Cancer Screening	67.4%	67.4%	68.5%	↔
Childhood Immunization Status—Combination 3	84.6%	81.7%	81.7%	↔
Comprehensive Diabetes Care—HbA1c Testing	88.6%	84.2%	81.1%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	23.5%	29.5%	29.1%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	61.8%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	81.8%	81.0%	79.6%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.4%	48.8%	45.6%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	79.0%	79.9%	70.9%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.4%	77.5%	86.2%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	69.8%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.1%	80.4%	81.7%	↔
Prenatal and Postpartum Care—Postpartum Care	77.9%	76.6%	74.4%	↔
Use of Imaging Studies for Low Back Pain	—	—	87.8%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	55.0%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	65.9%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	11.6%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.7%	72.2%	73.3%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.15 Central CA Alliance for Health—Monterey/Santa Cruz HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	47.2%	39.9%	51.8%	↑
Appropriate Treatment for Children With Upper Respiratory Infection	94.5%	94.5%	95.5%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	34.1%	30.3%	24.3%	↓
Breast Cancer Screening	59.1%	62.0%	62.0%	↔
Cervical Cancer Screening	80.5%	68.8%	74.7%	↑
Childhood Immunization Status—Combination 3	75.7%	67.9%	81.5%	↑
Comprehensive Diabetes Care—HbA1c Testing	85.6%	80.3%	90.3%	↑
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	31.6%	36.3%	21.4%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	58.6%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	80.3%	77.2%	85.2%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.2%	36.1%	47.7%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	71.3%	51.8%	70.3%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.0%	76.6%	86.6%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	70.8%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.2%	77.9%	88.1%	↑
Prenatal and Postpartum Care—Postpartum Care	71.3%	71.8%	77.9%	↑
Use of Imaging Studies for Low Back Pain	—	—	82.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	50.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	58.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	34.1%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.1%	77.3%	82.5%	↑

