

EVALUATION OF CALIFORNIA'S QUALITY OF CARE REPORT CARD



FINAL REPORT
to the California Office of the Patient Advocate
February 2005



Center for Health Services Research in Primary Care
University of California, Davis

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HEALTH SYSTEM

EVALUATION OF CALIFORNIA'S QUALITY OF CARE REPORT CARD

**Final Report to the
California Office of the Patient Advocate
February 2005**

UC Davis Project Staff:

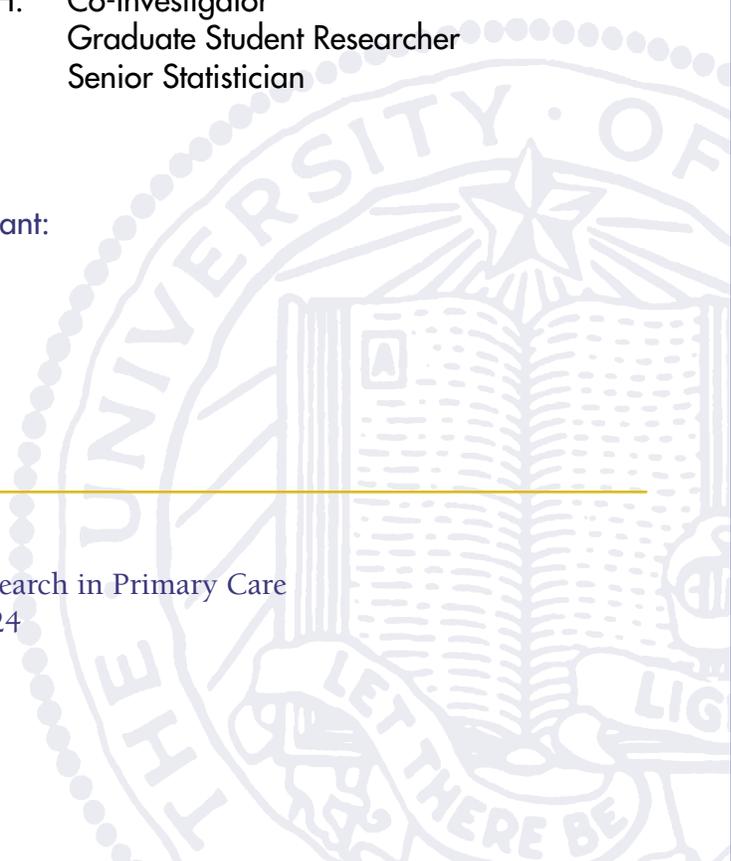
Julie Rainwater, Ph.D.
Sheila R. Enders M.S.W.
Patrick S. Romano, M.D. M.P.H.
Madan Dhamar, M.D.
Daniel Tancredi, M.S.

Principal Investigator
Co-Investigator/Focus Group Facilitator
Co-Investigator
Graduate Student Researcher
Senior Statistician

Research Affiliate and Consultant:

Albert Lowey-Ball, M.S., M.A.

University of California, Davis
Center for Health Services Research in Primary Care
2103 Stockton Blvd., Suite 2224
Sacramento, CA 95817



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The University of California, Davis Center for Health Services Research in Primary Care facilitates policy-relevant research in the areas of health care quality, access, delivery, costs, and outcomes. Since its founding in 1994, the Center has conducted numerous studies addressing important health research and policy issues. The Center is an interdisciplinary unit comprised of UC Davis faculty and researchers with backgrounds in medicine, program evaluation, public policy, quality of care, survey research, and statistics. The Center collaborates with other academic units and provides research and consulting services for health care organizations, governmental agencies and private industry.

For more information regarding the Center for Health Services Research in Primary Care, see www.ucdmc.ucdavis.edu/chsrpc or contact:

Center for Health Services Research in Primary Care
2103 Stockton Blvd., Suite 2224
Sacramento, CA 95817
tel (916) 734-2818
fax (916) 734-8731

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EVALUATION OF CALIFORNIA'S QUALITY OF CARE REPORT CARD

EXECUTIVE SUMMARY

Project Summary

The Center for Health Services Research in Primary Care, University of California, Davis, conducted an evaluation on behalf of the State of California's Office of the Patient Advocate (OPA) of *California's Quality of Care Report Card*. The *Quality Report Card* is published annually to provide consumers with comparative information on the performance of California's largest HMOs and medical groups. The print report, in booklet form, provides five summary ratings on HMO quality, four ratings on medical group quality, and a listing of HMO services in other languages. The website (www.opa.ca.gov/report_card) provides this information plus detailed results for more than 50 specific quality measures. In 2003/2004 the *Quality Report Card* included results for 10 HMOs and 118 medical groups. Both the web and print versions are available in English, Spanish, and Chinese.

Evaluation Approach and Methods

This report evaluates three research questions:

- Do consumers use *California's Quality of Care Report Card*?
- How useful to consumers are the quality measures included in the *Quality Report Card*?
- What is the impact of the *Quality Report Card* on quality improvement and other activities in the participating HMOs and medical groups?

Both qualitative and quantitative methods are used. Data are presented from six consumer focus groups, mail and Internet surveys of 2,341 *Quality Report Card* users, interviews with program staff, and in depth telephone interviews with 56 key informants within the health plans and medical groups included in the *Quality Report Card*. The results of the evaluation reported here pertain to the 2003/2004 *Quality Report Card* and some of the improvements suggested by the evaluation have recently been incorporated by OPA into the 2004/2005 *Quality Report Card*.

Highlights of findings

Consumer Use of the Quality of Care Report Card

- California consumers access *California's Quality of Care Report Card* to compare the performance of HMOs and medical groups. The *Quality of Care Report Card* website has over 28,000 visitors each year. The dissemination of the *Quality Report Card* booklet has increased each year, with more than 100,000 booklets distributed by request or through Walgreen's pharmacies and public libraries in 2003/2004.
- Most users (90%) identify themselves as belonging to OPA's intended audience for the *Quality Report Card* - consumers who are comparing HMOs, seeking information about HMOs, or are considering joining an HMO.
- Consumers learn about the existence of the *Quality Report Card* from newspaper or print media and, increasingly, Internet searches. Some recall hearing about the *Quality Report Card* through radio or television, but few recall seeing the booklets in Walgreen's pharmacies.
- Other users of the *Quality Report Card* website and booklets include health insurance brokers and representatives of health plans and provider groups.

Usefulness of the Quality Report Card

- Most *Quality of Care Report Card* website users review the statewide summary results page (i.e., "star chart") to see the overall quality scores for health plans. Less than half of these users remain on the website to look at similar information about one or more medical groups.
- Users of the *Quality Report Card* are most interested in comparing HMO performance in the area of *Plan Service* (e.g., how quickly the plan handles complaints, customer service, paying claims, getting patients needed care, and overall rating for service).
- When comparing medical groups, the most useful information pertains to *Specialty Care* (e.g., how easy it is to see a specialist within the medical group). Consumers also care about getting appointments in a timely manner and receiving timely care or tests from their doctor.
- Comparative information on prevention indicators (e.g., immunizations, cancer

screenings) are of less interest to consumers. In some cases, this is because the plans and providers all achieve a similar acceptable level of performance. In other cases, the indicator is only relevant to specific types of people, such as parents.

- Some specific measures included on the *Quality Report Card* website such as *Mental Health Care*, are accessed frequently and are particularly useful to consumers, possibly because the data are not easily accessed elsewhere.
- Presenting the comparative performance information by health topic or disease (e.g., diabetes, women's health, heart care, mental health) is preferred over the existing category labels used in the *Quality Report Card*.
- Except among senior citizens, focus group participants find the print *Quality Report Card* to be too general and have a clear preference for the detailed information on the website. However, consumers suggest wider distribution of the print report card to call public attention to the availability of comparative quality information, especially for individuals who do not have Internet access.
- Medical group performance could receive greater consumer attention in the future because the number of medical groups participating in the *Quality Report Card* increases each year and consumers report having a wider choice of medical groups than HMO plans.
- The amount of information on the website is more than sufficient for the average user. Consumers report they have a limited choice of plans so tailoring the website information to one's own choice-set would be an improvement. Additionally, consumers report they would welcome tailoring the information to include just the measures relevant to one's own health care concerns and demographic characteristics.
- Consumers acknowledge the value of a report card that contains both types of measures contained in the current report card – administrative or medical record data and patient satisfaction surveys.
- A useful enhancement to the *Quality Report Card* would be additional information on the number of consumer complaints and grievances against the HMO plans. Measures comparing plan performance for "lifestyle" topics, such as obesity, nutrition, physical activity, and smoking are of interest to consumers. Focus group participants

felt that health topics relevant to men, such as prostate cancer screening, should be available on the website.

- The website's usefulness would be improved for consumers if other information that is seen as critical to selecting a plan or provider, such as cost and covered benefits data, were presented side-by-side. However, consumers acknowledge these data might be complicated and difficult to present and interpret.
- Consumers have a generally positive attitude toward the publication of comparative quality data for health plans and medical groups. Although most focus group members were not familiar with OPA, they note a preference for information that is collected and distributed by an "objective" party or public agency, rather than the plans themselves.

Impact on Quality Improvement in HMOs and Medical Groups

- The participating HMOs and medical groups are highly familiar with the *Quality Report Card*. Information from the *Quality Report Card* is discussed or shared widely with medical and quality improvement staff as well as boards of directors within their organizations.
- The *Quality Report Card* is used primarily for benchmarking performance with similar providers. Its impact on market share and reputation is seen as relatively modest. A few health plans use the *Quality Report Card* in marketing proposals and some medical groups use the *Quality Report Card* in their rate negotiations.
- Medical groups (47%) are more likely than health plans (13%) to undertake quality improvement activities in response to their *Quality Report Card* performance, including instituting new processes of care, hiring of quality-oriented staff, and improved data reporting.
- HMO and medical group executives are somewhat critical of public reporting in general, stating that summary scores do not accurately reflect their organization's true quality of care. A majority of executives expect that their organization's performance will improve in the future.
- Most endorse including additional specific measures in the summary "stars" as an improvement to the *Quality Report Card*. About

half of the executives mentioned that a separate Medi-Cal reporting capability would be useful.

- Although they make limited use of the *Quality Report Card* for quality improvement, HMOs and medical groups devote time and attention to public reporting. The majority of health plans and medical groups support the continued production of the *Quality Report Card* by OPA or a similar state agency or by a public-private partnership.

Recommendations

Consumer Use of the Quality of Care Report Card

Build on the generally positive attitude toward public reporting. Consumers endorse the concept of publicly available quality comparisons as a positive step toward making managed care accountable to patients, even if it has limited direct influence on their choices. Publication of the data should be continued by OPA or a similar entity that does not appear to have a stake in the results.

Explore new approaches for publicizing the website.

Ideas suggested by consumers for searching the Internet and finding the website could be incorporated, including providing links on popular health-related websites. Advertising about the OPA website in print media, television and radio, especially at times when consumers are most likely to use the information, such as employer open enrollment months, should continue or increase. Health plans and doctor's offices should be enlisted to provide the website address on in-office posters or patient materials. Consumers report their contacts with health-advocacy groups often led them to the website. OPA should engage in outreach to these groups in order to make the *Quality Report Card* more visible. Consumers who have a problem with their HMO also have exposure to the website. The *Quality Report Card* should be easily accessed from the DMHC complaint website.

Consider additional venues for disseminating the booklet.

Many consumers interested in quality information but who lack Internet access or prefer summary measures (such as senior citizens) find the booklet helpful. OPA could expand the number of outlets for distribution of the print *Quality Report Card*. Venues suggested by these consumers included placement of the booklets in doctor's offices, mailings by health plans and employers, distribution to additional pharmacies, and placement at health fairs or community centers.

