July 2009

Puget Sound Community Checkup

A Recurring Report to the Community on Health Care Performance Across the Region

To compare health care organizations, go to
www.WACommunityCheckup.org

Puget Sound Health Alliance

Puget Sound Health Alliance

www.pugetsoundhealthalliance.org

July 16, 2009

Dear Community Member:

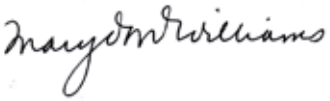
Welcome to the third Community Checkup report, the result of a collaborative effort to improve the quality and affordability of health care in our region.

Our country is in the midst of an exciting national dialogue about comprehensive health reform. As President Barack Obama has said, fixing what's wrong with our health care system is no longer just a moral imperative, but a fiscal imperative. Comprehensive reform will have to improve the quality of health care, expand access, *and* rein in costs. This is a multi-faceted challenge that will require a multi-faceted solution with all of us aligning our efforts. Objective measurement of quality, efficiency and ultimately costs is an important component of both understanding where improvements need to be made as well as increasing accountability for performance. The Community Checkup is one of our region's contributions to the work ahead.

The Community Checkup identifies what patients, physicians, employers and other purchasers, and health plans can do to achieve better health at a cost that more people can afford. The results underscore the collective effort required to truly enact change, understanding that no one person or group can make these changes alone. This is a challenge for all of us—doctors, hospitals, patients, health plans and even purchasers that buy health benefits—and we all share a responsibility to be part of the solution.

This report builds upon previous versions of the Community Checkup published in 2008 and includes results for 76 medical groups and nearly 240 clinics of four or more clinicians as well as 30 hospitals within King, Kitsap, Pierce, Snohomish and Thurston counties. We intend to publish the Community Checkup at regular intervals and with each report we will expand the contents to include additional data and measures as they become available. We expect to release the next version in Spring 2010.

The Community Checkup is published by the Puget Sound Health Alliance, a non-profit, non-partisan regional collaborative working to improve health care quality and affordability. Many community members contributed to this report including physicians, clinic leaders, patients, purchasers, and health plans. We extend our hearty thanks to these individuals and organizations who contributed valuable time, resources, data, and other efforts to make this report possible.



Mary McWilliams
Executive Director
Puget Sound Health Alliance

COLLABORATION • ACCOUNTABILITY • ACTION

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Puget Sound Health Alliance

Overview: 2009 Community Checkup Report

The July 2009 Community Checkup is a comprehensive report on health care performance in the Puget Sound region including medical groups, clinics and hospitals in King, Kitsap, Pierce, Snohomish and Thurston counties. It is an improved and expanded report, building on past Community Checkup reports published in 2008. Whether you are a patient, a doctor or other health care practitioner, a health professional working in a hospital or health plan, or an employer, union trust or other purchaser of health care services, there is information in this report to help you make decisions and take action to improve our health care system.

The Community Checkup report highlights how often patients in the region receive key elements of proven, effective care at medical groups, clinics and hospitals. The aim of the report is to gauge how well we are doing as a community and to support and encourage improvement. The information is intended to motivate all of us—patients, health care providers, employers and other purchasers, and health plans—to do our part to produce better health at costs that more people can afford.

The decisions we make affect our health as individuals and health care overall, and we can all do our part to make informed decisions that promote and support effective, safe and affordable health care.

The Community Checkup highlights results for medical groups, clinics and hospitals in our region in areas of care where there is clinical agreement on appropriate care. Knowledge of how we perform within our community—and how we perform compared to national benchmarks—can help us all to make more informed health care decisions and spur improvement in our region. Patients can use the information to gain an understanding of the importance of particular health care services and actively engage physicians in informed conversations about their care; health care professionals can use the results to target quality improvement initiatives; health plans can use the information to improve the design of benefits; and, employers and other purchasers can use the results in selecting health benefits and engaging their employees. Everyone has a role in making necessary improvements.

What's New in the 2009 Community Checkup?

This report continues to build on previous Community Checkup reports and includes the following changes from our November 2008 report:

Results for Medical Groups and Clinics.

- **Smaller groups and clinics are included.** This report contains results for smaller medical groups and clinics, now including those with at least four practitioners per clinic, whereas the previous report included medical groups and clinics with at least six practitioners per clinic. This change has increased the number of clinics in the report to nearly 240.
- **Additional data suppliers are included.** This report includes claims/encounter data from three new organizations: Washington State Department of Social and Health Services, CIGNA and Washington Teamsters. This change brings the total number of data suppliers to 18.
- **Results are broken down by payer population (Commercial and Medicaid).** This report presents results for all patients and also presents results separated out by those covered by commercial insurance and those covered by the state Medicaid program. See *www.WACommunity Checkup.org* for more information.
- **Changes in results over time are shown.** This report looks at how the regional results have changed from the November 2008 Community Checkup report to the current report.

- **Three new measures are included.** This report includes initial results at the regional level for three new measures: Avoidance of Antibiotics for Adults with Bronchitis, Adult Access to Preventive Care and Children's Access to Primary Care.

Results for Hospitals.

- **Changes in results over time are shown.** This report includes an analysis of selected hospital measure results over time for our region in the areas of heart failure care and surgical care.
- **Spotlight on patient experience and 'never events.'** Results are included for patient overall rating of care by hospital and statewide aggregate numbers of 'never events' which are serious events that are largely preventable.

Revised Rules of Use for 2009.

Beginning with this report, the Alliance has removed restrictions on how medical groups and data suppliers may use the information in the report. The Alliance's new "Rules of Use" policy permits organizations to use the public reports for business purposes, like marketing, contract discussions and benefit planning. Certain conditions still apply to ensure fair and constructive use. The revised policy addresses the philosophy, guidelines and rules for all uses of the results and is available on our website: *(www.pugetsoundhealthalliance.org/services/documents/RulesforUse_2009.pdf).*

Key Findings

The Community Checkup is now in its third edition, and some key themes have emerged:

- **Our region displays substantial variation in performance across measures and medical groups, clinics and hospitals.** This finding is consistent with national findings on the high level of variation in health care delivery.
- **Our region includes individual clinics, medical groups and hospitals that perform among the best in the nation.** The high results achieved by these providers in certain clinical areas demonstrate that excellent performance is possible and is happening in our community.
- **There are opportunities for improvement in nearly every medical group, clinic and hospital, and opportunities for organizations to learn from high performers by sharing best practices.**

- **The ability to report results separately for the commercially-insured and Medicaid populations highlights important differences in care provided to the Medicaid population and shows us that there are medical groups in our region that are high performers in delivering health care services to the Medicaid population.**
- **Everyone has a role in making necessary improvements.** The results for our region reflect the actions of *all* community members. Many factors contribute to the delivery of appropriate care, including whether doctors or other health professionals recommend certain services, whether patients follow through, whether employers include the service in their health coverage, and whether health plans make it affordable and convenient to obtain the services. We all have a role in educating ourselves about how we are doing and how we can improve.

About the Alliance

The Puget Sound Health Alliance was formed in 2004 as a non-profit, non-partisan regional collaborative with the vision of developing a state-of-the-art health care system that provides better care at a more affordable cost, resulting in healthier people in the Puget Sound region. Today, with over 150 participants, our mission is to build a strong alliance among patients, doctors and other health professionals, hospitals, employers, unions and health plans to promote health and improve quality and affordability. The Alliance's approach includes several activities to improve health, quality and cost:

- promoting preventive care;
- improving the management of chronic disease;
- using evidence to guide doctors and patients to make high-value health care decisions;
- reducing duplicative or unnecessary care; and,
- measuring and reporting how often patients get key elements of effective care, to gauge how well we are all doing in this region and to support and encourage improvement.

The Alliance has developed the regional Community Checkup report so that everyone in the community has comparative information that recognizes and encourages health care services and actions that are safe, effective in promoting or improving health, and affordable so everyone can access needed care. We hope the Community Checkup will help health care organizations improve performance, patients make informed decisions about their health and health care, and purchasers and health plans structure programs to reward value.

Questions or comments about this report?
Let us know at info@pugetsoundhealthalliance.org

To see all results in the Community Checkup report, go to *www.WACommunityCheckup.org.*

For more information about the Alliance, go to *www.PugetSoundHealthAlliance.org.*

What's in This Community Checkup?

The Community Checkup report includes results for our region on standard performance measures for medical groups, clinics and hospitals. The measures are developed from national clinical guidelines that address how certain conditions should be treated. Examples include managing diabetes in a one year period, treatment for a heart attack in the hospital or how often patients should be screened for cancers.

Medical Group Measures.

The table below lists the measures included in the Community Checkup for medical groups. All of the detailed results by medical group and clinic site may be found on the Community Checkup website: *www.WACommunityCheckup.org.*

Medical Group Measures and Sources		
Category of Care	Measure Description	Measure Source
Prevention	Breast cancer screening	HEDIS®
	Cervical cancer screening	
	Colon cancer screening	
	Chlamydia screening	
Appropriate Use of Services	Low back pain – avoidance of imaging	HEDIS
	Appropriate treatment – common cold	
	Appropriate treatment – strep throat	

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Medical Group Measures and Sources (continued)		
Category of Care	Measure Description	Measure Source
Diabetes	Blood sugar test	HEDIS®
	Eye exam	
	Cholesterol test	
	Kidney disease screening	
Heart Disease	Cholesterol test	HEDIS
	Blood pressure medications	HEDIS
	Cholesterol-lowering medication	American College of Cardiology and American Heart Association
Depression	Antidepressant medication – 12 weeks	HEDIS
	Antidepressant medication – 6 months	
Asthma	Use of appropriate medications	HEDIS
Use of Generic Prescription Drugs	Cholesterol-lowering medications	Puget Sound Health Alliance
	Antidepressants	
	Antacid medication	
	Pain relief	

® HEDIS is a registered trademark of the National Association for Quality Assurance.

The medical group and clinic measures used by the Alliance for the Community Checkup report are based primarily on the Healthcare Effectiveness Data and Information Set (HEDIS®) specifications developed by the National Committee for Quality Assurance (NCQA). These measures include detailed specifications for calculating the results, including eligibility definitions, age ranges, procedure codes, specified dates of service, exclusions and continuous eligibility requirements. The measure for the use of cholesterol-lowering medication for heart disease was developed by the American College of Cardiology and the American Heart Association. The four generic prescribing measures were developed by the

Alliance in response to the significant potential for cost savings associated with filling prescriptions using generic rather than brand name drugs. All of the above measure rates are calculated using data supplied by health plans, self-insured employers, union trusts and government agencies in our region. The data are collected, validated and aggregated on behalf of the Alliance for measure calculation and reporting. The Alliance provides individual practitioner-level results to all participating medical groups for private, internal use and produces medical group and clinic level results for public reporting. *Note: the Alliance receives no information that personally identifies any individual patient at any time during the process.*

Hospital Measures.