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.16 Community Health Group—San Diego HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	36.0%	39.9%	37.0%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	84.0%	84.8%	90.3%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.2%	20.5%	23.2%	↔
Breast Cancer Screening	49.9%	52.1%	55.9%	↑
Cervical Cancer Screening	66.4%	65.9%	63.0%	↔
Childhood Immunization Status—Combination 3	64.2%	77.4%	72.3%	↔
Comprehensive Diabetes Care—HbA1c Testing	77.6%	79.8%	81.0%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	49.1%	48.5%	44.0%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	38.2%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	74.0%	77.7%	73.4%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.3%	37.4%	26.5%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	46.0%	46.6%	41.6%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.2%	73.4%	71.0%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	59.0%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	73.0%	76.4%	76.6%	↔
Prenatal and Postpartum Care—Postpartum Care	51.3%	54.3%	52.1%	↔
Use of Imaging Studies for Low Back Pain	—	—	79.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	38.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	44.8%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	34.5%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.7%	75.9%	74.9%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.17 Contra Costa Health Plan—Contra Costa HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	38.9%	47.4%	38.7%	↓
Appropriate Treatment for Children With Upper Respiratory Infection	91.9%	93.6%	92.8%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	37.5%	32.5%	31.9%	↔
Breast Cancer Screening	47.6%	43.7%	56.2%	↑
Cervical Cancer Screening	69.7%	67.9%	69.3%	↔
Childhood Immunization Status—Combination 3	80.0%	82.5%	77.1%	↔
Comprehensive Diabetes Care—HbA1c Testing	82.0%	83.0%	85.4%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	38.0%	42.2%	31.8%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	52.6%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	77.9%	79.4%	78.6%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	42.1%	42.2%	40.7%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.6%	53.5%	48.5%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.3%	82.3%	86.5%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	53.1%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.2%	83.5%	84.7%	↔
Prenatal and Postpartum Care—Postpartum Care	61.5%	68.1%	68.1%	↔
Use of Imaging Studies for Low Back Pain	—	—	87.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	18.5%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	49.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	38.4%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.5%	77.4%	74.7%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.18 Health Net—Fresno HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	48.0%	49.3%	50.9%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	87.1%	87.1%	88.4%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	31.9%	45.7%	33.2%	↓
Breast Cancer Screening	45.5%	47.8%	52.8%	↔
Cervical Cancer Screening	70.8%	69.9%	72.1%	↔
Childhood Immunization Status—Combination 3	66.2%	77.4%	79.9%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.2%	85.2%	85.9%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	39.3%	39.9%	36.8%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	51.0%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	78.9%	79.2%	80.6%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.0%	34.2%	35.9%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.9%	64.8%	63.4%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.8%	77.3%	78.2%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	65.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.7%	90.2%	96.1%	↑
Prenatal and Postpartum Care—Postpartum Care	60.4%	62.3%	69.7%	↑
Use of Imaging Studies for Low Back Pain	—	—	84.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	56.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	70.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	40.7%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	83.4%	85.3%	86.0%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.19 Health Net—Kern HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	31.9%	39.3%	32.4%	↓
Appropriate Treatment for Children With Upper Respiratory Infection	74.2%	77.7%	78.4%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	22.8%	21.4%	17.6%	↔
Breast Cancer Screening	39.5%	44.5%	43.5%	↔
Cervical Cancer Screening	63.6%	64.3%	66.2%	↔
Childhood Immunization Status—Combination 3	65.7%	65.6%	66.2%	↔
Comprehensive Diabetes Care—HbA1c Testing	79.6%	80.3%	83.3%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	43.9%	43.9%	39.8%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	49.1%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	73.4%	76.6%	81.4%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.0%	37.1%	38.1%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	58.6%	54.8%	54.0%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.2%	82.3%	87.2%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	58.4%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.0%	87.4%	85.5%	↔
Prenatal and Postpartum Care—Postpartum Care	61.3%	59.7%	61.5%	↔
Use of Imaging Studies for Low Back Pain	—	—	79.0%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	49.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	59.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	23.8%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.4%	66.8%	66.3%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.20 Health Net—Los Angeles HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	35.7%	38.4%	40.1%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	78.7%	80.3%	83.8%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	29.9%	29.2%	31.0%	↔
Breast Cancer Screening	43.6%	49.2%	52.3%	↑
Cervical Cancer Screening	71.7%	73.2%	75.4%	↔
Childhood Immunization Status—Combination 3	71.5%	77.2%	73.1%	↔
Comprehensive Diabetes Care—HbA1c Testing	82.4%	84.7%	86.8%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	45.0%	40.9%	39.0%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	50.2%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	78.5%	80.2%	81.6%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.1%	36.5%	36.4%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	59.7%	64.4%	64.6%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.7%	82.5%	82.1%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	61.7%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.6%	83.0%	85.3%	↔
Prenatal and Postpartum Care—Postpartum Care	53.7%	56.2%	58.1%	↔
Use of Imaging Studies for Low Back Pain	—	—	77.8%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	62.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	73.3%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	46.7%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.8%	78.6%	77.2%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.21 Health Net—Sacramento HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	46.6%	46.7%	39.6%	↓
Appropriate Treatment for Children With Upper Respiratory Infection	79.0%	80.0%	84.3%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	27.6%	21.7%	22.3%	↔
Breast Cancer Screening	38.9%	44.6%	46.3%	↔
Cervical Cancer Screening	67.7%	65.1%	66.8%	↔
Childhood Immunization Status—Combination 3	70.1%	66.0%	63.3%	↔
Comprehensive Diabetes Care—HbA1c Testing	80.8%	81.3%	79.8%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	46.2%	38.4%	39.7%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	49.9%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	72.0%	75.8%	74.9%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	26.8%	33.5%	34.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	56.6%	57.9%	53.8%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.0%	79.9%	81.3%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	64.7%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.1%	84.9%	85.7%	↔
Prenatal and Postpartum Care—Postpartum Care	55.8%	57.0%	66.4%	↑
Use of Imaging Studies for Low Back Pain	—	—	85.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	62.8%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	67.0%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	33.0%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.5%	73.6%	79.2%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.22 Health Net—San Diego HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	41.7%	37.1%	32.1%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	90.9%	93.0%	93.7%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.6%	31.7%	24.8%	↔
Breast Cancer Screening	46.6%	45.3%	44.2%	↔
Cervical Cancer Screening	69.1%	60.6%	68.2%	↑
Childhood Immunization Status—Combination 3	73.9%	75.5%	75.3%	↔
Comprehensive Diabetes Care—HbA1c Testing	87.6%	89.6%	88.7%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	36.0%	36.0%	39.1%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	51.6%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	80.1%	83.7%	80.7%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	41.9%	52.6%	38.0%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	54.3%	60.2%	65.2%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.3%	85.1%	83.6%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	64.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.0%	88.5%	93.6%	↑
Prenatal and Postpartum Care—Postpartum Care	58.8%	58.5%	65.9%	↑
Use of Imaging Studies for Low Back Pain	—	—	78.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	56.0%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	64.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	36.1%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.0%	67.6%	68.4%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.23 Health Net—Stanislaus HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	36.0%	36.6%	31.5%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	90.3%	89.4%	90.1%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	19.8%	20.5%	26.5%	↔