Usefulness of the Quality of Care Report Card

Present the results by health topic. Only one of the current category titles (*Plan Service*) is intuitively appealing to consumers. Consumers prefer to go directly to the results for health topics or diseases that are relevant to them, such as women's health, diabetes, heart care, or mental health. Except for the *Plan Service* category, the current categories for organizing the results could be replaced with health topic categories in the booklet and made less prominent on the website opening pages.

Highlight measures that resonate most with consumers.

When comparing health plans, consumers consistently named a set of measures that should be more prominently displayed or easily accessed. Consumers want to move quickly to the results for the *Plan Service* measures (e.g., quick complaint resolution, prompt care, and good customer service), *Mental Health* measures, since they are not easily accessed elsewhere, and access to and delivery of *Specialty Care*. The website should simplify or reduce steps necessary to "drill down" to these results.

Consider adding measures in areas of increasing interest to consumers.

Consumers expressed interest in measures of plan and medical group performance in "lifestyle" topics, such as obesity, nutrition, and smoking cessation. Additional measures on topics relevant to men, such as prostate cancer screening, should be explored. A separate direct link to information about complaints and grievances would be useful.

Explore improvements to the website that would permit users to tailor the information to their own demographics and health care needs.

Some of the elements on the website are ignored by many users. OPA could improve the *Quality Report Card* by implementing existing technology for tailoring website paths based on user-supplied data, such as geographic location, age, gender, disease states or chronic conditions.

Make it easier for consumers to move quickly to medical group comparisons.

The *Quality Report Card* includes additional medical groups each year. Consumers report they have a wider choice of medical groups than health plans. Making the link to information on medical groups more prominent on the website opening page could improve its utility for consumers. A mapping of the medical group to HMO membership should be easily retrievable for users.

Retain measures based on both types of data – medical records and administrative data as well as patient survey.

Consumers value administrative data and also recognize

the patient experience and satisfaction survey results as an important source of information about people "like them".

Explore improvements to the website that would permit users to view quality results at the same time as cost and benefit data. Improved linkages between the OPA website and the health benefits websites of large employers and purchasing groups might move some consumers closer to their preference of viewing quality data "side-by-side" with cost and coverage information.

Continue annual efforts to evaluate the usefulness of the Quality Report Card for informing consumer choice. OPA should continue to survey both website and booklet users for feedback and suggestions for improvement. Consumer focus groups should be conducted throughout the state annually to facilitate modifications and refinements based on feedback from actual and potential users of the information.

Impact on Quality Improvement in HMOs and Medical Groups

Provide health plans and medical groups with additional guidance on how to use the Quality Report Card for quality improvement. The impact that the *Quality Report Card* has on plans and medical groups provides an indirect but important benefit to consumers because plans may focus on quality improvements that could impact their results. Currently, plans and medical groups report little in the way of specific quality improvement activities pertaining to the *Quality Report Card*. OPA should consider convening a workshop or some other form of outreach to quality improvement staff that explains how the specific measures are defined and calculated and how specific practices translate into performance results. Medical groups appear more inclined to institute quality improvement activities in response to their *Quality Report Card* results, so specific recruitment of their participation is warranted.

Continue to cultivate the endorsement of plans and providers in the public reporting "movement" by addressing some of their concerns about comprehensiveness and validity. Most key informants suggested that additional measures be included in the summary results and that additional reports be undertaken for Medi-Cal patients. OPA should consider convening work groups which include plans and providers to explore the feasibility of these ideas.

Take steps to ensure the Quality Report Card is responsive to the changing managed care environment in California. Meetings to stay abreast of new organizational arrangements and continued coordination with provider groups and plans and incentive arrangements such as "pay for performance" are critical.



I. INTRODUCTION AND BACKGROUND

The Office of the Patient Advocate

The primary mission of the Office of the Patient Advocate (OPA) is to inform and educate consumers about their rights and responsibilities as HMO enrollees. OPA's specific statutory mandates include:

- Annually publishing an Internet-based HMO Quality Report Card;
- Developing consumer education materials and programs;
- Collaborating with other patient advocacy organizations;
- Assisting HMO enrollees who are experiencing problems with their HMO;
- Advising the Department of Managed Health Care.

The Quality of Care Report Card

On September 30, 2003, OPA launched the third annual *Quality of Care Report Card*. The *Quality Report Card* includes quality and patient satisfaction data for HMOs and medical groups. The HMOs presented in the *Quality Report Card* are California's 10 largest and serve 95% of the state's residents enrolled in managed care plans. It also provides information on the availability of and access to HMO services in languages other than English. Printed summaries (100,000 booklets) in English, Spanish,

or Chinese are distributed via 625 libraries and 350 Walgreen's pharmacies throughout the state. Television commercials and coverage on news programs distributed the telephone and website contact information to obtain the print *Quality Report Card*. The full version of the *Quality Report Card* is available on the Internet at www.opa.ca.gov/report_card.

The 4th *Quality of Care Report Card* was released in September 2004. The Year 4 *Quality Report Card* updates data for the health plans, expands the number of included medical groups from 118 to almost 200, provides a comparative assessment of linguistic services provided by health plans, provides more consumer-friendly complaint data from the HMO Help Center, and expands information on the services available at each health plan.

Goals and objectives of the Quality Report Card

California's *Quality of Care Report Card* has three objectives:

- To provide consumers, purchasers, advocates, and regulators with comparative information on the performance of California HMOs and medical groups using clinical (HEDIS) and patient satisfaction (CAHPS and CAS) data reported by health plans¹.

- To assist HMOs in their own quality improvement efforts by providing them data on their performance in relationship to other HMOs in the state.
- To educate consumers about how to compare and obtain quality health care from their HMOs.

OPA and its contractors have taken steps to make the web and print versions of the *Quality Report Card* both useful and usable for consumers. Focus groups were conducted to obtain direct user feedback during both the design and post-launch phases of the project each year. Research and experts in the field of consumer reporting were consulted in order to ensure that the *Quality Report Card* incorporates “state-of-the-art” techniques in reporting on quality of care for consumers.²

According to OPA, there are a number of challenges in developing a consumer report card. Many consumers are not aware that there are differences in health care quality. They may have a limited choice of health plans (e.g., their employer may offer only one) and may therefore not be motivated to compare plans. At times, such as

during open enrollment periods, consumers are inundated with health plan information and may be less likely to seek quality comparisons when they most need them. In general, consumers are more motivated to consider cost and choice of provider when choosing a health plan.

Quality Report Card project activities

Each year OPA has reached a number of California consumers through web and print versions of the *Quality Report Card*.

In addition to the website and booklet dissemination, OPA's Mobile Information Center (MIC) plays a role in distributing the *Quality Report Card* to consumers. The MIC travels throughout the State providing consumers with face-to-face education and assistance about their rights as HMO enrollees. In 2003, OPA and its eight local, community based partners conducted over 350 MICs making direct, face-to-face contact with over 24,000 HMO consumers.

<i>Report Card</i>	<i>Time Period</i>	<i>Website Visitors</i>	<i>Website Visits</i>	<i>Print Booklets Distributed</i>
Year 1	9/26/01-9/30/02	30,372	59,168	54,503
Year 2	10/1/02-9/29/03	31,528	64,895	91,189
Year 3	9/30/03-10/28/04	23,802	50,138	103,757



II. EVALUATION APPROACH AND METHODOLOGY

Evaluation framework and questions

The evaluation assesses the following³:

Objective 1: Are California health care consumers using California's Quality of Care Report Card? The evaluation examines whether Californians use the *Quality Report Card* to compare among HMOs and medical groups and how they become aware of it.

Objective 2: How useful to consumers are the quality indicators that are currently included in the Quality Report Card? The evaluation describes the extent to which the quality categories and specific indicators are relevant to consumers. Issues explored include consumer interest in the indicators, the relative importance of each indicator for selecting a health plan, and consumers' suggestions for improving the *Quality Report Card*.

Objective 3: Does the Quality Report Card have an impact on the participating HMOs and medical groups? The evaluation examines whether HMOs and medical groups have made changes in their quality improvement activities as a direct or indirect consequence of the release of the public report card. This and other organizational responses to the publication of the *Quality Report Card* are described.

Evaluation methods

A complete description of the evaluation methods and data can be found in the Appendix. Sources of data for the evaluation include:

- Original survey data for the evaluation was collected from two sources:
 - 1) On-line survey of website users during the first six months after the launch of the *Quality Report Card* in September 2003.
 - 2) Mail survey of consumers who had requested the year 2 (2002) or year 3 (2003) print *Quality Report Cards*.
- Consumer focus groups discussed the usefulness of the *Quality Report Card* for decision-making, which specific indicators were most and least useful, and how the *Quality Report Card* could be improved. All groups were comprised of Californians who had requested the *Quality Report Card* in year 2 or 3 or who had volunteered to be contacted by the evaluators when using the website.
- Website usage was examined to summarize the popularity of specific aspects of the website. OPA provided reports generated by WebTrends© pertaining to usage of the website after the launch of the 2003/2004 *Quality Report Card*.

- Telephone interviews were conducted with key informants in California HMOs and medical groups to elicit opinions on the impact of the *Quality Report Card* on managed care organizations and the usefulness of the indicators for quality improvement.
- Findings from two recent surveys that examined the use of the *Quality Report Card* in 2002 are summarized.
- Information supplied by the director of OPA and program staff provided background on program activities and print *Quality Report Card* dissemination activities. OPA staff provided logs of requests for the print *Quality Report Card* for all three publication years.



III. ARE CALIFORNIA CONSUMERS USING THE QUALITY OF CARE REPORT CARD?

Use of the *Quality of Care Report Card* website

Review of the *Quality Report Card* website usage logs for 2003/2004 indicates that there were 1,413,780 hits between September 30, 2003 and March 17, 2004, representing 41,440 hits to the site's homepage, www.opa.ca.gov/report_card.⁴ The majority of website activity (approximately 55% of total visits) occurred on the release date and the month following. In the first 5.5 months following the release of the *Quality Report Card*, there were 33,388 visits to the site overall, representing an average of 197 visits per day. The number of unique visitors to the site for the six month period was 16,539.

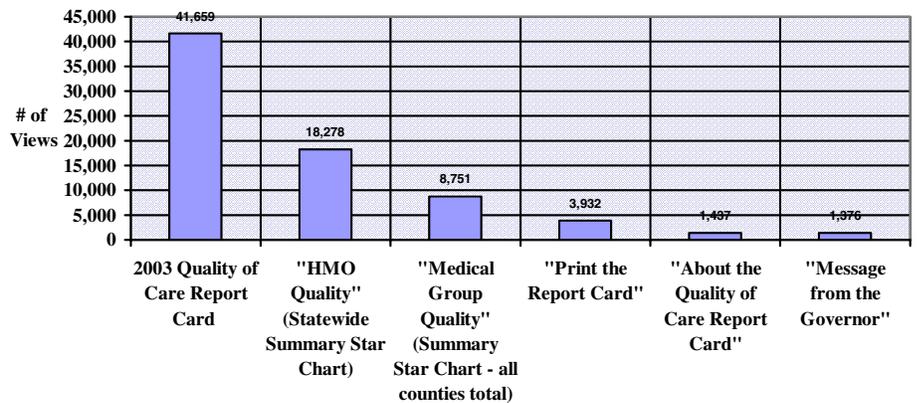
As shown in Chart 1, about 44% of the website pages viewed display the statewide summary results (i.e., "star chart") for the HMOs. The summary level results ("star chart") for medical groups (all counties combined) comprise about (21%) of the pages viewed. About 9% of views are of the page where a PDF copy of the *Quality Report Card* could be printed. A small percentage of pages viewed include the "About the *Quality of Care Report Card*"

information (3.5%) and the "Message from the Governor" (3.3%). According to the on-line survey of website users, the most frequently viewed sections of the website are the HMO star charts (74.5%), medical group star charts (46.7%), "About this *Quality Report Card*" (19.2%), HMO contact information (11.2%), and HMO services in other languages (4.2%).