The table below lists the hospital measures and the source of information included in the Community Checkup. All of the detailed results by hospital may be found on the Community Checkup website: *www.WACommunityCheckup.org.*

Hospital Measures and Sources		
Category of Care	Measure Description	Data Source
Heart Attack Care	Aspirin given at arrival to hospital	Hospital Compare (CMS)
	Medicine to reduce blood clots given within 30 minutes of arrival at hospital	
	Procedure to open blocked blood vessels done within 90 minutes of arrival to hospital	
	Medicines given to improve heart function	
	Patients advised to stop smoking	
	Blood pressure medicine prescribed at discharge from hospital	
	Aspirin prescribed at discharge from hospital	
	30-day mortality	

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Hospital Measures and Sources (continued)		
Category of Care	Measure Description	Data Source
Heart Failure Care	Test of how the heart is pumping (LVS function) is given Medicines given to improve heart function Patients advised to stop smoking Instructions given when patient is released from the hospital 30-day mortality	Hospital Compare (CMS)
Pneumonia Care	Blood test done before an antibiotic is given Correct antibiotic drug is given Antibiotic given within 6 hours of arrival to hospital Blood-oxygen level is measured Pneumonia vaccine (pneumococcal vaccination) is given Flu shot (influenza vaccination) is given Patients advised to stop smoking	Hospital Compare (CMS)
Surgical Care	Antibiotic given within one hour before surgery Correct antibiotic drug is given Treatment to prevent blood clots is ordered Treatment to prevent blood clots is given within 24 hours before and after surgery Antibiotics are stopped within 24 hours after surgery	Hospital Compare (CMS)

Hospital Measures and Sources (continued)		
Category of Care	Measure Description	Data Source
Never Events	Adherence to Leapfrog's Never Events Policy 28 Never Events as defined by the National Quality Forum	Leapfrog Washington DOH
Patient Experience	Cleanliness Communication with doctors Communication with nurses Information at discharge Explanation of medicines Pain control Quiet at night Timely assistance from hospital staff Overall rating Overall recommendation	CMS Hospital Compare (HCAHPS patient survey)

Unlike the medical group measure results, the Alliance does not calculate the hospital measure results that appear in the Community Checkup. Instead, the Alliance combines the results from several public sources to help all of us learn about hospital care across the Puget Sound region.

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Using This Report.

Due to the comprehensive nature of the Community Checkup, it is impractical to include all of the results in a printed report. We encourage you to visit *www.WACommunityCheckup.org* to see, search and sort all of the results based on your areas of interest, health conditions or geographic location.

This report summarizes performance in our five-county region. We have included the highest and lowest rates and the regional average and benchmark comparisons where available. Each section of results begins with an introduction and includes a summary of findings including how the Puget Sound region compares to national benchmarks when such data are available. The last section of the report includes a description of areas for future reporting.

The Community Checkup will continue to be improved and expanded over time. We encourage everyone to use the report to learn more about specific health services that are known to be effective and to see that there is variation in how consistently effective care is provided in clinics and hospitals in the region. Medical groups and hospitals can use the Community Checkup to identify organizations that are high performers and take advantage of the potential to learn about successful strategies for improving care. Patients can use the Community Checkup to look up their clinic or hospital, learn about effective care that is right for them, talk with their doctors and other health care team members to get advice, then follow through with that advice to be as healthy as possible.

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Results for Medical Groups

This section presents performance results for medical groups in King, Kitsap, Pierce, Thurston and Snohomish counties. The report measures how consistently patients receive care that the medical community agrees is effective to promote better health, especially for chronic conditions such as asthma, diabetes, heart disease and depression. The results reflect whether doctors and other health professionals recommend the care to patients *and* whether patients follow through with that advice. There are a variety of reasons that patients may not follow through to receive recommended care. The decision may be affected by whether the patient understands why the recommended care is important or whether the patient can pay for the service, either using health insurance or paying for it out-of-pocket. This report can help everyone make more informed decisions and to motivate improvement in health care quality and value.

This section summarizes the results for medical groups in our region in the areas of preventive care, chronic disease, avoidance of unnecessary care and generic prescribing rates. In addition to an overview of the measure results in the region, we also include an initial look at how results have changed since our last report, information on three new measures and an explanation of the data sources and methodology used to calculate the measures. *Readers should note that this section focuses on our performance as a region. Individual medical group and clinic results are available at www.WACommunityCheckup.org.*

Interpreting the Results.

There are several important factors to consider when interpreting these results. Primarily, the results should be evaluated as indicators of performance and should be considered across measures rather than isolating an individual result. It is also important to note that results can vary because of differences in performance, differences in the patient population, random chance and data issues. Because of these factors, measure results should be evaluated in terms of a medical group or clinic's performance across all of the measures tracked in this report as well as the performance through time, when available. Readers of this report should note the following:

- **July 2009 results not directly comparable to November 2008 results.** The results in this report reflect three additional data suppliers and are therefore not directly comparable to results in the November 2008 report[1]. This Community Checkup report includes a special section comparing results across time periods based on a separate analysis that applied the same specifications to the same data suppliers across both time periods.
- **Results presented by payer population.** The results in this report and on the website are presented by population—patients with commercial insurance and patients covered through the Medicaid program. Several factors likely to impact the commercially-insured and Medicaid populations differently are described below.

[1] The inclusion of Medicaid fee-for-service data from the Washington Department of Social and Health Services affected the regional averages . See the *Differences in Care for Medicaid vs. Commercially-Insured Populations* report at *www.pugetsoundhealthalliance.org* for further information.

- **Commercially-insured population.** Data for the commercially-insured population represent information on care provided to individuals and their dependents in King, Kitsap, Pierce, Snohomish and Thurston counties who have at least one working member of the household who receives health care coverage through his or her employer. Commercially-insured individuals have health care coverage with a variety of benefit designs, such as health maintenance organizations (HMOs), traditional indemnity insurance, preferred provider plans, health savings accounts and high deductible plans.
- **Medicaid population.** Medicaid is a program funded through the federal and state government that provides health insurance for low-income residents. In 2008, approximately 860,000 citizens depended on Medicaid for their health care coverage in Washington state. Medicaid/SCHIP generally covers all children in families with income up to 300 percent of the Federal Poverty Level (in 2008 the Federal Poverty Level for a family of four was income of $21,200 per year). Populations covered by Medicaid include low-income families, children, pregnant women, and the elderly and disabled. Medicaid clients receive services through two types of programs: Medicaid managed care or Medicaid fee-for-service (FFS). Medicaid managed care primarily covers low-income families, pregnant women and children while Medicaid FFS primarily covers low-income elderly and disabled clients. The Medicaid population also displays greater racial and ethnic diversity than the general population. Based on 2007 data from the Washington State Department of Social and Health Services, whites are underrepresented and every other racial group is overrepresented within the Medicaid population when compared to the statewide population.

- **Variation in results for the commercial versus Medicaid population.** Many socioeconomic factors affect the low-income population eligible for Medicaid compared to the commercially-insured population, so we expect the results to vary across the populations. Low-income individuals may face additional obstacles to obtaining medical care including lack of transportation choices, lack of childcare, language barriers, and low literacy rates. Research literature recognizes income as a significant determinant of health status; people with lower incomes generally experience more illness and have a lower life expectancy. Because of the numerous differences in population characteristics and programmatic issues between the commercially-insured and Medicaid populations, we should expect differences in measure results by population. While our dataset can highlight the differences by population, we cannot

definitively determine the reasons for those differences. By providing the information, we hope to spur further investigation as a community into the reasons behind the results and how to address them.

- **Continuous enrollment.** Many of the measures have a continuous enrollment requirement which means that individuals must be enrolled with the same health plan or insurance coverage for a specified time period before the data about their care are included in our analyses. This criterion likely affects the commercially-insured and Medicaid populations differently. The commercially-insured population has a higher proportion of people remaining with the same health plan or insurance coverage over a given time period. In contrast, individuals in the Medicaid program are more likely to gain and lose eligibility for the program as their status changes (e.g., pregnancy, job loss, job gain). Because of the continuous enrollment requirement, these results reflect care provided to people who have been on Medicaid for a specified period of time but information for individuals who cycle on and off Medicaid during the time period measured are not reflected in the results.
- **Attribution to providers and medical groups.** Our data process involves attributing patient data to providers based on their pattern of visits and subsequently assigning providers to medical groups to calculate a medical group level result. Many medical groups have more than one clinic site. To be named and listed in the report, a clinic location or medical group must have four or more clinicians and at least 160 patients appropriate to each measure. Regional averages are calculated using results from all medical groups in the five-county region, including those with fewer than four clinicians and fewer than 160 patients.

We recommend the results be interpreted as *indicators of patterns of care* that spur additional analyses to determine strategies for improving the quality of health care provided to everyone in our community.

The measure results in this section are presented as the range of performance, from 0% to 100%, for medical groups in our region. For each measure, the report presents the medical group results for the commercial and Medicaid populations, the regional average and a National Top 10% where available. National benchmark data are from NCQA and represent the 90th percentile of all HEDIS data submitted by commercial health plans for 2007 (the Alliance does not have access to comparable benchmark data for our Medicaid results). Arraying the data in this manner allows the reader to see the range of performance as well as the distribution of medical groups along the range – i.e., whether the performance in our region is clustered

around particular results or whether there are some medical groups that are outliers at either end of the range of results. To see specific medical group and clinic results please visit the Community Checkup website: *www.WACommunityCheckup.org*.

Medical group results are presented in the following areas of care:

- Prevention
- Appropriate Use of Services
- Diabetes
- Heart Disease
- Depression
- Asthma
- Use of Generic Prescription Drugs

Prevention: Effectively Screening for Disease

Prevention is taking steps to avoid disease or finding a disease early so it is easier and less costly to treat. Our goal as a community is to ensure that preventive care is a priority, that patients are informed and educated about the importance of recommended screening tests, that delivery systems are designed to efficiently provide those services and that employers and health plans structure benefit packages to encourage preventive services. Our report includes three measures of cancer screening and one measure of screening for chlamydia, the most commonly reported sexually transmitted disease in the United States. In our state:

- Breast cancer is the most frequently diagnosed cancer and the second leading cause of cancer death among Washington women – 5,401 new diagnoses and 791 deaths reported in 2005[2]
- In 2005, 63 women in Washington state died from invasive cervical cancer, which is often preventable with regular screening [3]
- Chlamydia is the most commonly reported sexually transmitted infection with 317 cases per 100,000 persons in 2008 in Washington[4]
- Colorectal cancer is the third most common cancer in Washington state with 2,776 cases diagnosed in 2004 and 942 people dying from colorectal cancer in 2005[5]

[2] Washington State Department of Health, Female Breast Cancer, 3 December 2007, available from http://www.doh.wa.gov; Internet; accessed 22 June 2009.