Breast Cancer Screening	52.7%	48.4%	52.2%	↔
Cervical Cancer Screening	61.0%	65.1%	68.9%	↔
Childhood Immunization Status—Combination 3	67.8%	74.6%	67.1%	↓
Comprehensive Diabetes Care—HbA1c Testing	77.7%	85.4%	86.5%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	44.9%	31.3%	29.0%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	60.1%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	74.5%	78.0%	79.5%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.4%	34.0%	38.6%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	55.1%	60.8%	57.1%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.9%	81.3%	81.8%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	68.6%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.1%	90.9%	92.3%	↔
Prenatal and Postpartum Care—Postpartum Care	65.3%	66.3%	54.9%	↓
Use of Imaging Studies for Low Back Pain	—	—	85.5%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	40.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	50.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	19.5%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.3%	73.2%	74.9%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.24 Health Net—Tulare HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	35.3%	36.5%	35.2%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	83.4%	84.0%	84.3%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.4%	25.6%	26.7%	↔
Breast Cancer Screening	44.7%	41.5%	46.7%	↔
Cervical Cancer Screening	71.4%	71.1%	72.0%	↔
Childhood Immunization Status—Combination 3	77.8%	76.1%	76.5%	↔
Comprehensive Diabetes Care—HbA1c Testing	85.1%	86.4%	85.2%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	39.2%	37.9%	42.7%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	48.5%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	76.6%	79.6%	77.0%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	27.5%	31.5%	29.4%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.4%	69.8%	66.3%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.9%	85.1%	84.0%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	68.6%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	92.7%	91.1%	93.0%	↔
Prenatal and Postpartum Care—Postpartum Care	64.0%	65.0%	63.1%	↔
Use of Imaging Studies for Low Back Pain	—	—	82.9%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	53.0%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	56.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	28.8%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.0%	79.3%	76.3%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.25 Health Plan of San Joaquin—San Joaquin HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	44.8%	53.8%	51.1%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	77.0%	82.5%	85.5%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.3%	23.3%	24.6%	↔
Breast Cancer Screening	55.8%	55.4%	58.0%	↔
Cervical Cancer Screening	68.1%	67.6%	65.5%	↔
Childhood Immunization Status—Combination 3	72.0%	74.7%	74.0%	↔
Comprehensive Diabetes Care—HbA1c Testing	80.8%	79.0%	77.6%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	47.2%	42.7%	44.5%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	46.7%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	78.1%	77.2%	77.6%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.8%	30.7%	30.2%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.4%	58.9%	52.1%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.3%	77.4%	74.9%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	66.2%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.5%	83.2%	81.0%	↔
Prenatal and Postpartum Care—Postpartum Care	63.7%	60.8%	62.8%	↔
Use of Imaging Studies for Low Back Pain	—	—	74.5%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	62.3%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	60.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	41.8%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.0%	83.9%	82.2%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.26 Health Plan of San Mateo—San Mateo HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	34.8%	41.6%	43.8%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	91.4%	89.0%	89.7%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.2%	26.4%	33.5%	↔
Breast Cancer Screening	56.2%	55.9%	57.0%	↔
Cervical Cancer Screening	60.4%	58.7%	62.6%	↔
Childhood Immunization Status—Combination 3	76.6%	79.1%	87.3%	↑
Comprehensive Diabetes Care—HbA1c Testing	80.9%	83.9%	86.6%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	49.1%	43.1%	35.8%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	56.9%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	74.8%	79.4%	80.5%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	31.3%	42.7%	45.0%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.1%	59.7%	60.3%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.0%	85.2%	85.4%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	62.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	78.0%	77.5%	85.3%	↑
Prenatal and Postpartum Care—Postpartum Care	54.3%	60.1%	63.5%	↔
Use of Imaging Studies for Low Back Pain	—	—	86.5%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	59.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	67.9%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	56.7%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.4%	72.8%	70.7%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.27 Inland Empire Health Plan—Riverside/San Bernardino HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	38.4%	40.0%	45.1%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	80.8%	85.7%	88.0%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	27.1%	29.9%	26.3%	↓
Breast Cancer Screening	50.0%	49.0%	50.6%	↑
Cervical Cancer Screening	66.9%	61.9%	69.6%	↑
Childhood Immunization Status—Combination 3	69.0%	69.7%	70.1%	↔
Comprehensive Diabetes Care—HbA1c Testing	80.1%	80.2%	79.4%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	43.2%	46.9%	45.3%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	45.9%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	80.8%	79.5%	79.4%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	35.7%	36.9%	36.0%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	54.9%	50.2%	52.6%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	88.3%	78.7%	81.0%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	71.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.9%	84.5%	86.7%	↔
Prenatal and Postpartum Care—Postpartum Care	61.2%	57.1%	60.8%	↔
Use of Imaging Studies for Low Back Pain	—	—	76.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	67.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	69.0%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	61.3%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.8%	73.1%	74.1%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.28 Kaiser Permanente (North)—Sacramento HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	26.0%	32.1%	32.1%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	96.7%	98.0%	97.0%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	35.4%	44.3%	61.4%	↑
Breast Cancer Screening	62.7%	69.3%	73.9%	↑
Cervical Cancer Screening	77.4%	78.1%	81.9%	↑
Childhood Immunization Status—Combination 3	73.0%	73.0%	75.5%	↔
Comprehensive Diabetes Care—HbA1c Testing	89.9%	90.1%	92.8%	↑
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	26.5%	23.8%	23.6%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	64.6%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	85.5%	85.6%	89.9%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	53.1%	56.8%	63.3%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	66.0%	67.7%	70.1%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	87.6%	83.8%	82.1%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	79.0%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.5%	89.1%	88.4%	↔
Prenatal and Postpartum Care—Postpartum Care	71.3%	70.3%	75.9%	↑
Use of Imaging Studies for Low Back Pain	—	—	88.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	38.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	46.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	24.5%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	62.1%	64.6%	66.3%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.29 Kaiser Permanente (South)—San Diego HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	28.0%	28.3%	28.1%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	95.1%	96.7%	97.3%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	20.3%	25.6%	28.0%	↔
Breast Cancer Screening	70.7%	71.6%	73.7%	↔
Cervical Cancer Screening	79.4%	84.3%	83.3%	↔
Childhood Immunization Status—Combination 3	78.2%	73.9%	80.0%	↔
Comprehensive Diabetes Care—HbA1c Testing	90.6%	90.2%	94.0%	↑
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	25.6%	25.9%	23.4%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	63.7%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	90.1%	88.7%	90.1%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	48.9%	54.4%	56.2%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	64.3%	63.3%	66.7%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	92.3%	89.6%	91.7%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	83.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.0%	86.6%	90.1%	↔
Prenatal and Postpartum Care—Postpartum Care	43.6%	50.5%	67.9%	↑
Use of Imaging Studies for Low Back Pain	—	—	85.0%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	95.5%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	14.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	14.2%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	59.4%	70.8%	61.6%*	↓