Who uses the *Quality of Care Report Card*?

Among the 1,798 website users who answered the on-

Chart 1:
Opening Pages Viewed
California's Quality of Care Report Card 2003/2004 Website
 September 2003-March 2004



line survey, most (84.6%) identified themselves as consumers. Chart 2 shows that the majority said they were HMO members who were looking at the website either to compare HMOs (48.1%) or to get information about their current HMO (37.5%)⁵. Some *Quality Report Card* website users indicated that they were not currently HMO members but were considering joining one (11.5%). A small number of respondents said they had come to the website in the process of considering whether to make a complaint about their HMO (1.3%) or for other reasons (2%).

Most users of the Quality Report Card (90%) identify themselves as consumers who are comparing plans, seeking information about HMOs, or are considering joining an HMO.

Among 543 print *Quality Report Card* requestors surveyed by mail, most (86.9%) identified themselves as consumers. The majority said they were HMO members who were looking at the *Quality Report Card* either to compare HMOs (51%) or to get information about their current HMO (34%). Some *Quality Report Card* requestors indicated that they were not currently HMO members but were considering joining one (8%). A small number of respondents said they had requested the *Quality Report Card* booklet in the process of making a complaint about their HMO (2%).

Other consumer surveys

In 2002, a survey of CalPERS members found that 12% had used *California's Quality of Care Report Card* during

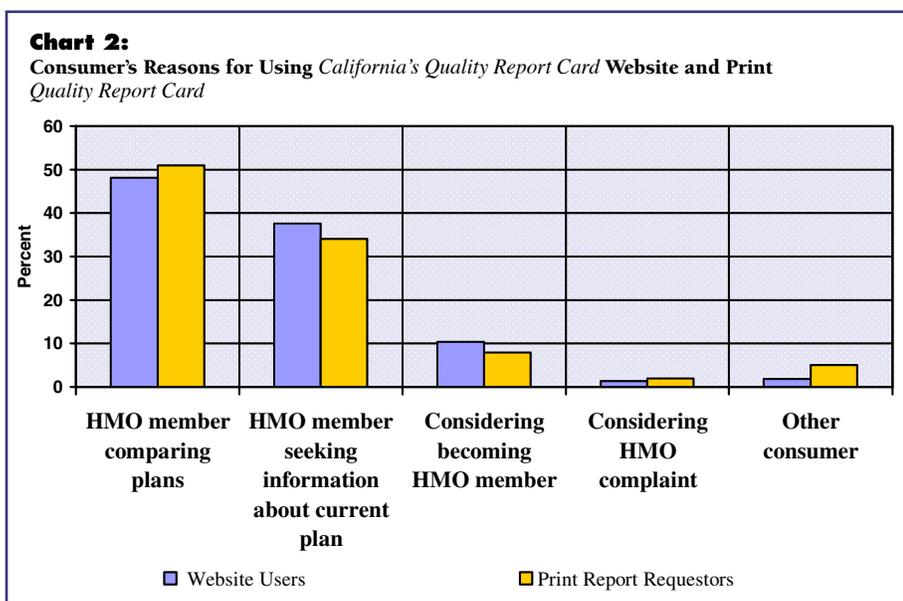
Open Enrollment 2002⁶. Among resources available to CalPERS members at that time, *California's Quality of Care Report Card* was the second most popular resource consulted during open enrollment, second only to CalPERS' own report card (CalPERS "Health Plan Quality and Performance Report"), which was viewed by 20% of CalPERS members. Members who had used the *Quality Report Card* were more likely to be among the group who were being forced to select a new plan during Open Enrollment 2002 because their plan was being discontinued as an offering to CalPERS members - 19% of those being forced to choose a new plan used the *Quality Report Card* compared to 10% of those who could continue with their current plan ($X^2=15.4$, $p < .000$). Among those in the optional choice group, members who used the *Quality Report Card* were less likely to switch health plans than members who did not use it or had never heard of it (2.1% v. 6.5%, $X^2=4.1$, $p < .05$). Those who had used the *Quality Report Card* during open enrollment were slightly more likely to report that they had "seriously considered switching health plan" compared to those who did not use it or had never heard of it (25.7% v. 22.6%, ns).

In 2003, a sample of PacAdvantage members received the print version of the *Quality Report Card* along with other materials during Open Enrollment.⁷ A group of members who did not

Consumers indicate that they most often heard about the website through the newspaper, Internet search, and radio or television.

receive the booklet were randomized to a control group. A post-Open Enrollment mail survey (N=1,106) found that 38% of the PacAdvantage members who received

the booklet read or reviewed it. Of those who used it, 46% spent less than 15 minutes reviewing it and 43% spent between 15 minutes and 30 minutes reviewing it. The group receiving the *Quality Report Card* was somewhat more likely to switch health plan (8.2% vs. 7.4%, ns). The direction of switching was unaffected; 24% of switchers who received the *Report Card* switched to a plan that received more stars (versus 34% of the switchers in the control group) and 28% of switchers in both groups switched to a plan that received fewer stars. For those answering the post-Open Enrollment survey, those who



received the *Quality Report Card* during open enrollment were more likely to say they had “seriously considered” switching their health plan (37% vs. 31%, $X^2=4.03$, $p < .03$).

How do California consumers find out about the *Quality of Care Report Card*?

For website users, the most frequently cited methods of finding out about the *Quality Report Card* site was an Internet search (30.1%), newspaper or other print media (30.9%) and radio or TV (17.1%). Some also said they heard about the site from their employer or health plan (6.9%). An additional 5.4% said they heard about it through an electronic message or group list serve. Friends or relatives were also cited as a method of hearing about the *Quality Report Card* website by 4% of respondents and health or consumer advocates were the source for about 3%.

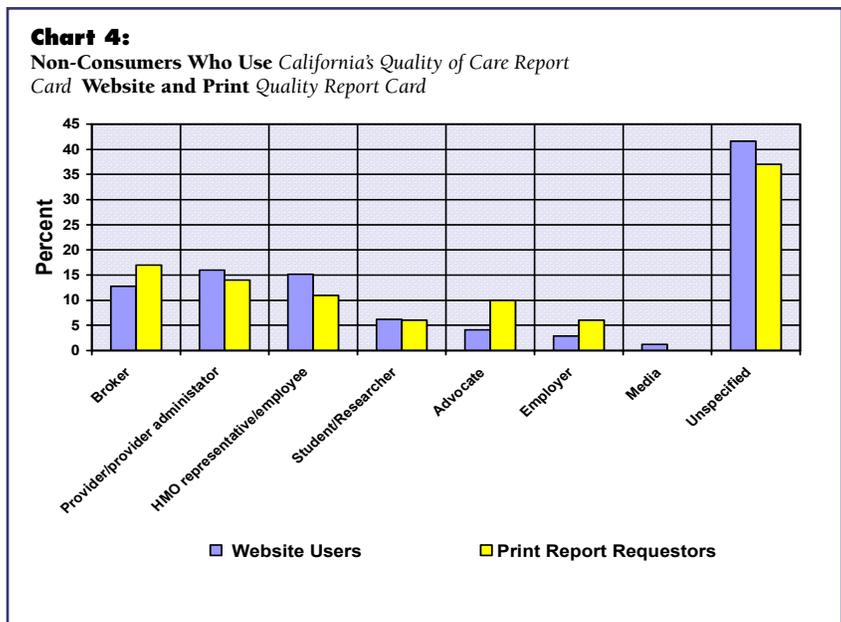
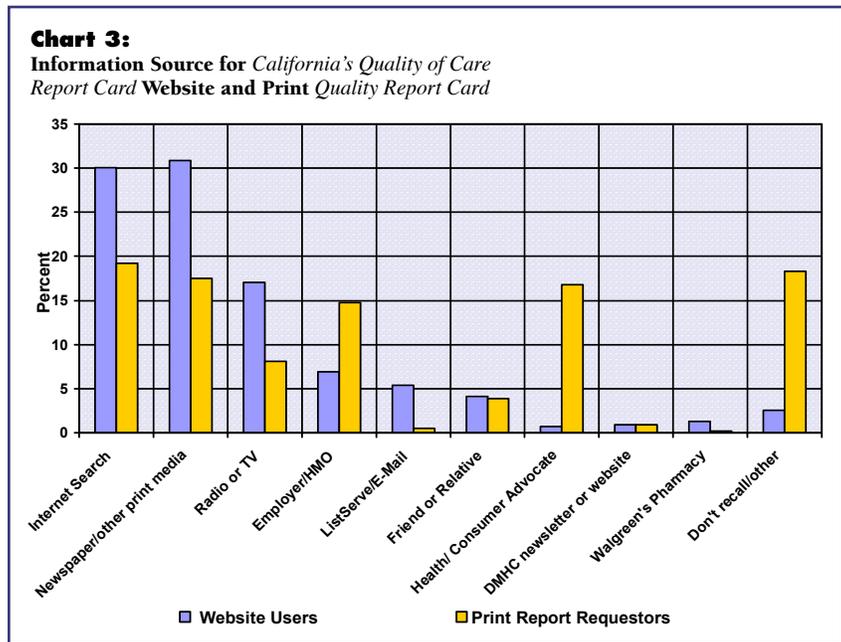
The newspaper (17.5%) and radio or TV (8.1%) were cited as ways of hearing about the print *Quality Report Card*, however some respondents said they heard about it through an Internet search (19.2%). Print report requestors also said they had heard about the *Quality Report Card* from their employer or health plan (14.8%) or from a health or consumer advocacy group (16.8%).⁸

Other users of California’s *Quality of Care Report Card*

A small percentage of website users and *Quality Report Card* requestors identify themselves as non-consumers. The identifiers for non-consumer *Quality Report Card* website users (n=275) include insurance brokers (12.8%), health care providers or provider group administrators (16%), employees or representatives of HMOs or health plans (15.2%), health advocates (4.1%), employers (2.9%), students or researchers (6.2%), and members of the media (1.2%) (Chart 4). The identifiers for non-consumer print *Quality Report Card* requestors (N=71) include insurance brokers (17%), health care providers or provider group administrators

(14%), employees or representatives of HMOs or health plans (11%), health advocates (10%), employers (6%) and students or researchers (6%).

The Quality Report Card is accessed by individuals who work for plans and providers as well as insurance brokers, health advocates, and researchers.





IV. HOW USEFUL IS THE QUALITY OF CARE REPORT CARD TO CALIFORNIA CONSUMERS?

Feedback from consumer focus groups

Focus groups comprised of Californians who had used the *Quality of Care Report Card* were convened to discuss the usefulness of the *Quality Report Card* for decision-making, which specific indicators were most and least useful, and how it could be improved. Findings from six groups conducted in April-June 2004 are presented here. A complete description of the focus group methods can be found in *Appendix – Methods – Consumer Focus Groups*.

Preferred Quality Categories and Measures The *Plan Service* measures were viewed as the most useful for comparing HMOs, followed by the measures included in the *Doctor Communication* category. Members preferred looking at the ratings by health topic or disease, such as diabetes or mental health, rather than the category headings currently used in the *Quality Report Card*. Some members found the category labels on the star chart difficult to understand and not very useful. In medical group ratings, *Overall Care Ratings* and *Specialty Care Access* were identified as key categories. Being able to access specialists easily and quickly was an important factor to all groups and most saw the ease of obtaining a referral as an important aspect of quality.