[3] Washington State Department of Health, Invasive Cervical Cancer, 28 September 2007, available from http://www.doh.wa.gov; Internet; accessed 22 June 2009.

[4] Washington State Department of Health, STI Fast Facts, 2008, available from http://www.doh.wa.gov; Internet; accessed 22 June 2009.

[5] Washington State Department of Health, Colorectal Cancer, 2 May 2008, available from http://www.doh.wa.gov; Internet; accessed 22 June 2009.

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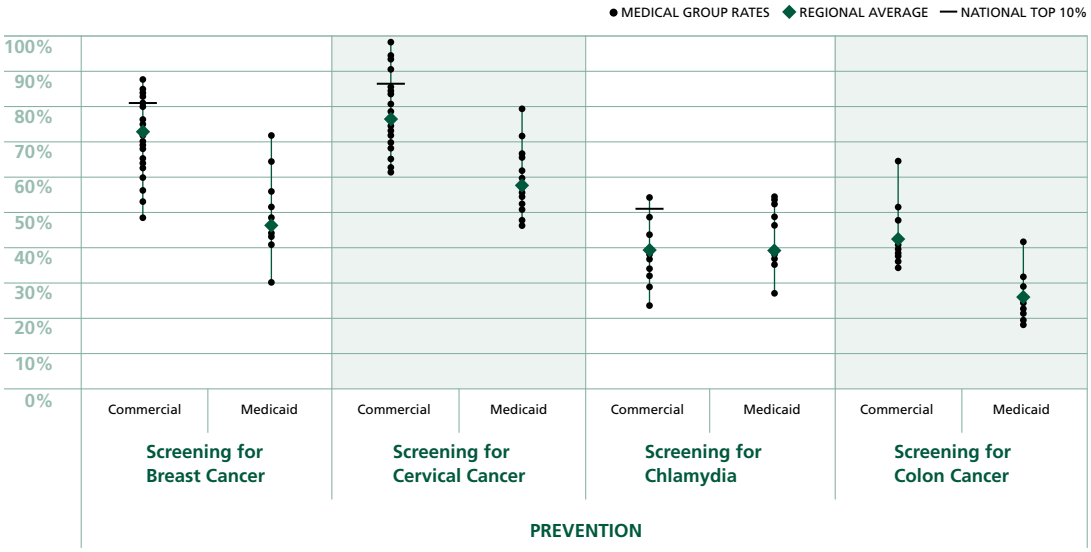
Regular screening to detect breast, cervical and colon cancer at its earliest, most treatable stages remains the best strategy to reduce mortality. All of the recommended tests that are measured in this report – screening for breast cancer, cervical cancer, chlamydia and colon cancer – are strongly recommended by the U.S. Preventive Services Task Force.

The graph below displays the results for the commercially-insured and Medicaid populations for these preventive care measures. The diamonds indicate each medical group's individual result and are arrayed from high to low with the regional average indicated by the green diamond. Additionally, the National Top 10% benchmark appears for the commercial population. We do not have a comparable benchmark for the Medicaid population.

Preventive Care: Commercial and Medicaid Results



	What is Measured?
Screening for Breast Cancer	The percentage of women ages 40 to 69 who had at least one mammogram during the two-year measurement period.
Screening for Cervical Cancer	The percentage of women ages 21 to 64 who had at least one Pap test during the three-year measurement period.
Screening for Chlamydia	The percentage of sexually active women ages 16 to 25 who had at least one test for chlamydia during the measurement year.
Screening for Colon Cancer for the Newly Eligible	The percentage of adults ages 51 to 54 who had appropriate screening for colon or colorectal cancer.

The graph shows the regional average is higher on screenings for breast and cervical cancer and lower on screenings for chlamydia and colon cancer within each population. For three of the prevention measures, the results for the commercial population are higher than the result for the Medicaid population. For chlamydia screening, however, the Medicaid and commercial regional averages appear to be comparable. The graph also displays individual medical group performance, revealing the range and clustering of medical group results within each measure and population type. For example, the Medicaid result for breast cancer screening indicates a wide range of performance with most groups clustered around the regional average, although there are outliers at both the high and low ends of the range. In contrast, the screening for colon cancer result displays one high performing medical group for both commercial and Medicaid populations with performance clustered around the regional average. The variability in medical group performance is high among both populations and across all four measures, indicating a significant opportunity for improvement in the delivery of preventive services in our region. Finally, there are many high-performing medical groups in our community demonstrated by results at or above the national top ten percent. This suggests an opportunity for medical groups in our region to learn from the best practices of these high performers.

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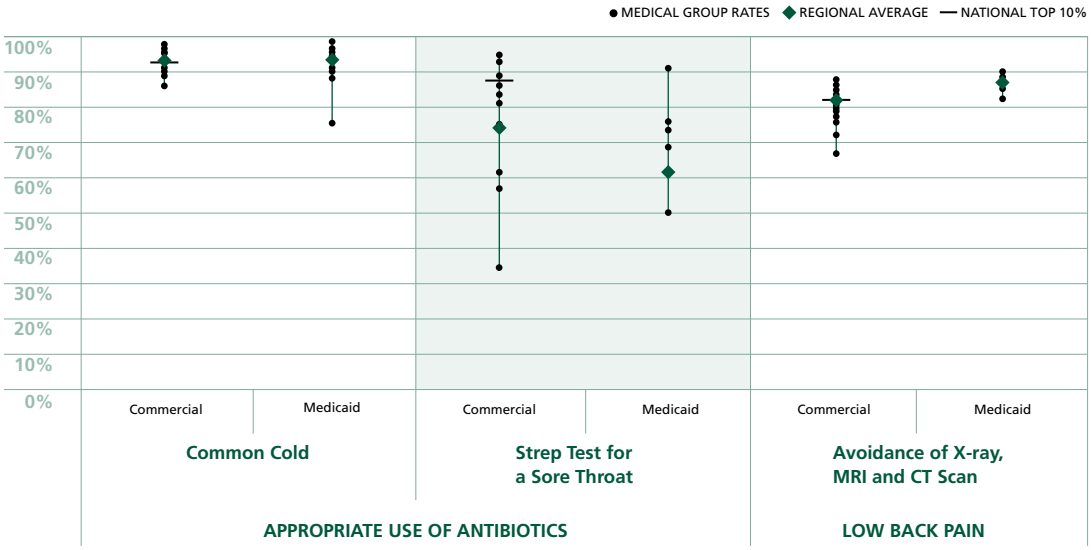
Appropriate Use of Services: Antibiotics and Imaging

In health care, some services are provided more often than necessary, increasing both risk and cost to the patient and to the community. Despite the fact that antibiotics do not cure infections caused by viruses, including most cases of sore throat and the common cold, tens of millions of antibiotics are prescribed in doctors' offices each year for viral infections.[6] Community-wide practices of taking antibiotics when they are not needed can lead to the development of bacteria that are resistant to commonly-used antibiotics and therefore no longer respond to treatment. Overuse of imaging services (e.g., x-rays and MRIs) has also emerged as an area of concern due to data showing rapidly increasing use and costs without a demonstrated benefit to patients. Unnecessary use of imaging increases costs for patients, employers and the health care system, while exposing patients to unnecessary risks such as exposure to radiation.

Our collective goal is to ensure both the delivery of needed health care services and the avoidance of unnecessary care. This section includes three measures of appropriate use of services: two assessing unnecessary use of antibiotics and one addressing overuse of imaging services such as X-rays and MRIs.

Appropriate Use of Services: Commercial and Medicaid Results



[6] National Center for Immunization and Respiratory Diseases / Division of Bacterial Diseases, Aug 18 2008

	What is Measured?
Appropriate Use of Antibiotics – Common Cold	The percentage of children ages 18 months to 18 years who went to the doctor for a common cold who were not prescribed an antibiotic for three days after the diagnosis.
Appropriate Use of Antibiotics – Strep Test for a Sore Throat	The percentage of children ages 2 to 18 who visited a doctor for a sore throat who received a "strep" test (group A streptococcus) before being prescribed an antibiotic.
Low Back Pain – Avoidance of X-ray, MRI and CT Scan	The percentage of patients ages 18 to 50 with a new diagnosis of low back pain who did not have an X-ray or other imaging study (MRI, CT scan) in the 28 days after they first visited a health care provider due to low back pain.

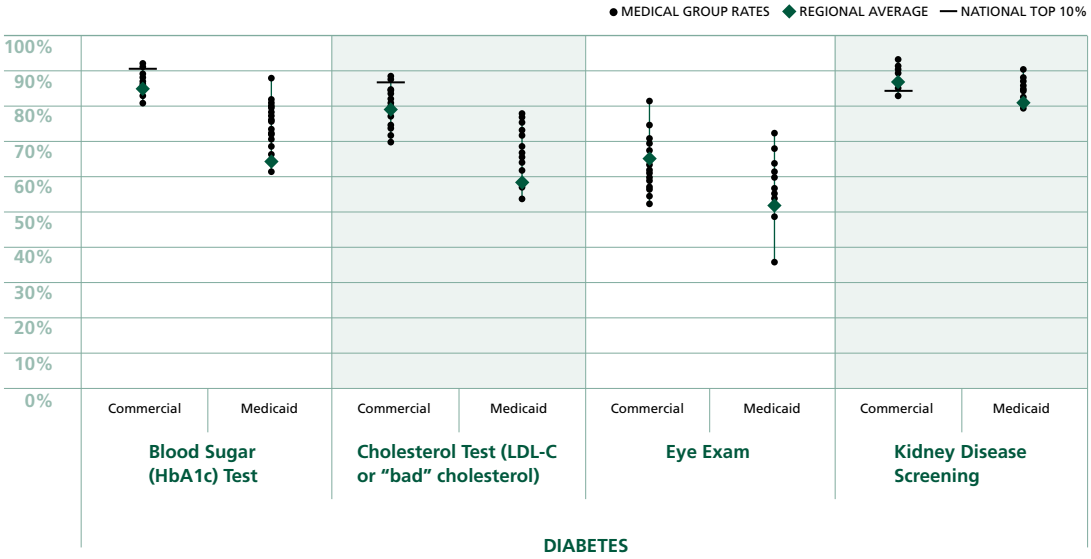
As shown in the graph, the region performs higher on Avoidance of X-ray, MRI and CT scan for Low Back Pain and Appropriate Use of Antibiotics for the Common Cold. For both measures, the regional averages are above 80 or 90 percent, with the Medicaid regional average exceeding the commercial regional average for the avoidance of imaging measure. In general, both Medicaid and commercial medical group results cluster at the high end of the range. Lastly, some medical groups in our community demonstrate performance at or above the national top ten percent.