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

*Reflects corrected rate

Table B.30 Kern Family Health Care—Kern HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	37.2%	38.0%	38.2%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	85.0%	86.0%	85.8%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.3%	20.6%	23.3%	↔
Breast Cancer Screening	49.9%	48.0%	52.1%	↑
Cervical Cancer Screening	64.1%	62.6%	62.4%	↔
Childhood Immunization Status—Combination 3	73.5%	77.1%	66.7%	↓
Comprehensive Diabetes Care—HbA1c Testing	74.8%	79.8%	79.9%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	48.1%	38.4%	51.3%	▼
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	40.0%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	67.6%	76.4%	77.2%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.7%	37.2%	29.7%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	42.1%	NR	35.2%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.8%	79.6%	81.2%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	65.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	78.4%	75.9%	79.1%	↔
Prenatal and Postpartum Care—Postpartum Care	58.6%	60.6%	61.8%	↔
Use of Imaging Studies for Low Back Pain	—	—	75.3%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	58.9%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	57.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	46.2%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.0%	71.3%	71.0%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.31 LA Care Health Plan—Los Angeles HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	37.0%	45.7%	53.1%	↑
Appropriate Treatment for Children With Upper Respiratory Infection	80.0%	81.2%	84.6%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	32.5%	30.9%	30.4%	↔
Breast Cancer Screening	49.4%	52.2%	54.8%	↑
Cervical Cancer Screening	67.3%	72.0%	71.8%	↔
Childhood Immunization Status—Combination 3	74.3%	78.0%	80.9%	↔
Comprehensive Diabetes Care—HbA1c Testing	83.9%	79.3%	82.1%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	42.7%	47.0%	42.1%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	45.0%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	79.3%	76.2%	80.1%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.3%	34.7%	36.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.8%	57.2%	52.8%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.2%	74.0%	83.3%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	60.8%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	81.4%	84.3%	85.5%	↔
Prenatal and Postpartum Care—Postpartum Care	55.9%	59.9%	61.5%	↔
Use of Imaging Studies for Low Back Pain	—	—	79.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	59.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	64.9%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	54.2%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.5%	80.1%	78.5%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.32 Molina Healthcare—Riverside/San Bernardino HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	48.8%	53.9%	45.1%	↓
Appropriate Treatment for Children With Upper Respiratory Infection	78.2%	89.5%	86.6%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	25.8%	18.4%	24.4%	↑
Breast Cancer Screening	42.7%	44.2%	50.2%	↑
Cervical Cancer Screening	67.0%	70.3%	62.3%	↓
Childhood Immunization Status—Combination 3	65.0%	67.1%	60.0%	↓
Comprehensive Diabetes Care—HbA1c Testing	76.4%	69.8%	79.6%	↑
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	52.5%	56.5%	57.9%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	32.8%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	78.0%	70.6%	77.1%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.8%	27.4%	29.2%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	58.6%	55.9%	43.1%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.2%	76.7%	80.0%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	58.6%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.4%	79.1%	80.5%	↔
Prenatal and Postpartum Care—Postpartum Care	53.1%	48.5%	52.3%	↔
Use of Imaging Studies for Low Back Pain	—	—	74.8%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	55.0%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	62.5%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	60.6%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.9%	77.8%	77.5%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.33 Molina Healthcare—Sacramento HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	53.2%	51.6%	52.3%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	90.0%	95.8%	94.2%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	27.3%	30.3%	29.5%	↔
Breast Cancer Screening	46.8%	40.9%	48.7%	↑
Cervical Cancer Screening	66.6%	65.6%	67.3%	↔
Childhood Immunization Status—Combination 3	65.5%	63.7%	61.1%	↔
Comprehensive Diabetes Care—HbA1c Testing	73.3%	78.6%	78.4%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	50.2%	44.9%	41.2%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	47.8%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	67.8%	68.6%	74.0%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.1%	37.7%	33.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	63.5%	61.3%	48.9%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.5%	79.6%	79.9%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	61.6%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.8%	78.0%	84.8%	↑
Prenatal and Postpartum Care—Postpartum Care	53.8%	51.9%	53.2%	↔
Use of Imaging Studies for Low Back Pain	—	—	87.3%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	63.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	70.3%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	59.6%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.6%	75.9%	79.6%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.34 Molina Healthcare—San Diego HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	46.6%	56.3%	47.7%	↓
Appropriate Treatment for Children With Upper Respiratory Infection	90.5%	96.1%	94.1%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	29.3%	20.6%	24.2%	↔
Breast Cancer Screening	49.1%	47.4%	54.6%	↑
Cervical Cancer Screening	68.5%	70.6%	70.3%	↔
Childhood Immunization Status—Combination 3	66.9%	77.8%	78.9%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.0%	79.3%	82.0%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	47.4%	48.5%	48.4%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	42.1%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	78.8%	76.9%	76.4%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.5%	33.8%	33.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	62.3%	58.1%	47.7%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.1%	79.0%	77.1%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	60.8%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.4%	87.4%	89.7%	↔
Prenatal and Postpartum Care—Postpartum Care	55.2%	62.5%	57.7%	↔
Use of Imaging Studies for Low Back Pain	—	—	77.4%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	56.9%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	57.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	51.6%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.8%	82.4%	78.5%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.35 Partnership Health Plan—Napa/Solano/Yolo HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	37.7%	39.4%	38.7%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	91.0%	91.8%	93.2%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	20.7%	22.4%	27.0%	↔
Breast Cancer Screening	57.9%	56.1%	49.7%	↓
Cervical Cancer Screening	63.1%	66.0%	61.6%	↔
Childhood Immunization Status—Combination 3	75.4%	72.3%	65.0%	↓
Comprehensive Diabetes Care—HbA1c Testing	86.3%	79.0%	82.7%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	34.5%	36.9%	35.2%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	53.5%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	81.6%	78.9%	79.0%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	47.5%	42.9%	46.9%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	68.8%	60.9%	53.8%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.8%	80.7%	80.5%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	64.8%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.8%	88.6%	84.8%	↔
Prenatal and Postpartum Care—Postpartum Care	64.7%	68.4%	64.8%	↔
Use of Imaging Studies for Low Back Pain	—	—	88.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	50.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	43.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	35.9%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.0%	68.0%	73.3%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.36 San Francisco Health Plan—San Francisco HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	52.8%	52.4%	60.6%	↑
Appropriate Treatment for Children With Upper Respiratory Infection	94.4%	95.3%	97.2%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	31.4%	32.2%	46.6%	↑
Breast Cancer Screening	58.3%	55.7%	60.3%	↑
Cervical Cancer Screening	74.2%	80.6%	79.7%	↔
Childhood Immunization Status—Combination 3	90.7%	90.3%	87.0%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.4%	89.5%	89.7%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	27.7%	25.9%	21.8%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	58.0%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	79.4%	80.8%	82.8%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.0%	47.4%	46.0%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	66.5%	73.1%	67.8%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.2%	87.1%	85.9%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	74.1%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.7%	92.3%	88.8%	↔
Prenatal and Postpartum Care—Postpartum Care	64.2%	69.5%	66.4%	↔
Use of Imaging Studies for Low Back Pain	—	—	85.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	72.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	74.5%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	55.8%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.3%	82.4%	86.6%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.37 Santa Clara Family Health—Santa Clara HEDIS 2010 Trend Table				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	39.4%	42.2%	41.0%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	91.3%	92.6%	94.5%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	27.4%	25.1%	30.4%	↔
Breast Cancer Screening	57.8%	55.2%	52.2%	↓
Cervical Cancer Screening	73.5%	74.4%	72.5%	↔
Childhood Immunization Status—Combination 3	78.5%	75.0%	75.8%	↔
Comprehensive Diabetes Care—HbA1c Testing	80.3%	85.7%	86.4%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	45.3%	38.7%	24.4%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	52.0%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	70.0%	78.2%	79.0%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.8%	42.1%	45.0%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	56.3%	59.0%	54.5%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	71.4%	77.7%	79.4%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	61.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.3%	83.2%	84.8%	↔
Prenatal and Postpartum Care—Postpartum Care	61.9%	66.4%	66.0%	↔
Use of Imaging Studies for Low Back Pain	—	—	84.1%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	44.7%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	58.5%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	33.6%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.1%	73.1%	70.8%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