While each category received endorsement from some group members, other categories were seen as having little or no relevance. In particular, discussants said they would not use performance on prevention measures, such

as immunization rates. These measures are not particularly useful because they are viewed as being of interest to small or specific subsets of the population. Most groups thought that *Breast Cancer Screening*, would be an appropriate indicator for comparing plan performance. However, discussants commented that the actual bar chart results on the webpage were less useful than expected because all the plans appeared to reflect the same acceptable level of performance. They reported that unless the results differentiated among plans, the information was not likely to affect their decision-making. Discussants noted that most of the prevention measures apply to women and children and do not include some important men's health issues such as rates of prostate cancer screening.

Consumers preferred quality information presented by health topic or disease (e.g., diabetes, mental health) rather than category headings such as "care for living with illness".

The specific measures on the website that focus group members find most useful are the Plan Service measures for the HMOs and the Ease of Obtaining Specialty Care for the medical groups.

Comparative information on prevention measures were of less interest to the participants because they are seen as relevant to only specific types of people.

Preference for Print and Web Versions Except among discussants over 65, consumers felt the information in the booklet was too general and not particularly useful. Consumers were not clear about the difference between one, two, or three stars, and the “star chart” ratings showed similar results for all the HMOs, reducing the usefulness of the information in the booklet. Discussants, with the exception of some of the older individuals who said they did not have access to the Internet, stated a clear preference for the detailed information presented on the *Quality Report Card* website. The website provides more detailed and personally relevant information necessary to make more informed decisions. Consumers endorsed wide distribution of the print version of the *Quality Report Card*, since the Internet is not available to everyone.

Customized Information A recurring theme among focus group members was that information tailored to one's own health problems and characteristics, or those of a family member, was more useful. Consumers were interested in accessing the specific measures matching their demographics, such as age and gender, or health needs, such as diabetes or heart care. The groups discussed whether technology is available to allow website users to customize the information on the website. If so, the utility of the *Quality Report Card* would improve. Consumers thought “on-demand” printing of a personalized booklet would be useful. Individuals without children or with grown children wanted to bypass certain information such as children's immunizations or asthma. One group member suggested that the printed booklet could provide more detailed information if there was a separate booklet for each region of the state.

The ability to easily tailor the extensive information to one's own characteristics or health concerns or those of a family member would improve the usefulness of the website.

Consumers acknowledge the value of a report card that contains both types of measures contained in the current report card - administrative or medical record data and patient satisfaction surveys.

Value of Administrative vs. Survey Data Focus group participants indicated equal preference for measures based on both administrative and patient survey data sources. However, discussants wondered if administrative data took into account the fact that doctors “sometimes do the right thing” but patients are not always compliant.

Data from medical records was considered especially worthwhile because it “forces plans to be audited and compliant with some standards”. There were concerns about the source and quality of the data and questions about methods, such as how the data was collected, the sample size, and survey return rates. Members of one group thought there should be basic methodological information on the results charts themselves – that it should not require leaving the chart to find out the type of data, sample size, and return rate.

Other Information Desired Consumers in all of the focus groups said they wanted information about costs of coverage. They stated that not knowing the cost of the different plans made it hard to use the quality information in the actual decision-making process. Most agreed that cost, as well as benefits covered, would have to be weighed in selecting a plan. Whether the plan actually pays for the level of care in the prevention measures (e.g., screening for breast cancer every two years) was viewed as important. For some members, the cost of the plan or provider would be given more weight than the quality ratings. They would not necessarily pay more for a plan or provider that rated highly in the *Quality Report Card*. In addition to the information in the *Quality Report Card*, to make a truly informed choice, one would need provider directories, premium/contribution rates, and benefit schedules for each plan being considered. However, consumers who have several HMOs available to them may find this task complicated and time-consuming.

Focus group members noted that some quality indicators of great interest to them were not included in the *Quality Report Card*. They suggested that it would be useful to see information on how plans and medical groups give attention to “lifestyle” issues, such as nutrition, smoking, and obesity and how the doctors and plans are doing in the area of patient education on these issues. Additionally, there was interest in how the plans followed up with patients. The information on post-diagnosis treatment for cancer and other illnesses would be useful in making choices about plans and physicians.

Other concerns or questions noted in most groups included how consumers could find out about complaints and grievances against a plan or provider, how well plans do at mail order of prescriptions and how the plans and doctors have done over time – whether they are improving or declining in performance. It was also noted that the website or booklet should contain information on how to switch plans or medical groups if one feels they are “in the wrong plan” or “in a bad group”.

Other Findings and Comments by Focus Group Members

A number of the participants reported having little if any choice of plans or providers. The *Quality Report Card* contains far more providers and plans than most people need for comparison. Some consumers commented that it is a good idea to produce this information, however, their decisions about plans and providers often come from talking with family, friends, and co-workers. Others said the information would supplement other ways of making the decision.

There was some confusion in all groups about the difference between a plan and a medical group. Some of the confusion appeared related to Kaiser being both a medical group and a plan. Several noted that in the 2003/2004 *Quality Report Card*, the Kaiser health plan looked like a “good performer” but, in some regions, the Kaiser medical group did not appear to perform as well.

Focus group members generally favored the concept of public reporting of health plan information. They liked the idea that the *Quality Report Card* is produced by a government entity and that the participation of health plans is voluntary. Some groups wanted to know how the state pays for the production of the *Quality Report Card*, and whether it includes taxpayer funds. Advertising the *Quality Report Card* through newspaper and television (public service announcements) was endorsed. The groups also felt that the plans themselves should distribute the information in some way. Other venues could include doctor’s offices, pharmacies, government offices, and schools. Other members wanted health plans and medical providers to make it available to employers during open enrollment.

Most popular quality categories viewed on the *Quality Report Card* website

In the six months after the launch of the 2003/2004 *Quality of Care Report Card* there were 33,388 visits to the website (www.opa.ca.gov/report_card) by 16,539 unique visitors. Approximately 44% of website users proceed to view the HMO Quality statewide summary “star” chart and 21% view the medical group summary “star” chart for a specific county.

The most frequently viewed category for HMO quality is the *Plan Service* category (Chart 5). *Care for Living with Illness* is the least popular category. The health topic that receives the most attention is *Women’s Health Care*, followed by *Mental Health Care*, *Diabetes*, and *Heart Care* (Chart 6).

Sample Focus Group Member Comments:

“I like that it is an independent reliable government agency. It is easy to find out costs, not so easy to find out about quality.”

“I disagree with rating on the 1-3 stars system. This doesn’t give a true picture of the differences or lack thereof.”

“Change the presentation to get greater differentiation between plans. For a number of categories all plans seem the same, but they are likely different.”

“I want to compare HMOs by how well they treat serious/severe illness with possibly expensive treatments, such as cancer, HIV, etc. and this is nowhere in the site. I am not worried about preventive treatment or easily medicated illness such as high blood pressure or cholesterol, but I am scared of going to an HMO because of the rumor that illnesses with expensive treatments get short shrift...”

“I would use this information as a starting point, but then I would still call the plan or its’ customer service to get the other information I need on co-payments, benefits, drug formulary, etc.”

“I followed my doctor to a new group and everything was pretty much the same. My experience with the doctor is more important.”

“My medical group is not listed. Even if it is too small to qualify, I would like to see it listed and say ‘N/A’ due to not enough information.”

“How do I know what medical groups go with what HMOs?”

“I would have to know the cost of the plan before I would be able to really use this.”

“I switched plans but not medical group and I didn’t notice any difference in my care.”

“In the booklet, what were the research methods? How were data collected? What questions were asked and what was the sample size? Need a little more detailed information regarding where the ratings came from.”

“I think my care has improved since they started all these surveys...”

“A step in the right direction...”

Chart 5:
HMO Quality Category Viewed -
Number of Views for Category Opening Page
 California's Quality of Care Report Card 2003/2004 Website

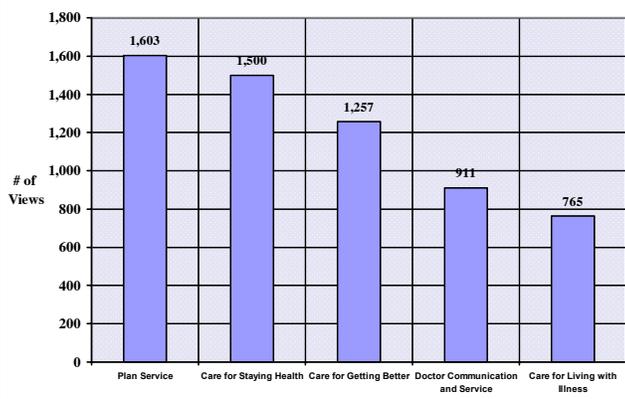


Chart 6:
Health Topic Category Viewed
 California's Quality of Care Report Card 2003/2004 Website

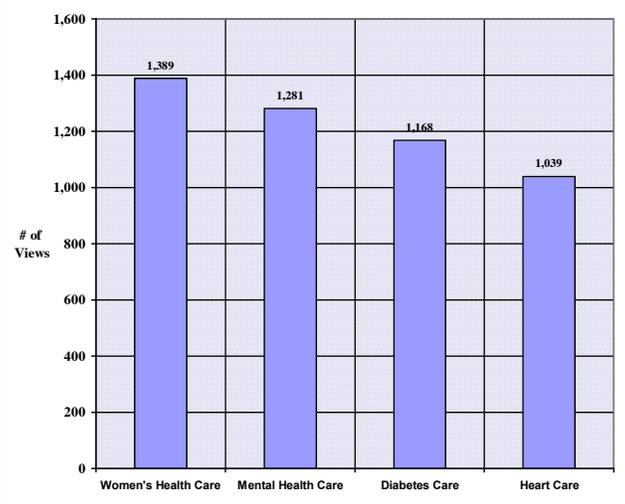
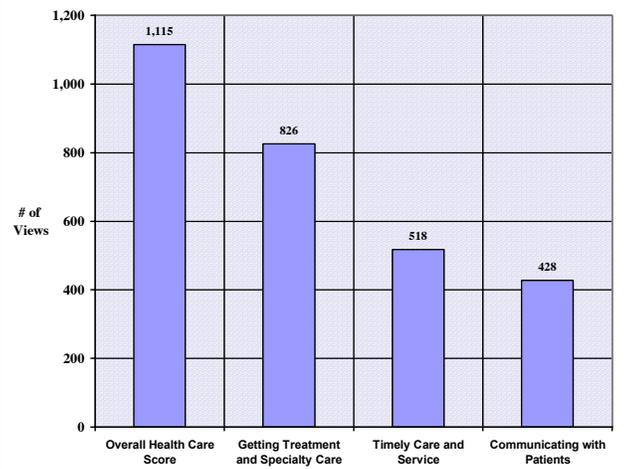


Chart 7:
Medical Group Quality Category Viewed
 California's Quality of Care Report Card 2003/2004 Website



The five *Plan Service* measures for the HMOs (overall plan rating for service, complaints handled quickly, getting needed care, customer service, paying claims) are among the top ten most popular specific performance indicators viewed by website users (Table 1).⁹ Two of the three mental health performance indicators (treatment visits for depression, anti-depressant medication ongoing treatment) are also among the top 10 most popular specific performance indicators viewed by website users. It is notable that the mental health performance indicators were rarely mentioned as being of particular interest during focus group discussions. This could indicate that the *Quality Report Card* website serves as a special resource where consumers can privately view comparative information on plan performance in mental health care.

*The five **Plan Service** indicators (i.e., overall plan rating for service, complaints handled quickly, getting needed care, customer service, and paying claims) are all among the top 10 most popular specific performance indicators viewed by consumers, a finding consistent with the comments of focus groups that this information resonates with consumers.*

The breast cancer screening and cervical cancer screening measures along with visits during pregnancy receive attention from both focus group members and website users. Some other HMO prevention/screening measures are not frequently viewed. Immunization rates, visits after delivery, and Chlamydia screening all appear in the lower half of the frequency distribution. Measures that apply to individuals with asthma are also infrequently looked at and considered of mild interest or importance in focus group discussions.