Care For Patients Who Have Diabetes

Diabetes is a disease in which the body does not produce or properly use insulin, a hormone that helps convert sugar, starches and other food into energy needed for daily life. Diabetes is a public health priority in Washington state, where over 300,000 people have been diagnosed with diabetes, an estimated additional 125,000 have undiagnosed diabetes, and nearly one million people are estimated to have pre-diabetes (risk factors that may lead to diabetes). Diabetes can lead to other health problems such as heart disease, kidney disease, blindness and poor circulation which may lead to loss of limbs. People with diabetes have at least two times greater risk of heart disease and stroke than those who do not. Actively managing diabetes can prevent or reduce these risks. Our collective goal is to help people who have diabetes to manage their disease and prevent additional health problems.

National guidelines for effective care for diabetes recommend several steps for managing diabetes, including the four key measures below that are essential to regulating blood sugar (i.e., glucose) and cholesterol levels, and maintaining eye and kidney functioning.

Diabetes Care: Commercial and Medicaid Results



What is Measured?	
Diabetes – Blood Sugar (HbA1c) Test	The percentage of patients ages 18 to 75 who have diabetes who had an HbA1c test during the one-year measurement period.
Diabetes – Cholesterol Test	The percentage of patients ages 18 to 75 who have diabetes who had a test for LDL cholesterol during the one-year measurement period.
Diabetes – Eye Exam	The percentage of patients ages 18 to 75 who have diabetes who had an eye exam in the two-year measurement period. The eye exam is a retinal or dilated eye exam by an eye care professional.
Diabetes – Kidney Disease Screening	The percentage of patients ages 18 to 75 who have diabetes who had a kidney disease screening test or were treated for kidney disease during the one-year measurement period.

As displayed in the graph, the region performs relatively well on the diabetes measures – especially blood sugar test and kidney disease screening. For the kidney disease screening measure, performance is clustered at the high end of the range for both the commercial and Medicaid populations. Additionally, the regional average for the commercial population exceeds that of the Medicaid population for all four measures. The benchmark comparison for the eye exam measure is not shown because the Alliance modified the specification due to the lack of clinical data from the medical record. The variation in medical group performance for these measures indicates opportunities for improvement within our region. Again, this is an area of care where some medical groups achieve high levels of performance compared to national benchmarks.

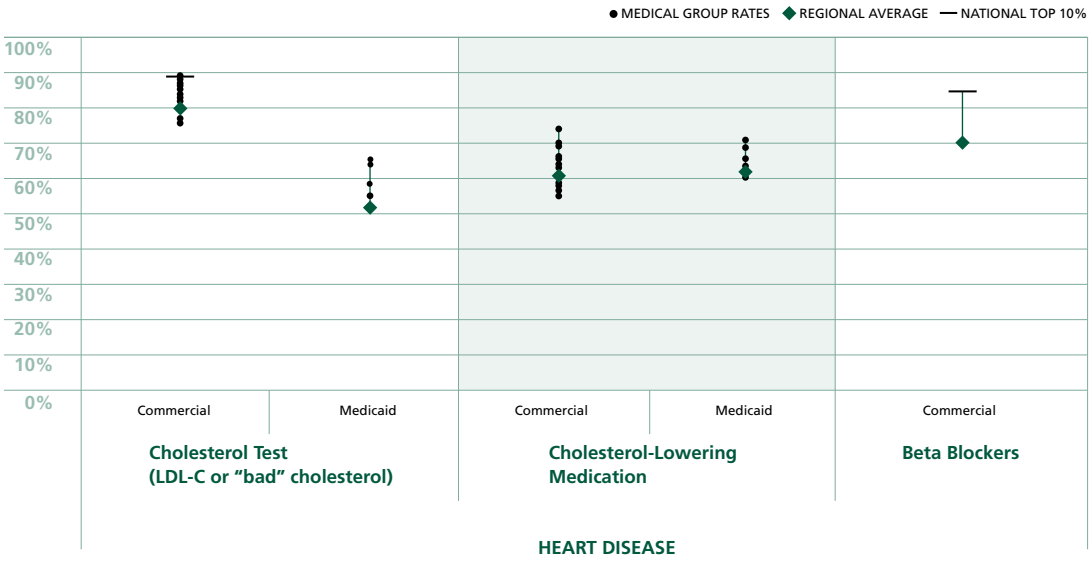
Care For Patients Who Have Heart Disease

Heart disease refers to conditions that affect the heart's ability to pump blood. The measures in our report focus on coronary artery disease (CAD) and stroke which are the second and third leading causes of death in Washington state. Together they accounted for almost 11,000 deaths in 2005 in Washington state[7]. CAD, also called coronary heart disease (CHD), involves the narrowing of blood vessels that supply blood to the organs and tissues, including the heart. Our collective goal is to help people who have heart disease keep their condition from getting worse. The keys to this effort are to monitor cholesterol levels and effectively manage patients' cholesterol and blood pressure levels.

This report includes three measures of heart disease care: whether patients received a cholesterol test after they were discharged from the hospital for an event due to heart disease; whether patients with heart disease filled a prescription for cholesterol-lowering medication; and whether patients who had a heart attack filled a beta blocker prescription for six months post hospital discharge.

[7] Washington State Department of Health, Coronary Heart Disease, 6 December 2007, available from http://www.doh.wa.gov; Internet; accessed 22 June 2009.

Heart Disease Care: Commercial and Medicaid Results



	What is Measured?
Heart Disease – Cholesterol Test	The percentage of patients ages 18 to 75 who had at least one LDL cholesterol screening test in the year after they were discharged from the hospital for heart attack, coronary artery bypass graft, percutaneous transluminal coronary angioplasty (PTCA), stroke or aneurysm.
Heart Disease – Cholesterol-Lowering Medication	The percentage of patients ages 18 to 75 who have heart disease who had at least one prescription filled to lower cholesterol during the one-year measurement period.
Heart Disease – Beta Blockers	The percentage of patients with a diagnosis of heart attack (acute myocardial infarction) that filled a prescription for beta blocker drugs (to improve the heart's ability to pump) for six month after being released from the hospital.

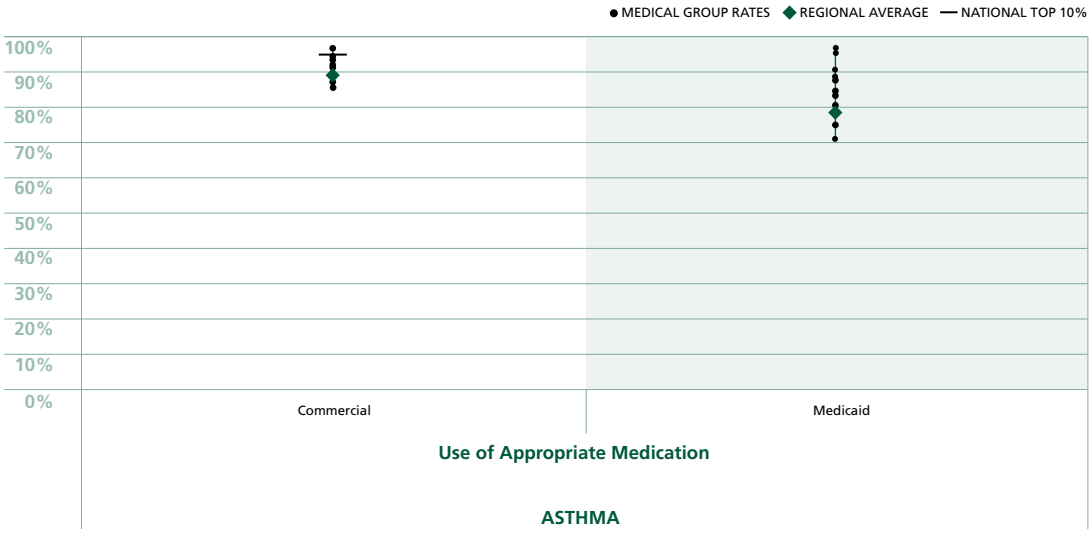
As shown in the graph, the region performs higher on cholesterol test for the commercial population compared to the Medicaid population. Because of low numbers of patients per medical group, the beta blocker measure is reported at the regional level only. For cholesterol-lowering medication for the Medicaid population, most of the reportable results cluster above the regional average, indicating that a number of medical groups that did not meet thresholds for public reporting had lower rates. A note of caution to readers: While not evident in this display of results,

the Alliance has noticed a notable decline in performance on the cholesterol-lowering medication measure. We suspect this decline may be attributed to measure specifications that have not been updated by the measure developer to reflect the availability of new drugs on the market. However, the result may also be due to actual declining performance in the region, patients buying generic drugs directly from retail stores (e.g., Wal-Mart) where their information is not captured by the health insurer, or other unknown reasons. The Alliance is re-evaluating this measure for inclusion in the next round of reporting.

Care For Patients Who Have Asthma

Asthma is the irritation of the airways or tubes that carry air into and out of the lungs. Symptoms may include cough, wheezing, and chest tightness. Washington state has one of the highest rates of asthma in the country, with almost one in ten Washingtonians suffering from asthma.[8] Medication can help control asthma and avoid serious breathing troubles, fatigue, visits to the hospital and even death. Asthma can be successfully managed through use of long-term controller medications. Our goal as a community is to assure that patients who have asthma receive the appropriate medication to manage the condition. The measure examines whether people who have asthma received these important long-term controller medications.

Asthma Care: Commercial and Medicaid Results



[8] Washington State Department of Health, Asthma, 7 December 2007, available from http://www.doh.wa.gov; Internet; accessed 23 June 2009.

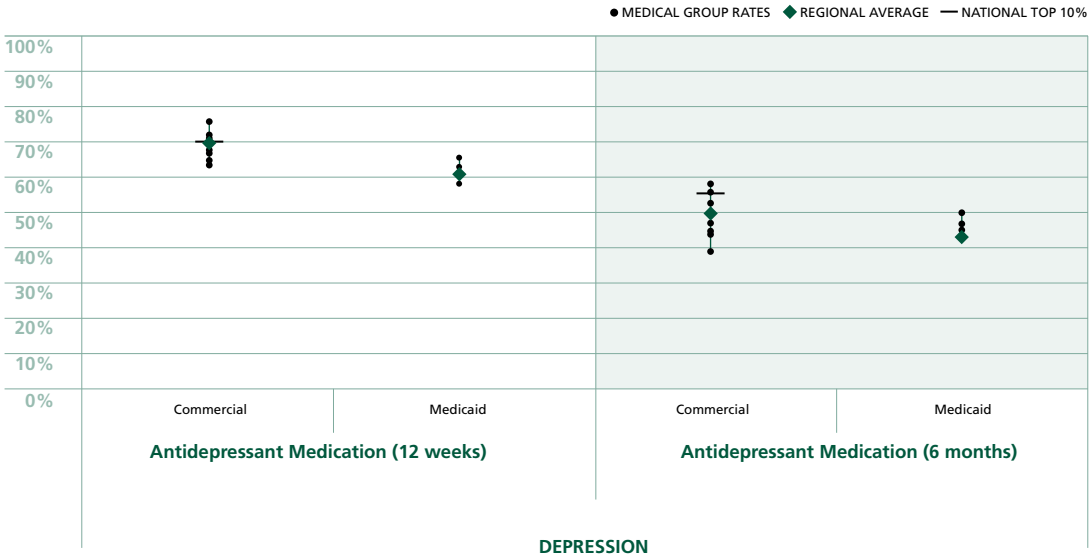
	What is Measured?
Asthma – Use of Appropriate Medication	The percentage of patients ages 5 to 56 identified as having persistent asthma and who filled a prescription for long-term controller medication during the measurement year.