Table B.38 Western Health Advantage—Sacramento HEDIS 2010 Trend Table[1]				
Measure	**2008**	**2009**	**2010**	**2009-2010 Rate Difference**
Adolescent Well-Care Visits	32.4%	37.7%	39.2%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	95.5%	95.3%	95.5%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	31.1%	51.2%	56.5%	↔
Breast Cancer Screening	41.4%	43.1%	44.0%	↔
Cervical Cancer Screening	59.9%	65.0%	61.1%	↔
Childhood Immunization Status—Combination 3	57.9%	59.8%	59.1%	↔
Comprehensive Diabetes Care—HbA1c Testing	78.8%	88.7%	85.4%	↔
Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)	51.6%	34.9%	41.4%	▼
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	48.9%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	67.2%	77.7%	72.5%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.0%	42.6%	38.2%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.8%	63.9%	55.7%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.7%	84.3%	87.3%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	62.0%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	71.0%	72.5%	80.7%	↑
Prenatal and Postpartum Care—Postpartum Care	53.3%	55.4%	58.2%	↔
Use of Imaging Studies for Low Back Pain	—	—	84.6%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	NR	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	NR	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	NR	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.1%	68.1%	64.4%	↔

For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.

[1] Western Health Advantage terminated its contract with the DHCS effective December 31, 2009; however, the plan was required to report HEDIS 2010 measures with the exception of the new *Use of Imaging Studies for Low Back Pain* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures.

Table B.39 AHF Healthcare Centers HEDIS 2010 Trend Table			
Measure	**2009**	**2010**	**2009-2010 Rate Difference**
Adults' Access to Preventive/Ambulatory Health Services—20-44 Years	98.5%	98.0%	↔
Adults' Access to Preventive/Ambulatory Health Services—45-64 Years	95.6%	100.0%	↑
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	NA	NA	NA
Colorectal Cancer Screening	55.6%	64.2%	↔

Table B.40 Kaiser PHP HEDIS 2010 Trend Table			
Measure	**2009**	**2010**	**2009-2010 Rate Difference**
Appropriate Testing for Children With Pharyngitis	90.3%	80.0%	↔
Appropriate Treatment for Children With Upper Respiratory Infection	97.5%	95.6%	↔

Table B.41 SCAN Health Plan HEDIS 2010 Trend Table			
Measure	**2009**	**2010**	**2009-2010 Rate Difference**
Glaucoma Screening in Older Adults	72.7%	75.2%	↑
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	NA

HEDIS Performance Measures Name Key

The table below provides abbreviations used throughout Appendix C.

Abbreviation	Full Name
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC-E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC-H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC-HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC-LC	*Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)*
CDC-LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC-N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS-3	*Childhood Immunization Status—Combination 3*
PPC-Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC-Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

HEDIS 2010 At-A-Glance Performance

This Appendix provides a summary of each plan's rates for each measure relative to the DHCS-established MPL and HPL**.** The four first-year measures for 2010, *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent), Comprehensive Diabetes Care—Blood Pressure Control (140/90)*, *Use of Imaging Studies for Low Back Pain* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, were not included since the DHCS does not establish an MPL or HPL during the first year of plan reporting.