The most popular category viewed when comparing medical group performance was *Getting Treatment and Specialty Care* (Chart 7). The most popular specific measure was *Easy To See A Specialist* followed by *After Hours Help* in the *Timely Care and Service* category (Table 2).¹⁰ In general, the analysis of the website use supports the feedback from focus groups where consumers frequently wanted to know about the accessibility of specialty care when considering a medical group. Compared to the HMO level indicators, the medical group detailed measures were not viewed as frequently, perhaps reflecting that users leave the website before viewing medical group results.

Table 1: HMO Quality Indicators: 10 Most Popular Specific Results Pages Viewed California's Quality Report Card 2003/2004 Website

Specific Measure	Description	# Views (6 mos)	Quality Category	Health Topic
Overall Plan Rating	51% of members who rated their health plan highly overall— 8, 9 or 10 on a 0-10 scale.	1324	Plan Service	Not applicable
Treatment Visits For Depression	% of depressed patients who were seen at least 3 times during the 12-week initial treatment phase	1152	Care for Getting Better	Mental Health
Complaints Handled Quickly	% of members who reported that the plan resolved their complaint within one week.	996	Plan Service	No applicable
Getting Needed Care	Members ratings of their HMOs on helping members get the care they need	965	Plan Service	Not applicable
Breast Cancer Screening	% of women enrolled in the HMO, ages 52-69, who had a mammogram to test for breast cancer during the past two years	954	Care for Staying Healthy	Women's Health
Customer Service	Members ratings of their HMOs on providing good customer service	934	Plan Service	Not applicable
Controlling Cholesterol	% of members' whose cholesterol levels were well controlled after a heart attack or other serious heart problem/surgery	857	Care for Getting Better	Heart Care
Anti-depressant Medication Ongoing Treatment	% of depressed patients who remained on anti-depressant medication for a 6-month on-going care period that followed the initial treatment	820	Care for Getting Better	Mental Health
Paying Claims	Members ratings of their HMOs on paying claims correctly and quickl	809	Plan Service	Not applicable
Personal Doctor Highly Rated	% of members who rated their personal doctor highly — 8, 9 or 10 on a 0-10 scale.	808	Doctor Communication and Services	Not applicable

Table 2: Medical Group Quality Indicators: 10 Most Popular Specific Results Pages Viewed California's Quality of Care Report Card 2003/2004 Website

Specific Measure	Description	# Views	Quality
Easy to See a Specialist	% of patients who reported not have a problem seeing a specialist	780	Getting Treatment and Specialty Care
After Hours Help	% of patients who reported getting the care that they needed from their doctor's office after it was closed for the day	695	Timely Care and Service
Getting Tests and Treatment	% of patients who reported not have a problem getting care or tests that they or a doctor believed necessary	600	Getting Treatment and Specialty Care
Getting Appointments Soon	% of patients who reported getting appointments as soon as they wanted.	595	Timely Care and Service
Getting to Specialist: Routine Care	% of patients who reported being seen by a specialist for routine care as soon as they needed.	471	Getting Treatment and Specialty Care
Urgent Problems Seen Quickly	% of patients who reported getting care as soon as they wanted for an illness or injury.	449	Timely Care and Service
Aware of Your Specialty Care	% of patients who reported that their personal doctor was informed and up-to-date about the patient's specialty care	432	Getting Treatment and Specialty Care
Getting to Specialist: Urgent Care	% of patients who reported being seen by specialist for an urgent problem as soon as they needed	424	Getting Treatment and Specialty Care
Doctor Spends Time with Patient	% of patients who reported that their doctors spend enough time with them.	413	Communicating with Patients
Seeing Doctor Quickly: Urgent Care	% of patients who reported getting illness or injury care from their personal doctor as soon as they wanted	368	Timely Care and Service

Usefulness of the quality categories on the Quality Report Card website

When asked to rate the usefulness of the ratings categories, the majority of website user rated all the categories as “very” or “extremely” useful when selecting a health plan.¹¹ Consistent with the findings from the consumer focus groups and the website usage trends, the HMO category that receives the highest usefulness rating is *Plan Service*; 65.5% find this category useful. The least useful category is *Care for Living With Illness*; 58.8% of respondents rated this as useful when selecting a plan (Chart 8). The category receiving the most favorable rating for usefulness among website users is *Medical Group—Overall Care Rating*. This category was rated as “very” or “extremely” useful when selecting a medical group by 66.7% of respondents. Most respondents also give high usefulness ratings (63% or greater) to the other 3 medical group categories. (Chart 9). When asked how important the HMO quality ratings were in choosing a health plan, the majority of consumers (76.7%) found the ratings to be very important.¹² Consumers also found the medical group quality ratings important in choosing a medical group (74.1%).

What do users like most about the Quality Report Card website?

Many consumers liked that the information on the website allowed them to directly compare HMOs and providers. The fact that the information is made available to consumers and that the plans themselves were not the

Sample Website User's Comments:

“One of the few sites that will directly compare HMOs...”

“I like ... the ability to rank my HMO with others; it gave me confidence in my choice...”

“The best thing about this site is.. that it exists...”

“It's the most comprehensive 'third party' report I've seen not linked to an HMO or medical group's website”..

“What I like most about the site is ...that this information is readily available...”

“It might help to keep insurance companies and medical groups striving to improve”

“It's very helpful knowing they are being checked”.

“Easy to use and navigate through..”

“Far better and quicker than paper research...”

“Easy to use and understand and compare ratings”.

source of the information was also cited as important. The website was judged easy to use by the majority of respondents. Over 75% said they either agreed or strongly agreed with the statement that “the instructions on the site were clear” and 77% either agreed or strongly agreed with the statement, “I could move through the site easily.” Ease of use was frequently mentioned as a positive aspect of the site. Almost all website users (89%) said that they would recommend the *Quality Report Card* to others.

What would users change about the Quality Report Card website?

Changes to the *Quality Report Card* website suggested by consumers included adding information on member complaints about plans and how they are resolved. Another frequent suggestion was that the site should provide data on PPOs in addition to HMOs. Some consumers noted that they do not have a choice of HMOs, but can choose among

Chart 8:
Usefulness of HMO Quality Categories When Selecting a Health Plan
California's Quality of Care Report Card Website and Print Report Card

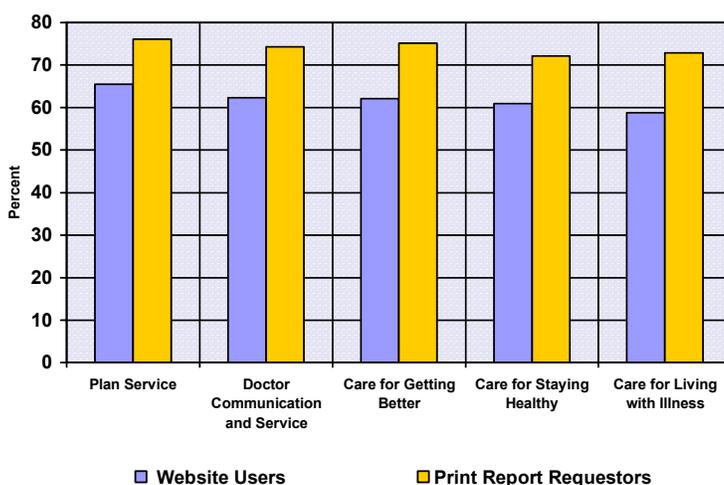
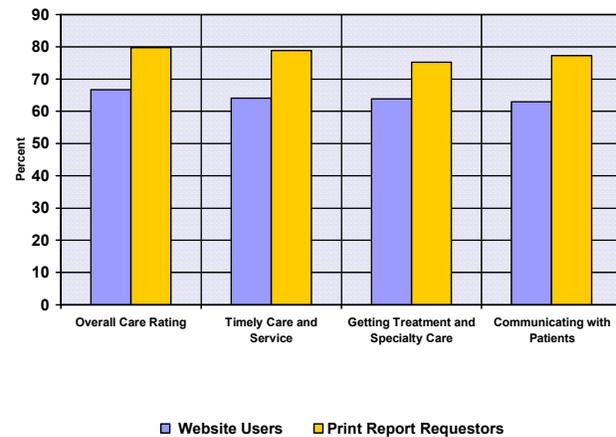


Chart 9:
Usefulness of Medical Group Quality Categories
When Selecting a Medical Group *California's Quality of Care Report Card Website and Print Report Card*



several medical groups within a PPO Plan. A suggestion was made that information on a greater number of medical groups and individual physicians should be included.

Some consumers indicated that they would have liked more information about the data and research methods. A frequent comment was that the star system did not provide enough information to evaluate the quality differences among the plans or groups. When asked whether there are aspects of health care that are important but not included in the *Quality Report Card*, consumers mentioned that the cost of plans and providers was an important factor and that including it on the website would make the information far more useful. The suggestion that the website include information on grievances and complaints against the plans was repeated. Another clear theme was the potential for including information on treatments covered, denials of referrals, and/or coverage for pre-existing conditions. Another suggested addition to the site was information that would allow users to compare the plans on their prescription drug benefits and service quality.

Usefulness of the print *Quality Report Card*

Users of the print *Quality Report Card* were asked to rate the usefulness of the HMO quality categories when selecting a health plan. The majority rated all the categories as “very” or “extremely” useful. Consistent with the findings from the consumer focus groups, the website usage trends, and the survey of website users, print *Quality Report Card* requestors find the *Plan Service* ratings to be most useful.

Website User's Comments:

“I would prefer to look at two plans and do a direct comparison. I can only choose from 2 of the ones listed”.

“Survey whether people have a choice of HMOs first. Though I see medical care providers to whom I would transfer, my employer does not offer coverage with those groups, so I can't ‘choose’ an HMO.”

“Present the medical group data according to which HMOs they are in...”

“Perhaps give a little more explanation of what the ratings mean. What does it take to get 3 stars, versus 2, versus 1; what 95% means to the typical patient experience.”

“Ratings are all too similar. Every plan always seems to score between 70% and 80% in every category. There needs to be better ways to differentiate the really bad ones from the ‘just a little bad’ ones. I can't believe every HMO in the state really has a 70% or better approval rating”.

“Since (name of plan) came out so high, I went to their site, only to find it is significantly more expensive than my current plan. Cost is not a factor in your survey.”

“You should list any complaints against the HMO and/or doctors, nurses, etc. The public has a right to know about complaints and medical mistakes.”

“Show the number of ‘adverse’ actions filed against an HMO – let us see who generally makes life difficult for its members.”

“Data for HMO providers regarding the number of referrals requested vs. denied would be helpful (if you could pull the teeth necessary to get the data).”

“How many times a decision to deny coverage is reversed by state authorities should be included in the analysis”.

“I am worried about getting the medicines prescribed to me. I wish I could be sure my HMO was no different from the others in offering drug benefits. That is one thing missing in these charts.”

“I am having an unforeseen problem with the (name of plan) prescription drug formulary. I expected my generics to be covered and they are not. I sure wish you had specific question like ‘Does the pharmacy benefit cover the prescription your doctor thought was most suitable for you?’”

Plan service was rated as useful by 76.1% of respondents. The two least useful categories are *Care For Staying Healthy* (72.1%) and *Care For Living With Illness* (72.8%). All of the categories received higher ratings from the print report requestors than the website users. (Chart 8)

The majority of Quality Report Card Booklet users surveyed say the quality ratings are "very important" in helping them choose a health plan (82%) or medical group (84%).