As presented in the graph, our region performs well on the asthma measure. The commercial regional average approaches 90 percent and the Medicaid average is almost 80 percent. Additionally, the commercial range of performance among medical groups is relatively small and clustered at the top, indicating that most medical groups achieve high rates on this measure. Medical group performance for the Medicaid population shows both greater variability and high performers within our region. These results suggest an opportunity for some medical groups to learn from those groups that excel on this measure.

Care For Patients Who Have Depression

Depression is an illness that affects a person's mood, thoughts and body. Depression is a common and serious illness that often requires treatment to get better. About 20 to 25 percent of women and 7 to 12 percent of men will experience depression in their lifetimes. Depression is now recognized as an important factor in many chronic health conditions including heart disease, stroke, cancer and diabetes. Depression is the most common cause of disability in the U.S. and annually costs employers an estimated $80 billion in health care costs, absenteeism and lost productivity. Many people who have depression never seek treatment, which may include antidepressant medication and/or psychotherapy. Our goal as a community is to assure that people with depression receive recommended treatment. For patients who begin treatment with medication, it is important to continue the medication until the episode has been fully treated to reduce the likelihood of the depression becoming chronic. This report includes two measures of antidepressant medication management – one examining a twelve-week period to address the acute symptoms of depression and the other examining a six-month period to prevent the depression from becoming chronic.

Depression Care: Commercial and Medicaid Results



What is Measured?	
Depression – Antidepressant Medication (12 weeks)	The percentage of patients age 18 and older who were newly diagnosed with depression and prescribed an antidepressant and remained on an antidepressant for 12 weeks after the diagnosis.
Depression – Antidepressant Medication (6 months)	The percentage of patients age 18 and older who were newly diagnosed with depression and prescribed an antidepressant and continued taking an antidepressant for a least 180 days (6 months) after the diagnosis.

As shown in the graph, the region performs at or near national benchmarks on these two measures. However, these results indicate substantial room for improvement. Our results for the commercial population indicate that 30 percent of patients in our region who have depression do not remain on antidepressant medication for the first 12 weeks, and more than half do not maintain treatment for six months. Our results for the Medicaid population indicate that almost 40 percent of patients in our region who have depression do not remain on antidepressant medication for the first 12 weeks, and more than half do not maintain treatment for six months. Additionally, for the commercial population, there is variability in medical group results for the six month measure indicating that high-performing medical groups may have identified some successful strategies for maintaining patients on antidepressants that could be shared across the community to improve care of other

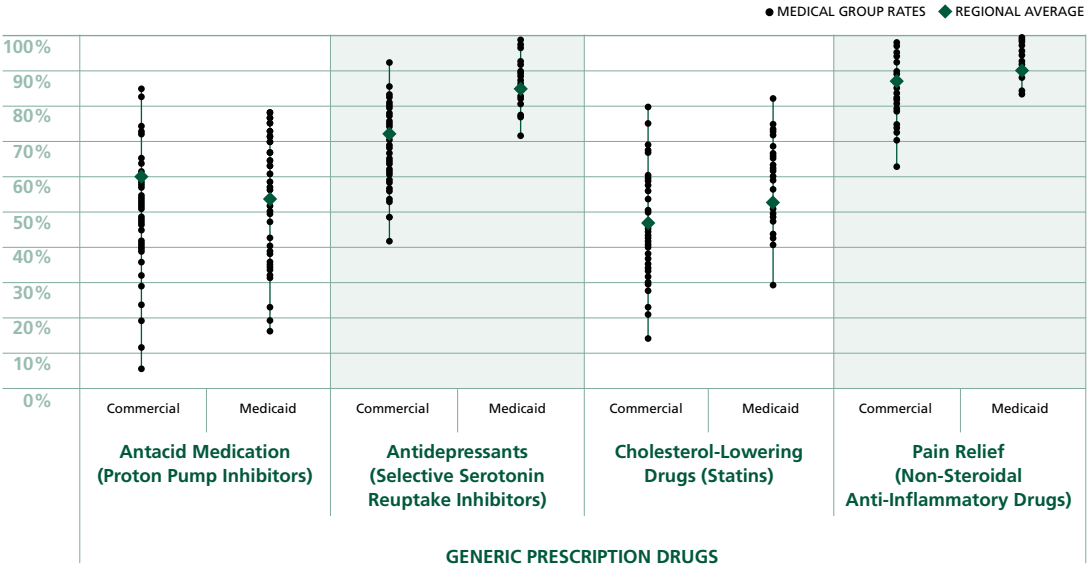
patients with depression. The Medicaid medical group results for the six month measure cluster above the regional average, indicating that a number of medical groups that did not meet thresholds for public reporting had lower rates.

Use of Generic Prescription Drugs

Generic prescription drugs have the same chemical composition and, for most people, work as well as brand-name drugs. Additionally, generic drugs usually cost less than their brand-name counterparts. In 2007, the Alliance assessed potential savings from increasing the use of generic prescriptions across four classes of drugs in which generic drug options are widely available: cholesterol-lowering medication, antidepressants, pain relief, and antacid medication. The Alliance found that more than $2.5 million could be saved annually in the five-county region for each percentage point increase in the "generic fill rate" – that is, when a generic equivalent is available, how often a prescription is filled with a generic rather than a brand-name drug – in these four classes of drugs.

Our goal as a community is to assure the use of generic drugs when appropriate to increase affordability for patients and the health care system. The current Alliance database lacks information to link a result to the prescribing provider; to produce results for this report we attributed each prescription to the patient's primary care physician. This report presents the range of medical group performance in our community based on this attribution; the Community Checkup website reports the results at the regional level only. This report includes four measures of generic prescribing rates.

Use of Generic Drugs: Commercial and Medicaid Results



	What is Measured?
Generic Drugs – Antacid Medication	The percentage of prescriptions for antacids to reduce stomach or gastric acid (proton pump inhibitors or PPIs) that were filled with a generic PPI during the one-year measurement period.
Generic Drugs - Antidepressants	The percentage of prescriptions for antidepressant drugs (all second generation antidepressants) that were filled with a generic antidepressant during the one-year measurement period.
Generic Drugs – Cholesterol-Lowering Drugs	The percentage of prescriptions for cholesterol-lowering drugs (statins) that were filled with a generic statin during the one-year measurement period.
Generic Drugs – Pain Relief	The percentage of prescriptions for certain pain relief drugs (non-steroidal anti-inflammatory drugs or NSAIDS) that were filled with a generic NSAID during the one-year measurement period.

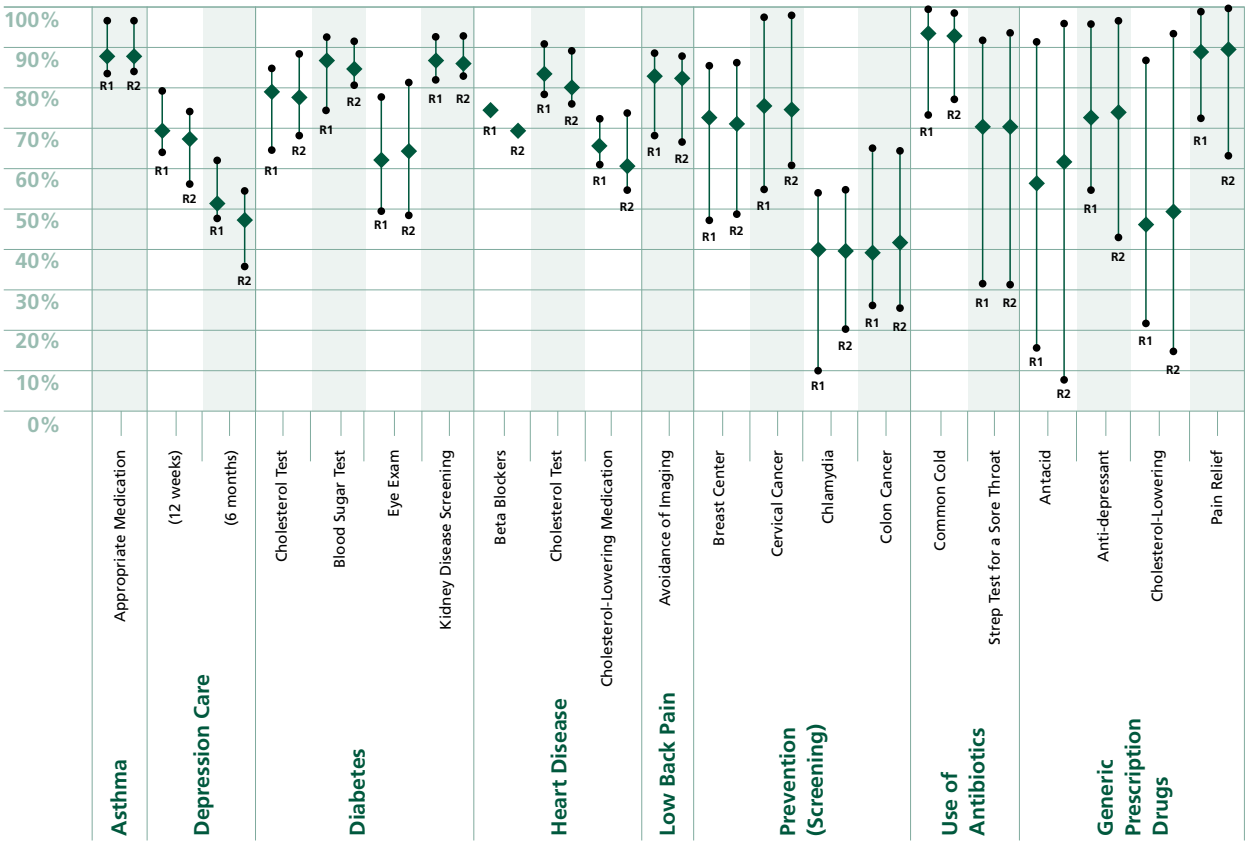
National benchmark data are not available for these measures. As shown in the graph, the region performs higher on the prescribing of generic antidepressants and pain relief than antacid medication and cholesterol-lowering drugs. More striking however, is the substantial variability across all of the measures. Results for the commercial population on the antacid measure range from about 5 percent to 85 percent. Differences of these magnitudes suggest substantial opportunity for increasing the rate of generic prescribing to realize significant cost savings. Interestingly, results for the Medicaid population exceed the commercial population for three out of the four measures. Because these measures rely on data from pharmacy claims, we do not know how the availability of over-the-counter drugs or discounted generic drugs available from retail stores affects the measure results.