Health Plan Name and County	Total Measures Below MPL (λ)	Total Measures At or Above HPL (O)
Alameda Alliance for Health—Alameda	6	1
Anthem Blue Cross—Alameda	10	0
Anthem Blue Cross—Contra Costa	12	1
Anthem Blue Cross—Fresno	3	1
Anthem Blue Cross—Sacramento	11	0
Anthem Blue Cross—San Francisco	1	4
Anthem Blue Cross—San Joaquin	5	0
Anthem Blue Cross—Santa Clara	1	2
Anthem Blue Cross—Stanislaus	3	0
Anthem Blue Cross—Tulare	5	1
CalOptima—Orange	0	4
Care 1st—San Diego	0	1
CenCal Health—San Luis Obispo	2	2
CenCal Health—Santa Barbara	0	7
Central CA Alliance for Health—Monterey/Santa Cruz	0	9
Community Health Group—San Diego	6	0
Contra Costa Health Plan—Contra Costa	0	1
Health Net—Fresno	0	2
Health Net—Kern	4	1
Health Net—Los Angeles	0	0
Health Net—Sacramento	0	0
Health Net—San Diego	2	1
Health Net—Stanislaus	2	2
Health Net—Tulare	1	1
Health Plan of San Joaquin—San Joaquin	0	1
Health Plan of San Mateo—San Mateo	0	4
Inland Empire Health Plan—Riverside/San Bernardino	0	0
Kaiser Permanente (North)—Sacramento	1	9
Kaiser Permanente (South)—San Diego*	2	8
Kern Family Health Care—Kern	2	0
LA Care Health Plan—Los Angeles	0	1
Molina Healthcare—Riverside/San Bernardino	4	0
Molina Healthcare—Sacramento	2	0
Molina Healthcare—San Diego	1	0
Partnership Health Plan—Napa/Solano/Yolo	0	1
San Francisco Health Plan—San Francisco	0	11
Santa Clara Family Health—Santa Clara	0	3
Western Health Advantage—Sacramento	2	3

Legend:
O = At or above the high performance level
λ = Below the minimum performance level

***Note: This table was revised to include the corrected rate for the WC34 measure.**

Health Plan Name and County	AAB	AWC	BCS	CCS	CDC-E	CDC-H9	CDC-HT	CDC-LC	CDC-LS	CDC-N	CIS-3	PPC-Pre	PPC-Pst	URI	W34
Alameda Alliance for Health—Alameda					λ	λ			λ	λ		λ	λ	O	
Anthem Blue Cross—Alameda		λ			λ		λ	λ	λ	λ	λ	λ	λ		λ
Anthem Blue Cross—Contra Costa	O	λ	λ	λ	λ		λ	λ	λ	λ	λ	λ	λ		λ
Anthem Blue Cross—Fresno			λ		λ	O							λ		
Anthem Blue Cross—Sacramento		λ	λ	λ	λ		λ	λ	λ	λ	λ	λ	λ		
Anthem Blue Cross—San Francisco	O					O							λ	O	O
Anthem Blue Cross—San Joaquin				λ	λ		λ	λ					λ		
Anthem Blue Cross—Santa Clara			O			O							λ		
Anthem Blue Cross—Stanislaus		λ			λ								λ		
Anthem Blue Cross—Tulare		λ			λ	O						λ	λ		λ
CalOptima—Orange								O	O		O				O
Care 1st—San Diego								O							
CenCal Health—San Luis Obispo	O	λ		λ						O					
CenCal Health—Santa Barbara	O				O	O		O		O	O		O		
Central CA Alliance for Health—Monterey/Santa Cruz						O	O	O	O	O	O		O	O	O
Community Health Group—San Diego		λ			λ			λ		λ		λ	λ		
Contra Costa Health Plan—Contra Costa										O					
Health Net—Fresno												O			O
Health Net—Kern	λ	λ	λ							O				λ	
Health Net—Los Angeles															
Health Net—Sacramento															
Health Net—San Diego		λ	λ									O			
Health Net—Stanislaus		λ				O						O	λ		
Health Net—Tulare		λ										O			

Health Plan Name and County	AAB	AWC	BCS	CCS	CDC-E	CDC-H9	CDC-HT	CDC-LC	CDC-LS	CDC-N	CIS-3	PPC-Pre	PPC-Pst	URI	W34
Health Plan of San Joaquin—San Joaquin															○
Health Plan of San Mateo—San Mateo	○							○		○	○				
Inland Empire Health Plan—Riverside/San Bernardino															
Kaiser Permanente (North)—Sacramento	○	λ	○	○		○	○	○	○				○	○	
Kaiser Permanente (South)—San Diego*		λ	○	○		○	○	○	○	○				○	λ
Kern Family Health Care—Kern					λ	λ									
LA Care Health Plan—Los Angeles											○				
Molina Healthcare—Riverside/San Bernardino					λ	λ					λ		λ		
Molina Healthcare—Sacramento											λ		λ		
Molina Healthcare—San Diego													λ		
Partnership Health Plan—Napa/Solano/Yolo								○							
San Francisco Health Plan—San Francisco	○	○		○		○	○	○	○	○	○			○	○
Santa Clara Family Health—Santa Clara						○		○						○	
Western Health Advantage—Sacramento	○		λ							○	λ			○	

***Note: This table was revised to include the corrected rate for the WC34 measure.**

Abstraction Error

An error made by a medical record reviewer in documenting information from the medical record as part of the medical record abstraction process. An abstraction error occurs when a medical record reviewer miscodes information. The reviewer may, for example, indicate that a specified test or procedure was performed when the medical record does not show evidence of the test or procedure. A reviewer may document incorrect information such as a date, lab value, etc. Also, an abstraction error can occur when a medical record reviewer does not document a specified procedure or test when the medical record shows evidence that it was performed.

Administrative Data

Any automated data within a health plan (e.g., claims/encounter data, membership data, provider data, hospital billing data, pharmacy data, and laboratory data).