As with website users, the most useful category to *Quality Report Card* requestors is *Medical Group – Overall Care Rating*, which is seen as useful by 79.8% of respondents. Two-thirds of respondents also give high usefulness ratings (75% or greater) to the other three medical group categories (Chart 9)

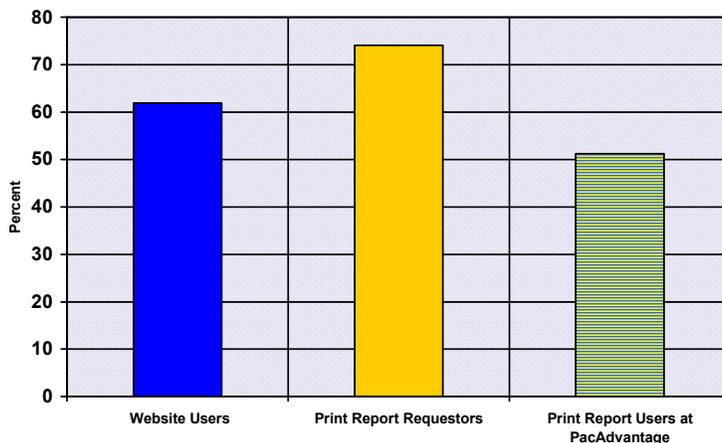
When asked how important the HMO quality ratings were in choosing a health plan, the majority of consumers who used the booklet (81.6%) found the ratings to be "very" or "extremely" important in helping them choose a plan. Booklet users also found the medical group quality ratings important in choosing a medical group (83.5%).

Findings from other surveys on the usefulness of the Quality Report Card

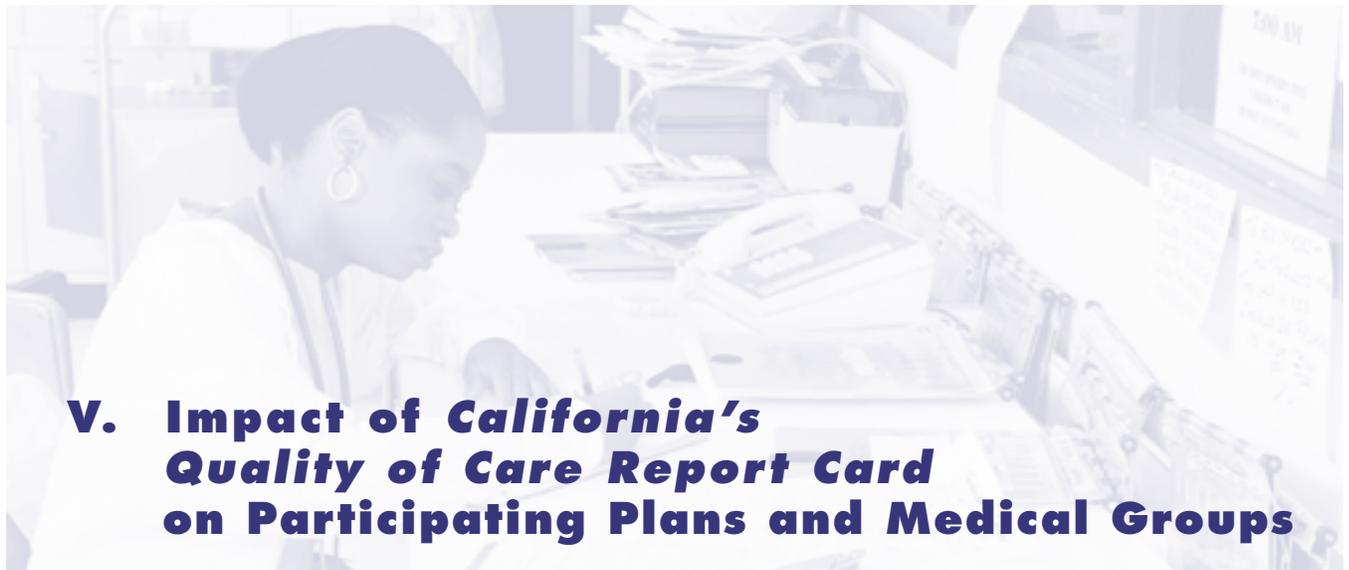
Among PacAdvantage members who had reviewed the *Quality Report Card* booklet during Open Enrollment 2003, 51% said the booklet was at least somewhat useful when making a decision about which health plan to select for the upcoming year.¹³ When asked how much influence the *Quality Report Card* had on their decisions during Open Enrollment, 37% said the *Quality Report Card* had at least some influence on their choice of health plan and 22% said it was influential in their choice of medical group.¹⁴ Comparing the usefulness ratings of website users, print report requestors, and Pac Advantage members, the most positive ratings are from print report requestors (Chart 10).

CalPERS members reviewed a list of 19 factors and were asked to rate them in terms of their importance in their selection of health plan. Five of six measures included in the *Quality Report Card* were selected as among the ten most important, including "easy to see a doctor quickly when needed", "ease of getting a referral for specialty care", "rates of screening for serious problems (e.g., breast cancer)", "management of chronic health problems (e.g., diabetes, asthma, heart disease, or depression)", and "overall satisfaction rating according to plan members". Another measure included in the *Quality Report Card*, "rates of immunizing children and older adults", was not highly rated (15th out of 19).

Chart 10:
Overall Usefulness of California's Quality of Care Report Card (Print)
When Selecting a Health Plan



% rating Report Card as "very" or "extremely" useful
(average rating for all HMO quality categories combined)



V. Impact of California's Quality of Care Report Card on Participating Plans and Medical Groups

Interviews with Key Informants in HMOs and Medical Groups

An objective of California's Quality of Care Report Card is to assist HMOs in their own quality improvement efforts by providing them with data on their performance in relationship to other HMOs in the state. As the number of participating medical groups increases, the *Quality Report Card* may play an expanding role in providing medical groups with timely data on their performance in relation to other provider groups in the state. To what extent and in what ways has the *Quality Report Card* impacted the 10 HMOs and 118 medical groups included in the 2003/2004 *Quality Report Card*? A survey of key informants in health plans and medical groups sought to address the following research questions¹⁵:

- Are HMO and medical group quality leaders familiar with the *Quality Report Card*, in either print or web format?
- How useful are the specific performance measures in the *Quality Report Card* for quality improvement at HMOs or medical groups? What other uses do providers find for the *Quality Report Card*?
- What impact, if any, does the *Quality Report Card* have on the market share and reputation of California HMOs and medical groups?
- What are the attitudes of HMOs and medical

groups with respect to the *Quality Report Card* and public reporting of quality information?

Interviews were completed with 21 key informants from the HMOs, with at least two respondents from each plan. Half the individuals interviewed were senior executives, such as CEOs, and half were clinical quality leaders, such as medical directors and directors of quality improvement who had oversight of the plan's participation in quality reporting activities. One or more informants in each of the 118 participating medical groups were sent a survey via e-mail. A subset of informants in 24 medical groups was interviewed by telephone. The majority of respondents in the medical groups were medical directors (62%) or quality managers (33%).

Familiarity with California's Quality of Care Report Card

At least one key informant in each of the 10 HMOs recalled seeing California's Quality of Care Report Card 2003/2004, either in print or on the Internet. With one exception, all medical group respondents were familiar with the *Quality Report Card* (Chart 11). The majority of key informants in HMOs (68%) spent 20 minutes or less reviewing the information in the *Quality Report Card*. Most medical group informants (63%) said they spent twenty minutes or less reviewing it but more than one-third indicated they spent more than 20 minutes.

Three-quarters of HMO respondents said they had shared or discussed their plan's performance in the *Quality Report Card* with medical staff or quality improvement staff or both. Other departments with whom they shared the report include public relations, board of directors, or marketing departments (Chart 12). Medical groups reported somewhat greater distribution of the *Quality Report Card* within their organizations than HMOs. Two-thirds of medical group respondents reported sharing or discussing their medical group's performance in the *Quality Report Card* with clinical quality improvement

staff. Over half (54%) also said it was shared with their board of directors. Only a few medical group respondents (23%) indicated their results had been shared with marketing or public relations units.

Usefulness of the Quality Report Card for Quality Improvement

HMOs: In general, the HMO informants find the measures in the *Quality Report Card* to be of limited usefulness in improving the quality of care provided by their organization. When asked to rate the overall usefulness of the measures in the *Quality Report Card*, only 13% of those interviewed reported they were useful for quality improvement.¹⁶ The measures in the *Doctor Communication and Services* category receive the highest ratings from respondents.¹⁷ With one exception (*Helpful Office Staff*), all the specific measures in this category were rated as useful by at least half of respondents. The *Getting Care Quickly* measure was rated as useful for quality improvement by 70% of informants. Two other indicators in this category; how patients rate their *Specialty Care Doctor* and how well *Doctors Communicate* with patients, were viewed as useful by 60% of those interviewed.

The measures included in the *Care for Getting Better* category are considered the least useful for quality improvement. Four of the seven indicators in this category are seen as useful by no more than half of those interviewed. The measures pertaining to *Depression Treatment* and *Anti-Depression Medication* are considered not useful by more than 70% of those interviewed. In the *Care for Staying Healthy* category, only one measure, *Breast Cancer Screening*, is viewed as useful for quality improvement by 60% of respondents. In the *Care for Living with Illness* category, 40% of respondents felt that none of the specific quality measures were useful. Only one indicator in the *Plan Service* category, *Customer Service*, received positive endorsement for quality improvement from more than half of those interviewed.

Medical Groups Informants from medical groups report that the specific measures in the *Quality Report Card* are at least

Chart 11: Familiarity with California's Quality of Care Report Card Website and Print Report Card Among HMO and Medical Group Informants

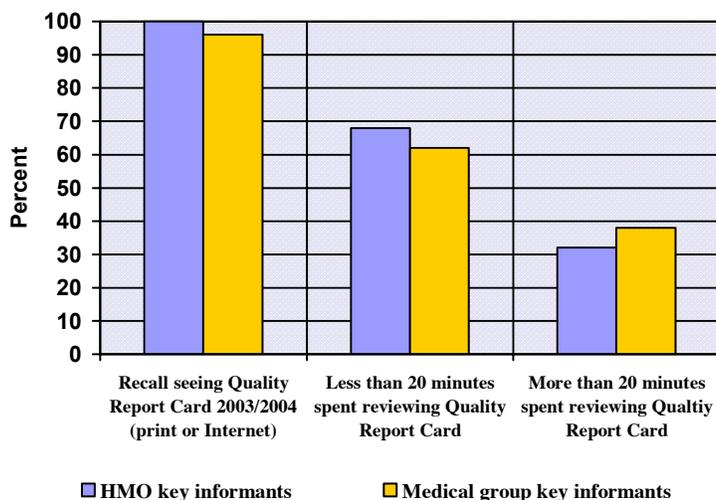
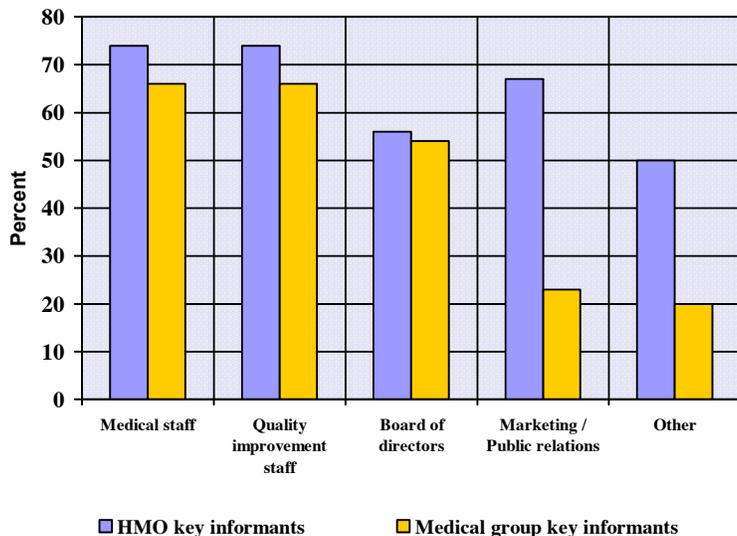


Chart 12: Dissemination of California's Quality of Care Report Card Within Participating HMOs and Medical Groups



somewhat useful in their quality improvement activities. The majority of respondents viewed each specific quality indicator in the *Communicating with Patients* category favorably.¹⁸ *Doctor Explains Clearly* was rated as useful by 78% of those surveyed. Several of the measures in the largest category, *Timely Care and Services*, were rated as being useful for quality improvement by more than two-thirds of those surveyed, including *After Hours Help*, *Help Over the Phone*, *Seeing Doctor Quickly for Urgent Care*, and *Seeing Doctor for Preventive Care*. The measures included in the category *Getting Treatment and Specialty Care* are the least useful for quality improvement in medical groups. The majority of respondents rated only one specific measure, *Getting Tests and Treatments*, as useful.