Changes in Results Over Time

Because of changes in data suppliers, results from the November 2008 report and the July 2009 report are not directly comparable. To begin examining the question of how the results have changed through time, we calculated results for both time periods using the same measure specifications and the same data suppliers as the November report. These results include only commercial and managed Medicaid populations. The managed Medicaid program primarily includes low-income families, pregnant women and children.

The graph below displays the regional average and range of performance for medical groups across all measures for our November report (R1) and the July report (R2). Readers should note that the November report was based on claims dates from October 2006 through September 2007 and the July report is based on claims dates of July 2007 through June 2008; therefore the time periods overlap for one quarter – July 2007 through September 2007.

Comparison of Regional Average and Highest/Lowest Medical Group Performance:
November 2008 and July 2009 Reports



As shown in the graph, the analysis demonstrates substantial stability in the measure results for our region across the two time periods. There are observable decreases in the regional average for the depression measures and all three heart disease measures. The graph also displays increases in the regional average rates for eye exams for diabetics, colon cancer screening and the generic prescribing measures. Ideally, we would see increasing regional averages over time, accompanied by a narrowing of the range of performance across medical groups. That is, improving performance with less variability.

This is a first look at changes over time; the pattern will become clearer as we add more time periods to the data in future Community Checkup reports. This initial analysis establishes the overall stability of the measures as well as the ability to detect differences through time. The ability to compare results through time will allow medical groups, clinics and hospitals in our region to effectively and consistently track performance and where applicable, demonstrate improvement.

Results for New Measures

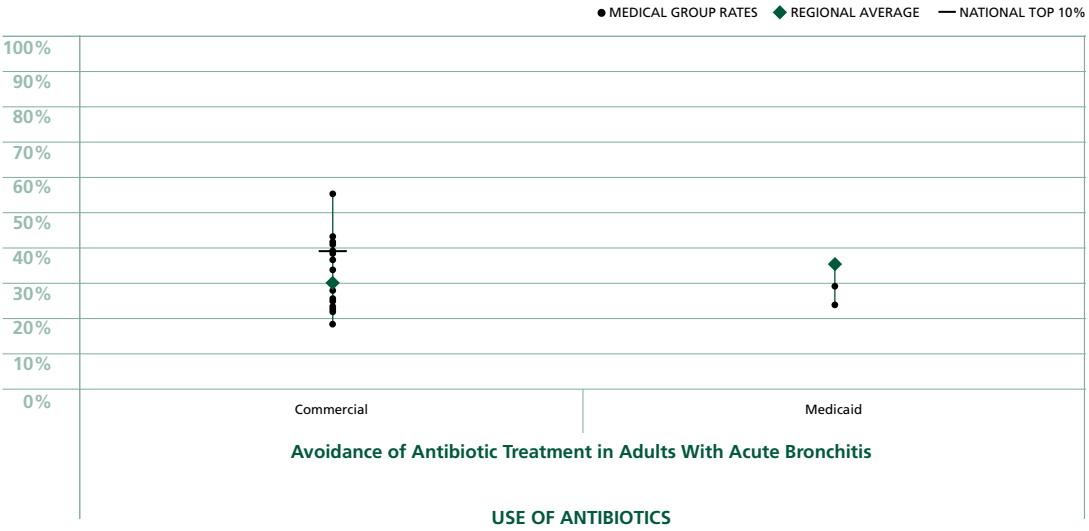
One way that the Alliance seeks to improve the Community Checkup over time is by continuing to expand the set of measures included in the report. This report introduces three new measures of care – one measure assessing appropriate antibiotic use in adults and two measures of access to preventive care. All three measures are based on HEDIS specifications. Since we are publicly reporting these measures for the first time, we present the results (both in the printed report and on the Community Checkup website) at a regional level only. We invite community feedback on the measures, results, and usefulness of the information. Please direct comments to Karen Onstad, Director of Health Information *(konstad@pugetsoundhealthalliance.org).*

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis.

This measure looks at inappropriate antibiotic prescribing in adults. Antibiotics are not recommended in clinical guidelines for treating adults with acute bronchitis who do not have another condition or other infection for which antibiotics may be appropriate. Because misuse and overuse of antibiotics lead to antibiotic drug resistance, inappropriate use of antibiotics is of clinical concern to the community. Acute bronchitis consistently ranks among the ten conditions that account for the most ambulatory office visits to physicians in the United States. Despite the fact that a great majority of acute bronchitis cases have a nonbacterial cause (greater than 90%), antibiotics are prescribed 65 percent to 80 percent of the time[9]. Our collective goal is to ensure appropriate use of antibiotics and reduce or eliminate inappropriate use.

[9] Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services, National Quality Measures Clearinghouse (NQMC), available from http://www.qualitymeasures.ahrq.gov; Internet; accessed 11 June 2009

Avoidance of Antibiotics in Adults with Bronchitis: Commercial & Medicaid Results



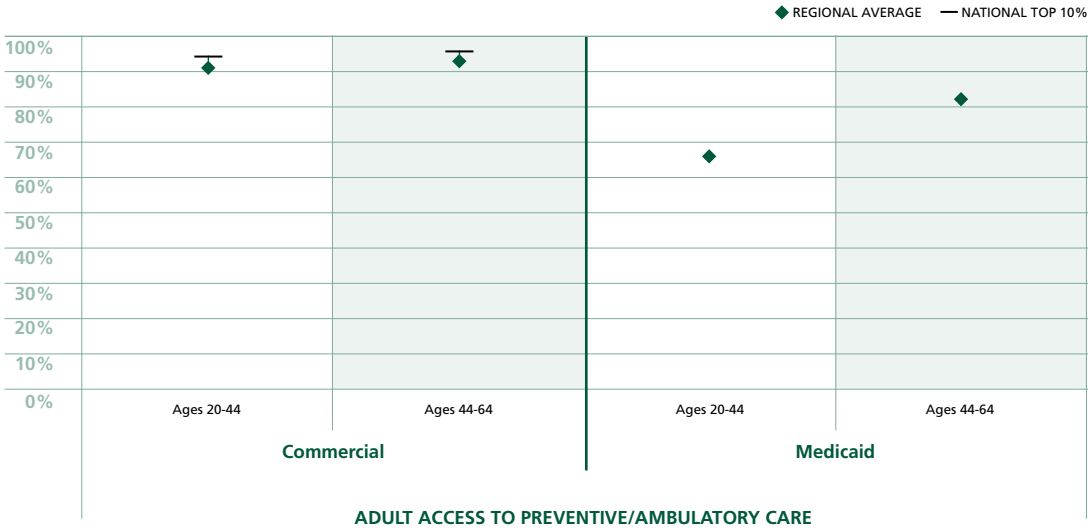
What is Measured?	
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	The percentage of adults age 18 to 64 diagnosed with acute bronchitis who were not dispensed an antibiotic prescription.

As displayed in the graph, there is substantial variability among medical groups on this measure – performance for the commercial population ranges from about 19 to 55 percent. For the Medicaid population, two groups had results below the regional average, indicating higher performance among medical groups that do not meet the threshold for public reporting. For the commercial population, medical group performance clusters at the low end of the range with only a handful of medical groups reporting results above the National Top 10%. These initial results suggest an opportunity for some medical groups to learn from those groups that excel on this measure.

Access to Care.
Access to preventive care services is a critical element of a high-performing health care system. Access to primary care has been shown to correlate with reduced hospital use while maintaining the quality of care delivered (Bodenheimer, 2005, Bindham, 1995)[10], and research demonstrates that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed patients and physicians. Encouraging and giving access to effective primary and preventive care services is one potential strategy to manage health care costs while maintaining the quality of care delivered.

Our collective goal is to ensure that patients in our community can get primary and preventive care when they need it. The measures below assess overall access to preventive care, where access is defined as the proportion of patients who had at least one preventive care visit during the measurement time period.

Adult Access to Care: Commercial & Medicaid Results



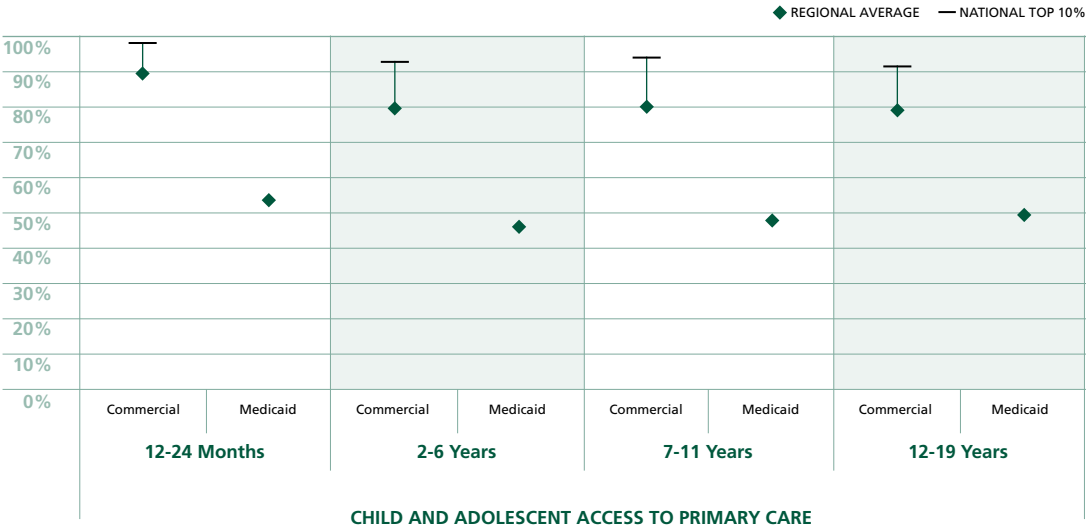
[10] Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services, National Quality Measures Clearinghouse (NQMC), available from http://www.qualitymeasures.ahrq.gov; Internet; accessed 11 June 2009

	What is Measured?
Adults' Access to Preventive Health Services - Commercial	The percentage of commercially insured adults 20 years and older who had a preventive care visit within the past three years.
Adults' Access to Preventive/Ambulatory Health Services - Medicaid	The percentage of Medicaid insured adults 20 years and older who had a preventive care visit within the past year.