Administrative Method

The administrative method requires health plans to identify the eligible population (i.e., the denominator) using administrative data. In addition, the administrative method derives numerator(s), or services provided to members in the eligible population, solely from administrative data. Health plans cannot use medical records to retrieve information. The administrative method uses the entire eligible population as the denominator and does not allow sampling.

The administrative method is cost-efficient but can produce lower rates due to incomplete data submission by capitated providers. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care—Postpartum Care* measure. The health plan chooses to perform the administrative method and finds that 4,000 members out of the 10,000 had evidence of a postpartum visit using administrative data. The final rate for this measure, using the administrative method, would be 4,000/10,000, or 40 percent.

Audit Finding

The auditor's final determination, based on audit findings, of the appropriateness of the health plan publicly reporting its HEDIS measure rates. Each measure included in the HEDIS audit receives a *Report*, *Not Applicable*, *No Benefit*, or *Not Report* audit finding.

Capitation

A method of payment for providers. A capitated payment arrangement reimburses providers on a per-member/per-month basis. The provider receives payment each month, regardless of whether the member receives services or not. Because payment is not dependent upon submission of encounter data, providers have less incentive to submit individual encounters.

Certified HEDIS Software Vendor

A third party, with source code certified by NCQA, that contracts with a health plan to write source code for HEDIS measures. For a vendor's software to receive NCQA certification, the vendor must submit all of the programmed HEDIS measures to NCQA for automated testing of program logic, and a minimum percentage of the measures must receive a "Pass" or "Pass with Qualifications" designation.

CMS

The Centers for Medicare and Medicaid Services is a federal agency within the U.S. Department of Health and Human Services (DHHS) that regulates requirements and procedures for external quality review of managed care organizations. CMS provides health insurance to individuals through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). In addition, CMS regulates laboratory testing through Clinical Laboratory Improvement Amendments (CLIAs), develops coverage policies, and initiates quality-of-care improvement activities. CMS also maintains oversight of nursing homes and continuing care providers. These include home health agencies, intermediate care facilities for the mentally retarded, and hospitals.

Continuous Enrollment Requirement

The minimum amount of time that a member must be enrolled in a health plan to be eligible for inclusion in a measure to ensure that the health plan has a sufficient amount of time to be held accountable for providing services to that member.

CPT®

Current Procedural Terminology is a listing of billing codes generated by the AMA to report the provision of medical services and procedures.

Data Completeness

The degree to which occurring services/diagnoses appear in the health plan's administrative data systems.

Denominator

The number of members who meet all criteria specified in the measure for inclusion in the eligible population. When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.

The DHCS

The Department of Health Care Services. The DHCS works closely with health plans and county governments to provide a health care safety net for California's low-income population and individuals with disabilities. DHCS finances and administers a number of individual health care service delivery programs, including the Medi-Cal program (both managed care and fee-for-service), the California Children's Services program, the Child Health and Disability Prevention program, and the Genetically Handicapped Persons Program.

DRG Coding

Diagnostic-Related Group coding sorts diagnoses and procedures for inpatient encounters by groups under major diagnostic categories with defined reimbursement limits.

DTaP

Diphtheria and tetanus toxoids and acellular pertussis vaccine.

EDI

Electronic data interchange is the direct computer-to-computer transfer of data.

Electronic Data

Data maintained in a computer environment versus a paper environment.

Encounter Data

Billing data received from a capitated provider. Although the health plan does not reimburse the provider for each encounter, submission of encounter data to the health plan allows the health plan to collect the data for future HEDIS reporting.

EQRO

An external quality review organization is an external, independent organization that has expertise in Medicaid health care quality. CMS requires that state Medicaid managed care

programs contract with an EQRO to receive enhanced federal financial participation. CMS requires that EQROs meet competency requirements that include having staff with demonstrated experience and knowledge of Medicaid members, policies, data systems, and processes; managed care delivery systems, organizations, and financing; quality assessment and improvement methods; and research design and methodology, including statistical analysis. CMS also requires that EQROs have the clinical and nonclinical resources necessary to conduct EQRO-related activities.

Exclusions

Conditions outlined in HEDIS measure specifications that describe when a member should not be included in the denominator.

FFS

Fee-for-service: a reimbursement mechanism that pays providers for services billed.

Final Audit Report

The written report completed by the auditor, following the health plan's completion of any corrective actions, that documents all final findings and results of the HEDIS audit. The final report includes the summary report, IS capabilities assessment, medical record review validation findings, measure findings, and audit opinion (the final audit statement).

HbA1c

The HbA1c test (the hemoglobin A1c test or glycosylated hemoglobin test) is a lab test that reveals average blood glucose over a period of two to three months.

HCPCS

Healthcare Common Procedure Coding System: a standardized, alphanumeric coding system that maps to certain CPT® codes (see also CPT®).

HEDIS

The Healthcare Effectiveness Data and Information Set, developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.

Formerly the Health Plan Employer Data and Information Set.

HEDIS Measure Determination Standards (HD)

The standards that auditors use during the audit process to assess a health plan's adherence to HEDIS measure specifications.

HEDIS Repository

The plan's data warehouse that stores all data used for HEDIS reporting.

HEDIS Warehouse

See HEDIS repository.

HiB Vaccine

Haemophilus influenzae type B vaccine.

HPL

High performance level: the DHCS defines the HPL as the most recent national HEDIS Medicaid 90th percentile, except for one measure, *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*. For this measure, a lower rate indicates better performance, with the 10th percentile (rather than the 90th percentile) showing excellent performance.

HSAG

Health Services Advisory Group, Inc. An EQRO that serves as a contractor to state Medicaid plans to provide state-specified activities related to federal requirements for managed care plans. For the Medi-Cal program, the DHCS contracts with HSAG to validate performance measures for its external accountability set, validate quality improvement projects, and produce an annual technical report.