Quality Improvement Activities Informants described a number of quality improvement activities undertaken in response to quality reporting (Table 3). In addition, other quality improvement activities mentioned by key informants in the HMOs include:

- Working on new disease management programs for diabetes, asthma, cancer
- Encouraging case management by physician extenders
- Initiating diet, anti-smoking, exercise programs
- Strengthened RN/MD teams

When asked whether any of the activities in the past 18 months were directly related to the organization's

performance in the *Quality Report Card*, only 13% said yes.

Medical group informants mentioned several types of quality improvement activities, including increased quality discussions with internal staff and boards of directors (46%), changes in the way data are reported (54%), and the introduction of computerized physician order processes (27%). Examples of data-related changes include:

- More standardized computer reports for internal use
- Increasing the frequency of data reporting to plans and others
- Use of hard copy standardized questionnaires for patients
- Linking data to financial incentives
- Improved responsiveness to external data requests

Medical group respondents indicated that at least some of these quality improvement activities had been undertaken in response to the *Quality Report Card* – about 46% of medical group respondents indicated that the *Quality Report Card* had at least some influence, direct or indirect, on the type and emphasis of quality improvement activities within their medical groups. Overall, more than half of the medical group respondents (54%) thought the *Quality Report Card* was useful for monitoring or improving quality.

Table 3: Quality Improvement Activities Related to Public Reporting (past 18 months) According to Key Informants in HMOs and Medical Groups

Activity	Informants reporting activity within their HMOs (N=21)	Informants reporting activity within their Medical Group (N=35)
Instituted a new or revised process of care	74%	40%
Provided guidelines for best practices and shared benchmark information with providers	53%	55%
Changed the way data are reported or how frequently	63%	55%
Initiated computerized medical record or physician order entry	63%	26%
Sent reminders for preventive care	58%	49%
Instituted use of cross functional workgroups, conducted workshop or training in doctor-patient communication	63%	38%
Collected data out of medical records and shared results	53%	49%
Used staff incentives, rewards, recognition	47%	49%
Held board meetings or staff discussions	37%	47%
Other activities	37%	35%

Other Uses for the Quality Report Card

In both HMOs and medical groups, the *Quality Report Card* serves another important purpose – benchmarking performance to allow comparisons with similar plans or providers. This was frequently mentioned as one of the ways in which it was helpful. Almost half of HMO respondents and a majority of medical group informants said they had looked at the report card in order to compare their results with their competitors (Chart 13).

About two-thirds of HMO respondents and three-fourths of medical group informants were unable to recall any media coverage of their organizations' performance in the *Quality Report Card*. However, some recalled that a story had appeared in local newspapers or on local television news programs. The HMOs themselves rarely utilize the comparative quality information for marketing purposes. Two informants stated that their results had been part of a marketing or advertising campaign, highlighting the HMO's good performance. In a few cases, a medical group's marketing unit utilized the report card for advertising (17%).

Impact of the Quality Report Card on Market Share and Reputation

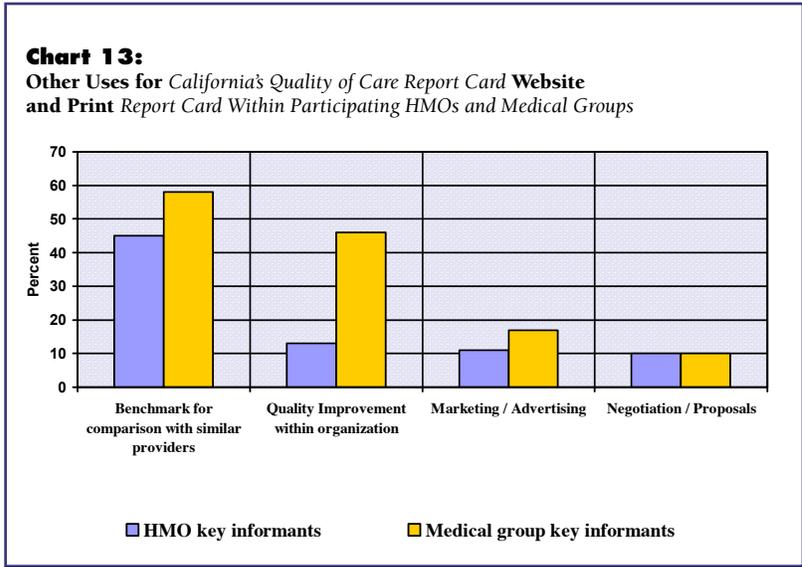
HMOs The majority of the respondents (68%) felt the *Quality Report Card* would have no impact on their organizations' market share (Chart 14). Two-thirds of those who said it would have an impact indicated that it would decrease rather than enhance the HMOs market share. When asked whether they thought it would affect their organizations' public image, most (53%) felt it had no discernible impact. Among those who felt it would have an impact, 44% thought it would detract rather than enhance the HMOs public image, primarily due to the impact of negative media coverage on consumers.

Medical Groups Even fewer medical group informants felt that the *Quality Report Card* would impact their medical groups' market share, with the majority (72%) indicating it would have no effect. Sixty-two percent felt it would have no discernible impact or affect on their medical groups' reputation. Among those who thought it would impact their reputation, most (70%) thought the impact would be positive.

Opinions about the Quality Report Card and the Public Reporting of Quality Information

Key informants in the HMOs and medical groups expressed a wide range of opinions regarding the *Report Card* and the public reporting of quality information in general. Key findings and suggestions for improvement are highlighted below.

Validity of the Data: Most respondents (63% HMO informants, 51% medical group informants) indicate that the data behind the *Quality Report Card* has moderate validity (Chart 15). However some expressed concern that the data are not well reflected in the "star charts" that appear in the booklet and on the website summary



pages. A few mentioned that the weights used to calculate summary measures were not transparent and appeared to have changed from year to year. Medical group respondents expressed that more should be done to account for differences among types of groups and felt that OPA did not appear to have adequate technical expertise in statistics.

Reflection of Actual Performance: Less than half of both HMO and medical group informants (42% and 40% respectively) stated that the *Quality Report Card's* scores were an accurate reflection their organization's true quality of care (Chart 15). However, the medical group respondents indicated that the information was "very useful", especially in comparative quality benchmarking among medical groups and in negotiations with HMOs.

Appropriateness for Public Use: Respondents suggested

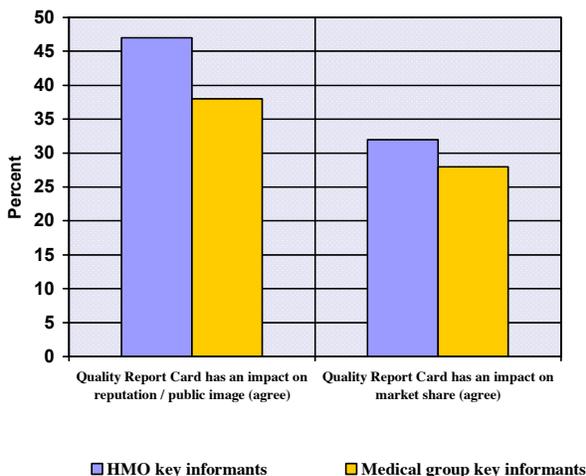
that if the number of detailed measures included in the *Quality Report Card* was increased, consumers could see how plans and groups actually compare. However, there was considerable criticism of the usefulness of the clinical measures themselves in their inability to reflect actual physician performance. Less than half of the informants in HMOs and medical groups (42% each) said that the *Quality Report Card's* results were appropriate for use by consumers in selecting plans or providers (Chart 15).

Responsibility for public reporting of quality information:

Although most respondents are familiar with the *Quality Report Card*, there is confusion as to its source. Four respondents believed that the Department of Managed Health Care (DMHC) was responsible for the production of the *Quality Report Card* and the collection of the data it includes. Many considered OPA to be part of DMHC, although some respondents did recognize OPA as a separate entity, even if closely linked to DMHC. Some HMO respondents (75%) volunteered negative opinions of DMHC, including the perception that its leadership was antagonistic to the health plan industry and did not appear to appreciate the complexities of the health plan arena. They acknowledged that some of this antagonism “spilled over” to OPA, possibly due to the ambiguity of organizational linkages between OPA and DMHC.

Despite the somewhat negative view of the state entity responsible for oversight of HMOs, a majority of HMO respondents said OPA or a similar public agency should continue to be responsible for developing and distributing the *Quality Report Card* (Chart 15). The majority of

Chart 14:
Perceived Impact of California's Quality of Care Report Card on Reputation and Market Share of Participating HMOs and Medical Groups



Opinions of Key Informants in Health Plans and Medical Groups: Quality Report Card Is Biased or Unfair

“At (health plan), we think it is unfair and discriminates against honest reporters by making them appear worse.”

“The Quality Report Card doesn’t measure quality of care... It mostly measures customer satisfaction”.

“OPA should adjust the data in the Quality Report Card to take into account smaller medical groups that can’t afford to hire data-gathering and quality improvement staff.”

The Quality Report Card should distinguish among medical groups by type of group, type of contract with health plans, and by type of payor.

The weights used for the ‘star’ summary measures “are not statistically sound” and “have been capriciously changed without input from medical groups”.

“Medical groups don’t serve patients, doctors serve patients”.

The underlying data sets in the Quality Report Card need “more measures with more emphasis on clinical outcomes and better consumer samples”.

Opinions of Key Informants in Health Plans and Medical Groups: Quality Report Card Is Too General

“The Quality Report Card measures are too general, they do not get at quality of care and ‘seemingly’ focus on what doctors do, not health plans.”

“The ‘star measures’ are valid indicators but the Quality Report Card should add more specific clinical measures that get at patient outcomes.”

“The printed Quality Report Card needs to include a (simple) explanation of what the stars mean and how they are developed...”

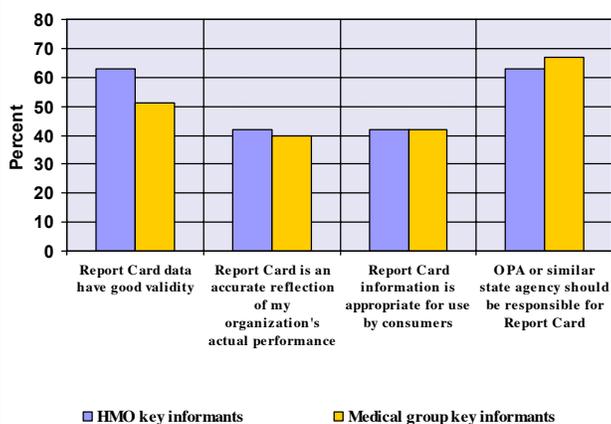
medical group informants also supported OPA's role as the pertinent state agency. However, some HMO respondents favored reducing OPA's role and giving the plans more input in the *Report Card*. They suggest a public-private partnership be responsible for production and distribution of the *Quality Report Card*. Some commented that steps were being taken in this direction through IHA and the Pay-for-Performance program. Other medical group respondents specifically commended OPA's role in coordinating with IHA, PBGH and CCHRI and said these efforts should be strengthened. Most respondents in both HMOs and medical groups are opposed to a report card produced exclusively by a private entity, whether non-

profit or for-profit.