For this measure, the measurement time period differs between the commercial and Medicaid populations due to the different patterns of care and risks associated with each population. Results for our region indicate that over 90 percent of commercially-insured patients had a visit in the past three years and that regional rates are in line with the top ten percent nationally. These results suggest that commercially-insured patients are able to access preventive care services. Lower rates for the Medicaid population are not necessarily comparable to the commercial results; they might indicate that this population faces challenges with regard to access to care or they might be explained by the shorter measurement period. By reporting the proportion of adults who had a preventive care visit, the measure may not capture preventive care delivered during visits for other purposes such as treating a chronic condition.

Childhood and adolescence are important periods in a person's development. Through these years, children are developing physically, intellectually, and emotionally. The American Academy of Pediatrics recommends that children see their doctor for a preventive visit at least every year until age six and then every other year. Preventive visits provide an opportunity to assess a child's or adolescent's growth and development, provide guidance on health issues, administer recommended screening and immunizations and promote healthy behaviors. The children's access measures reveal the portion that had a preventive visit with a primary care provider during the measurement period.

Child and Adolescent Access to Primary Care: Commercial & Medicaid Results



	What is Measured?
Children's Access to Primary Care Practitioners – 12-24 months and 25 months to 6 years	The percentage of children 12-24 months and 25 months- 6 years who had a visit with a primary care practitioner in the past year.
Children's Access to Primary Care Practitioners – 7-11 years	The percentage of children 7–11 years who had a visit with a primary care practitioner in the past two years.
Adolescent's Access to Primary Care Practitioners – 12-19 years	The percentage of adolescents 12-19 years who had a visit with a primary care practitioner in the past two years.

As displayed in the graph, results indicate that about 90 percent of children under age two and about 80 percent of all commercially-insured children age 25 months to 19 years in our community had a preventive care visit. These results are substantially below the top ten percent nationally. Regional results for the Medicaid population are substantially below those for the commercial population and indicate that only 45 to 55 percent of children insured by Medicaid received a preventive care visit in our community. This measure will be particularly valuable as results accumulate over time.

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Data Sources and Methods

The medical group results presented in this report are generated from claims or encounter data supplied by 18 health plans, self-insured purchasers, union trusts and government programs. Submitted data include information about tests, diagnoses and services provided by doctors and other clinicians. By sharing their data with the Alliance, these organizations helped create the most comprehensive health care information to be contained in a single report ever produced in this region. **The Alliance receives no information that personally identifies any individual patient.** Participating data suppliers include:

- The Boeing Company *(via Regence)*
- Carpenters' Trust
- CIGNA
- City of Seattle *(via Aetna)*
- Community Health Plan of Washington
- First Choice
- Group Health
- Washington State Health Care Authority Uniform Medical Plan *(via FIServ)*
- King County *(via Aetna)*
- Molina Healthcare of Washington
- Premera Blue Cross
- Recreational Equipment Inc. *(via Aetna and Group Health)*
- Regence Blue Shield
- Retail Clerks *(via Zenith Administrators)*
- Snohomish County *(via Regence)*
- Washington Mutual *(via United/MedStat)*
- Washington State Department of Social and Health Services *(Medicaid FFS)*
- Washington Teamsters

The organizations listed above provided the universe of information currently included in our dataset. This represents care for about two million people within the Puget Sound region which is greater than 50 percent of the total population. The dataset does not include data reflecting care to people who have individual insurance policies or who are uninsured, and specific books of business (e.g., HMO products) that some data suppliers do not include with their data submission, data from health plans or self-insured employers who do not participate in the Alliance, and the Federal government (e.g., Medicare, Veterans Affairs).

After the data were submitted, the Alliance engaged in a multi-step process to produce the measure results in this report. The steps were:

1. **Data validation** – Milliman Inc. (the Alliance's data vendor) worked with each data supplier to validate the data submitted. There were two levels of validation – one that ensured the correct transmission of the data and another that ensured measure results were consistent between Milliman and each data supplier. Once the data were validated, they were aggregated and de-identified for measure calculation.

2. **Medical group roster update** – The Alliance worked with medical groups to update their lists of physicians and other practitioners using OneHealthPort, an organization that uses secure portal technology for the exchange of business and clinical information between health plans and providers. Because measure results were attributed first to practitioners and secondly to clinic location, it was vital to have accurate and current information about which doctors practice at which clinic locations.

3. **Measure calculation and attribution** – Milliman aggregated the data from all of the data suppliers and calculated measure results. During this process, measure results were attributed to practitioners. The Alliance then used the updated medical group rosters to attribute practitioners – and their results – to clinic locations.

4. **Medical group/clinic review** – Medical groups and their clinics received their draft measure results to review and benchmark against internal sources for a "reasonableness review." The Alliance and Milliman worked with clinics to resolve any identified data issues.

5. **Patient verification** – To verify the project methodology, volunteer data suppliers and medical groups worked together directly to confirm that specific measure results reflected a given clinic's patients. The data suppliers re-identified patients for medical groups who then verified that the particular patient met the measure criteria and received a particular service from a particular practitioner and clinic according to the measure specifications. Medical groups worked with the Alliance and Milliman to resolve any identified data issues.

After these steps were complete and any necessary adjustments made, the data were finalized and prepared for public release via this report and our website *(www.WACommunityCheckup.org)*. To encourage practitioners to work with patients and others to improve the results over time, all medical groups listed in the report also have access to the final results at a more detailed practitioner level using a private secure portal developed by the Alliance with OneHealthPort and Milliman, Inc.

Results for Hospitals

This section of the Community Checkup report presents performance information for hospitals in King, Kitsap, Pierce, Snohomish and Thurston counties. There are over forty hospital measures with results being drawn from several public sources into a "one-stop shop" to help hospitals, doctors and nurses, patients, health plans, employers, unions and others learn about hospital care across the Puget Sound region. This report is intended to build community understanding so that we can work together to improve the safety, effectiveness and affordability of local hospital care.

Overall, hospital care results for this region reveal several important conclusions:

- **There is variation in the quality of care delivered in hospitals in this region.** Most patients assume that they will receive safe, effective, and appropriate care whenmthey go to the hospital. Although hospitals try to provide the best possible care, doing so is complex and there are many opportunities for errors or breakdowns in the process of providing care.

- **Everyone has room to improve.** While many hospitals perform well on certain measures, there is no single hospital that demonstrates excellent performance across all areas of care that are measured. Hospitals routinely look at their performance on these types of measures and recognize where they have room for improvement. Many share information about promising practices to learn from each other. By increasing awareness of the need for improvement across all hospitals in the region, each of us can help support and encourage improvement over time.

- **Everyone has a role.** Although this section of the report focuses on how well hospitals deliver certain elements of care, we each can take action to improve the results. With information about hospital care in hand, each of us can ask questions about how hospitals, physicians, nurses, patients, and others can work together to improve safety and effectiveness of care.

Hospitals in our region are active in various collective quality improvement initiatives.

Robert Wood Johnson Foundation National Collaboratives.

- **Aligning Forces for Quality: Transforming Care at the Bedside Collaborative** - Tacoma General Hospital of the MultiCare Health System and St. Francis Hospital of the Franciscan Health System were selected to participate in this new collaborative to engage nurses and frontline staff to improve the quality and safety of patient care on medical and surgical units.

- **Aligning Forces for Quality: Language Quality Improvement Collaborative** - Harborview Medical Center and Valley Medical Center were selected to participate in this collaborative to engage health care providers, language services providers, and leaders at all levels of the health care organization to:
  - improve the delivery and availability of language services for persons with limited English proficiency (LEP);
  - improve the safety of LEP patient care; and
  - implement performance measurement to improve language services.
- **Aligning Forces for Quality: Equity Collaborative** - In 2009 and 2010, the Foundation will be sponsoring an additional collaborative in the area of equity, which will focus on creating standardized methods for collection of race, ethnicity and primary language data to link to quality reporting.

  As an Aligning Forces for Quality grant recipient, the Puget Sound Health Alliance is the local coordinating contact for the Foundation in these efforts. We will work with the hospitals to understand their successes and help spread lessons learned and other insights about the new quality improvement innovations across this region.

SCOAP Surgical Checklist.
The Puget Sound Health Alliance is an active member of the SCOAP Surgical Checklist Coalition, focused on getting every hospital in Washington state to use the *SCOAP Surgical Checklist* in all operating rooms by the end of 2009. The Surgical Care and Outcomes Assessment Program (SCOAP) is a clinician-led, voluntary collaborative that links hospitals and surgeons with clinicians from across the state to increase the use of best practices in surgical care. This collaborative effort is to ensure that the necessary steps for safe surgery are taken every time surgery is performed, to reduce the risk of avoidable complications and improve patient outcomes. The SCOAP Surgical Checklist promotes better communication and supports the use of best practices in the operating rooms.

Washington State Hospital Association (WSHA) Intensive Care Unit (ICU) Safe Care Initiative.
This two-year initiative expands skills of ICU staff to reduce patient harm by focusing on eliminating central line infections. Washington state hospitals are leading the nation in this effort and are part of the first cohort. Seventy percent of hospitals in the state are participating in this active learning process being led by WHSA staff with content and guidance from national experts. Sponsors of the work include WSHA, Puget Sound Health Alliance, Washington State Medical Association, and several others. Hospitals in Colorado and North Carolina are also included in this effort.

Reducing Preventable Rehospitalizations.
WSHA is also working with community partners, including the Institute for Healthcare Improvement, the Puget Sound Health Alliance, the Washington State Health Care Authority, Qualis Health, and the nursing home and home health associations to reduce hospital readmissions in Washington state. Based on current data, it is estimated that the average 30-day readmission rate in Washington is 14-15%, with some hospitals experiencing readmission rates of more than 30 percent. The aim is to reduce statewide 30-day rehospitalization rates by 30 percent and to increase patient and family satisfaction. Although Washington has a comparatively low rate of readmission compared to other states, significant gains can still be accomplished in the area of unplanned readmissions. The Alliance has a particular interest in seeing improvements in measurement of rehospitalization to better understand the magnitude of the problem and to track improvement over time. Ideally, we would be able to track readmissions by hospital, by medical group in order to target interventions and improvements in transitions of care. Going forward, the Alliance is interested in adding new hospital data that has the potential for increasing awareness and motivating improved patient safety and affordability of care.

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Health Care Associated Infections.
We plan to include hospital-level data on health care associated infections as it becomes available from the Washington State Department of Health (DOH). In December 2009, DOH expects to publicly release the first set of results on central line-associated bloodstream infections in intensive care units. Over the following two years, DOH will publicly release data on ventilator-associated pneumonia and surgical site infection for:

1. deep sternal wound for cardiac surgery, including coronary artery bypass graft;
2. total hip and knee replacement surgery; and
3. hysterectomy, abdominal and vaginal.