Hybrid Measures

Measures that health plans can report using the hybrid method.

Hybrid Method

The hybrid method requires health plans to identify the eligible population using administrative data and then extract a systematic sample, typically 411 members from the eligible population, which becomes the denominator. The health plans then use administrative data to identify services provided to those sampled members. Finally, the health plan

conducts medical record review of members for whom administrative data does not show evidence that a service was provided.

The hybrid method generally produces higher rates but is considerably more labor intensive. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care—Postpartum Care* measure. The health plan chooses to perform the hybrid method. After randomly selecting 411 eligible members, the health plan finds that 161 members have evidence of a postpartum visit using administrative data. The health plan then obtains and reviews medical records for the 250 members who do not have evidence of a postpartum visit using administrative data. Of those 250 members, the health plan finds that 54 have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would be (161 + 54) /411, or 52 percent.

IDSS

Interactive Data Submission System—a Web-based tool used to submit data to NCQA.

Inpatient Data

Data derived from an inpatient hospital stay.

IRR

Interrater reliability: The degree of agreement exhibited when a measurement is repeated under the same conditions by different raters.

IS

Information System(s): an automated system for collecting, processing, and transmitting data.

IS Standard

Information System(s) Standards: an NCQA-defined set of standards that measure how an organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor data.

IPV

Inactivated poliovirus vaccine.

IT

Information technology: the technology used to create, store, exchange, and use information in its various forms.

LDL-C

Low-density lipoprotein cholesterol.

Manual Crosswalks

Written documentation that maps nonstandard service codes to industry standard codes. Manual crosswalks must contain one-to-one links between nonstandard codes and industry standard codes.

Manual Data Collection

Collection of data through a paper process rather than an automated one.

Mapping Codes

The process of translating a health plan's propriety or nonstandard billing codes to industry standard codes specified in HEDIS measures. Mapping documentation should include a crosswalk of relevant codes, descriptions, and clinical information, as well as the policies and procedures for implementing the codes.

Material Bias

For most measures reported as a rate, any error that causes a ± 5 percent difference in the reported rate is considered materially biased.

MCO

Managed care organization; a federal designation. In California, most MCOs are Health Maintenance Organizations (HMOs).

Medical Record Abstraction

The process used by plans to retrieve and review medical records as part of the hybrid method. Medical record abstraction determines if there is evidence that a specified service was provided, such as a Pap test or an immunization, or gathers information about a specified lab value, such as a blood glucose or cholesterol level.

Medical Record Validation

The process that auditors follow to verify that a health plan's medical record abstraction meets industry standards and that abstracted data are accurate.

Medicaid Percentiles

The NCQA national percentiles for each HEDIS measure for the Medicaid product line, used to compare health plan performance and assess the reliability of a health plan's HEDIS rates.

Membership Data

Information about members in electronic health plan files, such as name, date of birth, gender, current address, and enrollment (i.e., date when the member became eligible for health plan coverage.

Mg/dL

Milligrams per deciliter.

MMR

Measles, mumps, and rubella vaccine.

MPL

The DHCS establishes the minimum performance level (MPL) as the most recent national HEDIS Medicaid 25th percentile, except for one measure, *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*. For this measure, a lower rate indicates better performance, with the 10th percentile (rather than the 90th percentile) showing excellent performance. The MPL for this measure is the 75th percentile.

NA

Not Applicable: a finding given to a result/rate when a health plan's denominator for a measure is too small (i.e., less than 30) to report a valid rate.

NCQA

The National Committee for Quality Assurance is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed health care delivery systems. NCQA reports the results of these assessments to employers, consumers, public purchasers, and regulators, ultimately seeking to improve health care provided within the managed care industry.

NR

The *Not Report* HEDIS audit finding.

A measure has an *NR* audit finding for one of three reasons:

The health plan chose not to report the measure.

The health plan calculated the measure but the result was materially biased.
The health plan was not required to report.

Numerator

The number of members in the denominator who received all the services as specified in the measure.

Over-read Process

The process of re-reviewing a sample of medical records by a different abstractor to assess the degree of agreement between two different abstractors and ensure the accuracy of abstracted data. A health plan should conduct an over-read process as part of its medical record review process. Auditors overread a sample of a health plan's medical records as part of the audit process.

Pharmacy Data

Data derived from the provision of pharmacy services.

Provider Data

Information about physicians in electronic files, such as type of physician, specialty, reimbursement arrangement, and office location.

Record of Administration, Data Management, and Processes (Roadmap)

The Roadmap, completed by each MCP undergoing the HEDIS audit process, provides information to auditors regarding an MCP's systems for collecting and processing data for HEDIS reporting. Auditors review the Roadmap prior to the scheduled on-site visit to gather preliminary information for planning/targeting assessment activities for the on-site visit; determining the core set of measures to be reviewed; determining which hybrid measures will be included in medical record validation; requesting the source code for core measures, as needed; identifying areas that require additional clarification during the on-site visit; and determining whether to expand the core set of measures.

Previously the Baseline Assessment Tool (BAT).

Source Code

The written computer programming logic for determining the eligible population and the denominators/numerators to calculate the rate for each measure.

Standard Codes

Industry standard billing codes such as ICD-9-CM, CPT®, DRG, Revenue, and UB-04 codes used for billing inpatient and outpatient health care services.

Vendor

Any third party that contracts with a health plan to perform services. The most common delegated services are pharmacy, vision care, laboratory, claims processing, HEDIS software, and provider credentialing.

VZV

Varicella-zoster virus (chicken pox) vaccine.