Suggested Improvements for California's Quality Report Card

The most frequently mentioned suggestion from both HMO and medical group respondents (40%) was to include more measures as part of the "stars" ratings (Chart 16). More measures of clinical quality, even if more complex, would improve the *Quality Report Card's* validity and make it a more accurate measure of quality of care and consumer satisfaction. Medical group informants

Chart 15:
Opinions About California's Quality of Care Report Card Among HMO and Medical Group Informants



Opinions of Key Informants in Health Plans and Medical Groups: Usefulness of the Quality Report Card

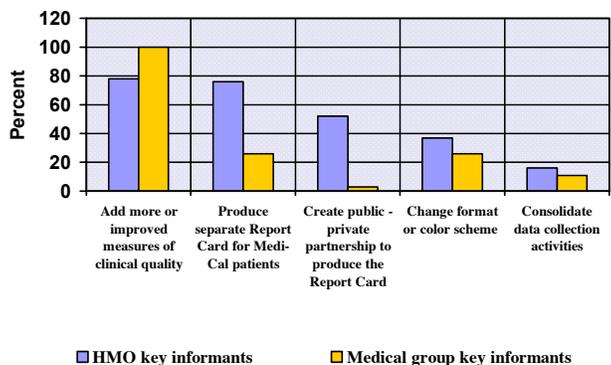
"We love the Quality Report Card because it helps consumers and doctors and is easy to understand and use as benchmark."

"The Quality Report Card changed the organization... (we) added a 'quality initiatives' department and hired an MD and RN to run it and used scores (on the Report Card) in employer proposal price quotes."

(We) "use the Report Card in negotiations with affiliated medical groups... it offers leverage to (the health plan)."

"The Quality Report Card, along with the Pay-for-Performance program, has resulted in (our) hiring more data gathering and reporting staff and has allowed medical groups to compare themselves in California".

Chart 16:
Suggested Improvements for California's Quality of Care Report Card Among HMO and Medical Group Informants



Opinions of Key Informants in Health Plans and Medical Groups: Future of the Report Card

"Reporting on quality of care to (the public) will greatly expand in the near future because that is what government and consumers want."

"There should be more cooperation and coordination among IHA, PBGH, CCHRI and OPA and OPA as a public agency should be in the lead on this initiative".

We are impressed with ... "the efforts of (the OPA Director) and staff."

"The future of reporting to the public on (health care) quality by state (agencies) is very bright and (the role of) OPA will expand."

stated that the “star” system was less than ideal because it was too simplistic for provider feedback or quality improvement purposes, and at the same time too difficult for consumers to fully understand.

Many informants were not aware that the *Quality Report Card* included only commercial enrollees and indicated that OPA should make this clearer in its presentation of results. Medicare and Medi-Cal enrollees are viewed as distinct types of patients and informants believe that performance on the quality measures may differ by type of patient. HMO informants expressed an interest in a separate and/or separable Medi-Cal Report Card, on the

basis that these enrollees are different from commercial enrollees and respond to different incentives.

Medical group informants mentioned that a single consumer-oriented report card, produced by OPA or some other neutral public agency, would be welcome, especially if there were an increased advisory role for the medical groups. Strengthening data-reporting collaboration among OPA, CCHRI and other pertinent organizations is a positive step.



VI. Recommendations

Consumer Use of the Quality of Care Report Card

Build on the generally positive attitude toward public reporting. Consumers endorse the concept of publicly available quality comparisons as a positive step toward making managed care accountable to patients, even if it has limited direct influence on their choices. Publication of the data should be continued by OPA or a similar entity that does not appear to have a stake in the results.

Explore new approaches for publicizing the website.

Ideas suggested by consumers for searching the Internet and finding the website could be incorporated, including providing links on popular health-related websites. Advertising about the OPA website in print media, television and radio, especially at times when consumers are most likely to use the information, such as employer open enrollment months, should continue or increase. Health plans and doctor's offices should be enlisted to provide the website address on in-office posters or patient materials. Consumers report their contacts with health-advocacy groups often led them to the website. OPA should engage in outreach to these groups in order to make the *Quality Report Card* more visible. Consumers who have a problem with their HMO also have exposure to the website. The *Quality Report Card* should be easily accessed from the DMHC complaint website.

Consider additional venues for disseminating the booklet. Many consumers interested in quality information but

who lack Internet access or prefer summary measures (such as senior citizens) find the booklet helpful. OPA could expand the number of outlets for distribution of the print *Quality Report Card*. Venues suggested by these consumers included placement of the booklets in doctor's offices, mailings by health plans and employers, distribution to additional pharmacies, and placement at health fairs or community centers.

Usefulness of the Quality of Care Report Card

Present the results by health topic. Only one of the current category titles (*Plan Service*) is intuitively appealing to consumers. Consumers prefer to go directly to the results for health topics or diseases that are relevant to them, such as women's health, diabetes, heart care, or mental health. Except for the *Plan Service* category, the current categories for organizing the results could be replaced with health topic categories in the booklet and made less prominent on the website opening pages.

Highlight measures that resonate most with consumers.

When comparing health plans, consumers consistently named a set of measures that should be more prominently displayed or easily accessed. Consumers want to move quickly to the results for the *Plan Service* measures (e.g., quick complaint resolution, prompt care, and good customer service), *Mental Health* measures, since they are not easily accessed elsewhere, and access to and delivery

of *Specialty Care*. The website should simplify or reduce steps necessary to “drill down” to these results.

Consider adding measures in areas of increasing interest to consumers. Consumers expressed interest in measures of plan and medical group performance in “lifestyle” topics, such as obesity, nutrition, and smoking cessation. Additional measures on topics relevant to men, such as prostate cancer screening, should be explored. A separate direct link to information about complaints and grievances would be useful.

Explore improvements to the website that would permit users to tailor the information to their own demographics and health care needs. Some of the elements on the website are ignored by many users. OPA could improve the *Quality Report Card* by implementing existing technology for tailoring website paths based on user-supplied data, such as geographic location, age, gender, disease states or chronic conditions.

Make it easier for consumers to move quickly to medical group comparisons. The *Quality Report Card* includes additional medical groups each year. Consumers report they have a wider choice of medical groups than health plans. Making the link to information on medical groups more prominent on the website opening page could improve its utility for consumers. A mapping of the medical group to HMO membership should be easily retrievable for users.

Retain measures based on both types of data – medical records and administrative data as well as patient survey. Consumers value administrative data and also recognize the patient experience and satisfaction survey results as an important source of information about people “like them”.

Explore improvements to the website that would permit users to view quality results at the same time as cost and benefit data. Improved linkages between the OPA website and the health benefits websites of large employers and purchasing groups might move some consumers closer to their preference of viewing quality data “side-by-side” with cost and coverage information.

Continue annual efforts to evaluate the usefulness of the Quality Report Card for informing consumer choice. OPA should continue to survey both website and booklet users for feedback and suggestions for improvement. Consumer focus groups should be conducted throughout the state annually to facilitate modifications and refinements based on feedback from actual and potential users of the information.

Impact on Quality Improvement in HMOs and Medical Groups

Provide health plans and medical groups with additional guidance on how to use the Quality Report Card for quality improvement. The impact that the *Quality Report Card* has on plans and medical groups provides an indirect but important benefit to consumers because plans may focus on quality improvements that could impact their results. Currently, plans and medical groups report little in the way of specific quality improvement activities pertaining to the *Quality Report Card*. OPA should consider convening a workshop or some other form of outreach to quality improvement staff that explains how the specific measures are defined and calculated and how specific practices translate into performance results. Medical groups appear more inclined to institute quality improvement activities in response to their *Quality Report Card* results, so specific recruitment of their participation is warranted.

Continue to cultivate the endorsement of plans and providers in the public reporting “movement” by addressing some of their concerns about comprehensiveness and validity. Most key informants suggested that additional measures be included in the summary results and that additional reports be undertaken for Medi-Cal patients. OPA should consider convening work groups which include plans and providers to explore the feasibility of these ideas.

Take steps to ensure the Quality Report Card is responsive to the changing managed care environment in California. Meetings to stay abreast of new organizational arrangements and continued coordination with provider groups and plans and incentive arrangements such as “pay for performance” are critical.

Endnotes

- ¹ A detailed description of the content of *California's Quality of Care Report Card 2003/2004* is given in *Appendix – Description of California's Quality of Care Report Card 2003/2004*.
- ² Information provided by OPA.
- ³ The Evaluation does not include an assessment of the linguistic services portion of the Report Card because a separate report was recently commissioned to evaluate these services, including the collection of detailed data from California consumers. The usability of the website was also not specifically addressed, since the contractor who designs the website for OPA conducts extensive usability testing throughout site development each year.
- ⁴ A complete description of the method used for website log analyses is given in *Appendix – Methods: Analysis of Website Logs*.
- ⁵ Survey question: Why did you come to come to *California's Quality of Care Report Card 2003/2004* website? Or Why are you interested in *California's Quality of Care Report Card*? Source: "Website Users": online survey responses of 1,798 OPA website users, October 2003 through March 2004. "Print Report Requestors": mail survey responses of 543 individuals who requested print *Quality Report Card* from OPA in 2003 or 2004.
- ⁶ A detailed description of the survey of CalPERS members can be found in *Appendix - Methods*.
- ⁷ A detailed description of the dissemination of the Report Card to and subsequent survey of PacAdvantage members can be found in *Appendix - Methods*.
- ⁸ Survey question: How did you hear about *California's Quality of Care Report Card 2003/2004*? Source: "Website Users": online survey responses of 1,798 OPA website users, October 2003 through March 2004. "Print Report Requestors": mail survey responses of 543 individuals who requested print *Quality Report Card* from OPA in 2003 or 2004.
- ⁹ The complete list of number of views for each HMO quality specific measure can be found in the Appendix-Data Tables.
- ¹⁰ The complete list of number of views for each medical group quality specific measure can be found in the Appendix-Data Tables.
- ¹¹ "Very" or "extremely" useful is defined as a rating of 4 or 5 on 5-point scale, where 1="not at all useful" and 5="extremely useful".
- ¹² "Very" or "extremely" important is defined as a rating of 4 or 5 on 5-point scale, where 1="not at all important" and 5="extremely important".
- ¹³ The usefulness rating for the PacAdvantage sample used a 6-point scale. For the PacAdvantage sample, usefulness is defined as a rating of 4 or 5 or 6 on the 6-point scale, where 1="not at all useful" and 6="extremely useful".
- ¹⁴ Influence is defined as a rating of 4 or 5 or 6 on a 6-point scale, where 1="not influence at all" and 6="large amount of influence".
- ¹⁵ A complete description of the key informant interviews is included in *Appendix – Methods – Interviews with Key Informants in HMOs and Medical Groups*.
- ¹⁶ Respondents were asked to rate the overall usefulness and usefulness of each specific measure include in the Report Card on a scale of 1 to 6, where 1 equals "not at all useful" and 6 equals "extremely useful". Responses of 4, 5 or 6 are considered a "useful" rating in the results presented here.
- ¹⁷ A complete list of the usefulness ratings assigned by HMO informants can be found in *Appendix – Data Tables – HMO Key Informants Usefulness Ratings*.
- ¹⁸ A complete list of the usefulness ratings assigned by the Medical Group informants can be found in *Appendix – Data Tables – Medical Group Key Informants Usefulness Ratings*.