Our intent is to improve and expand the Community Checkup report on the delivery of hospital care over time. This includes adding measures and making the layout and text more useful and relevant to an increasing number of patients, hospitals and other health professionals, employers, unions, health plans and others.

This section of the report highlights hospital care results for our five-county region in the areas of heart failure, surgical care, patient experience and never events (events which are serious and largely preventable). Detailed results on all of the measures are available at *www.WACommunityCheckup.org.*

Heart Failure Care

Heart failure is a weakening of the heart's ability to pump blood. When heart failure occurs, the heart cannot pump enough blood to the lungs and other tissues in the body to provide needed oxygen and nutrients. When a patient goes to the hospital to be treated for heart failure, they should expect the following:

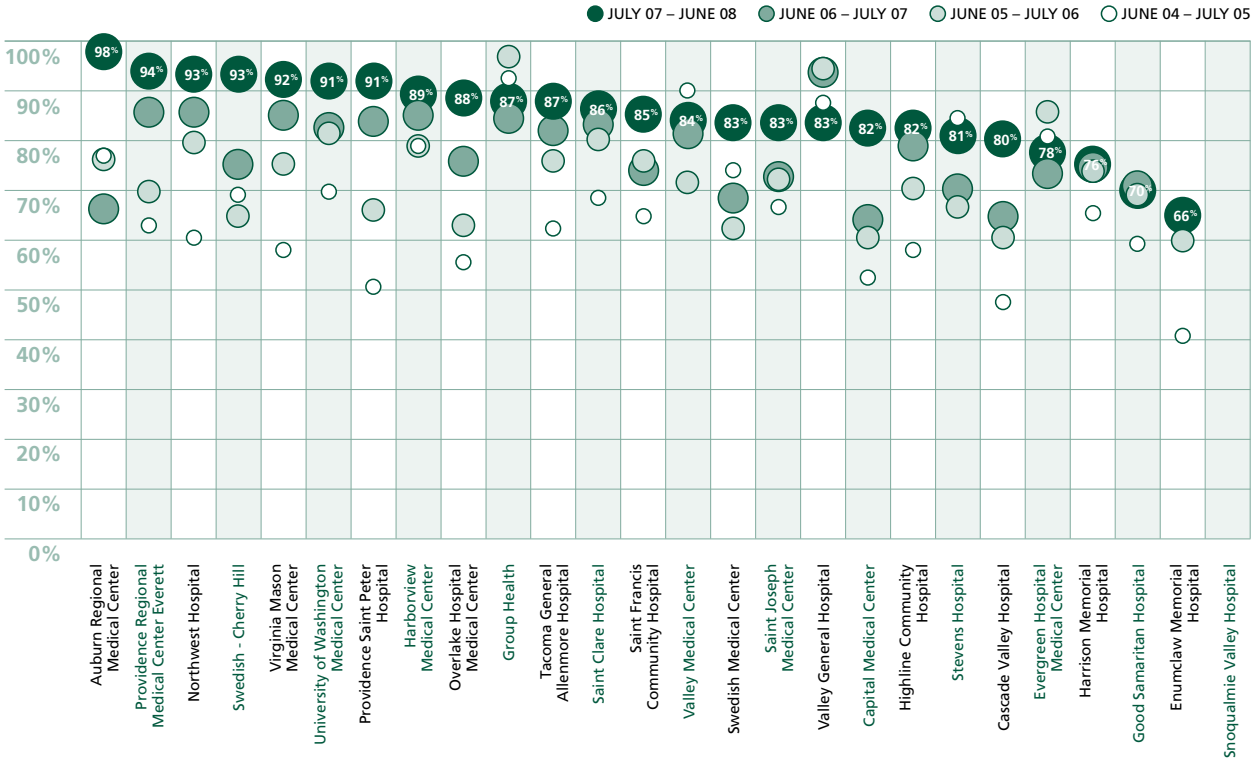
- **A left ventricular systolic (LVS) function assessment.** Proper treatment for heart failure depends on what area of the heart is affected. This test tells medical professionals whether the left ventricle, the main pumping chamber, is working properly.
- **Medicines to improve the heart's ability to pump.** The medicines, called ACE (angiotensin converting enzyme) inhibitors and/or ARBs (angiotensin receptor blockers), are required in different instances, so the medical team will decide which drug is most appropriate for each patient.

- **Clear instructions at discharge.** Each patient should receive clear instructionsbefore leaving the hospital on what the patient should do to reduce the risk of more complications due to coronary artery disease or heart failure. When discharging patients from the hospital, the goal of the health care team should be to help the patient manage their heart failure and prevent additional health problems and hospital visits.

- **Counseling or advice to the patient to quit smoking.** The doctor or health care team can provide information and resources to help patients quit smoking. Quitting improves patients' overall health, and plays a significant role in keeping the heart pumping properly.

The graph below displays a summary of the heart failure care performance of hospitals in the Puget Sound region over a four year period. The results are arrayed from highest to lowest rate in the most recent time period measured – July 2007 to July 2008. Hospitals without reportable results in the '07-'08 period appear at the right side of the chart in alphabetical order.

Heart Failure Care



Note: These results come from data submitted by hospitals to the Centers for Medicare and Medicaid Services (CMS) for public reporting. Summary results are calculated by The Commonwealth Fund and reported at *www.whynotthebest.org/.*

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Puget Sound Health Alliance

	What is Measured?
Heart Failure Care	A composite measure of care for heart failure that includes performance on four measures of heart failure care: 1. Test of how the heart is pumping (LVS function) is given 2. Medicines given to improve heart function 3. Patients advised to stop smoking 4. Instructions given when patient is released from the hospital The composite rate is the sum of the number of times a hospital performed the appropriate action for each of the four heart failure measures, divided by the number of opportunities the hospital had to provide appropriate care for that condition.

The graph displays substantial variability in performance for this measure in our region – results vary from 66 to 98 percent for the most recent measurement year. Several hospitals perform particularly well on these measures and may have developed best practices that could be shared across the community. When examining the performance through time, the results suggest substantial improvement for most hospitals over the four years measured with many hospitals demonstrating consistent year-over-year gains.

Surgical Care

Surgical care includes the care patients receive before, during and after surgery. These measures look at certain steps that are important to reduce the risk of developing problems like blood clots and infections. Of the estimated 30 million surgeries performed each year, approximately 500,000 patients develop surgical site infections, at an estimated annual cost of $1.5 billion. Surgery involves many steps taken by doctors, nurses and others in a hospital. To reduce the risk that a patient will get an infection or blood clots, the health care team should make sure each patient receives the following care based on national guidelines for safe practices:

- **An antibiotic during the hour before the surgery begins (before "surgical incision").** Research shows that patients who get antibiotics within the hour before an operation are less likely to get wound infections. Getting an antibiotic earlier, or after surgery begins, does not work as well.

- **The right antibiotics.** Not all antibiotics are the same. The right antibiotic for a given patient depends on the kind of surgery being performed.

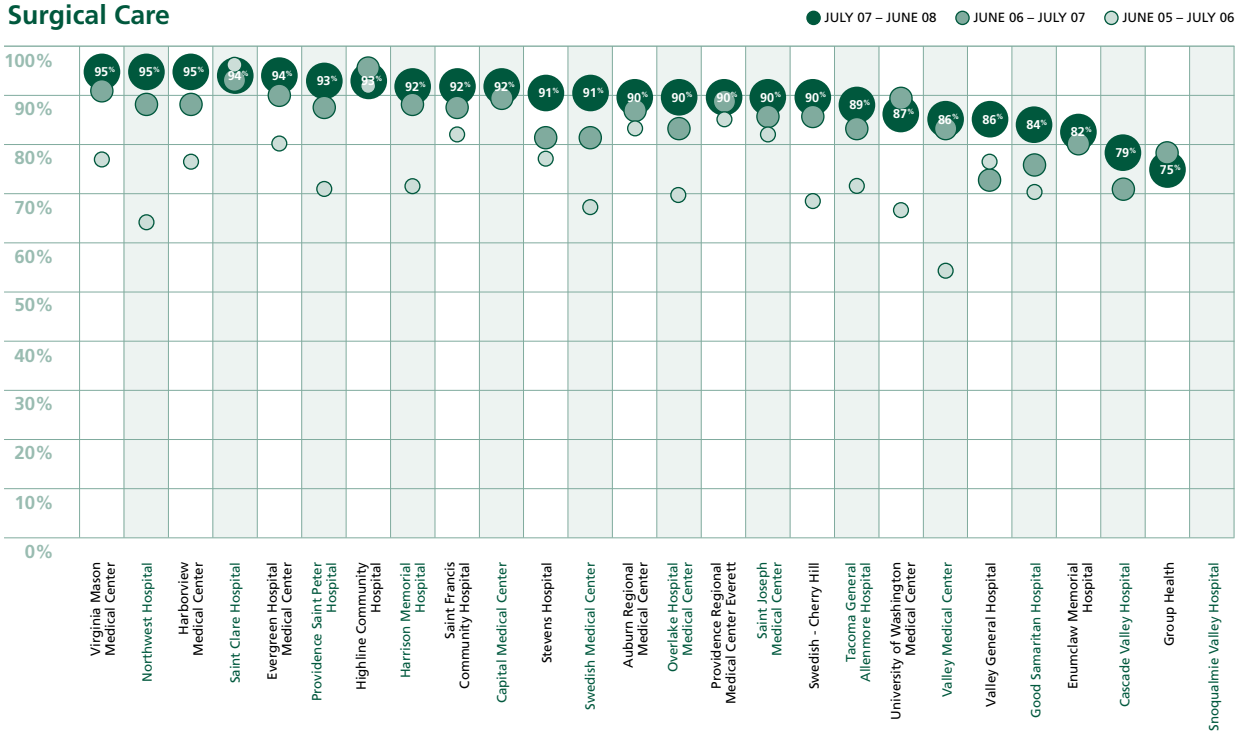
- **Order treatment to reduce the risk of blood clots developing.** Doctors should order specific treatments, such as blood-thinning drugs, elastic support stockings, or "air stockings" to help the blood in a patient's legs keep moving.

After surgery, the goal of each health care team should be to help patients remain free of infection and recover as soon as possible. Taking the following steps is important:

- **Stop providing antibiotics to the patient within 24 hours after surgery.** While antibiotics before surgery can lower the risk of infection, administering the drugs for more than 24 hours after surgery usually does not help and can cause other problems.
- **Provide treatment to reduce the risk of blood clots.** Certain types of surgery can increase the chance of blood clots because patients don't move during surgery and they may not move much after surgery. Steps may include providing blood-thinning drugs and making sure that elastic support stockings or mechanical "air stockings" are being used.
- **Help patients understand more about infections and how to watch for warning signs and possible problems.**

The graph below presents a summary of the surgical care performance of hospitals in the Puget Sound region over the last three years. The results are ordered from highest to lowest in the most recent time period measured – July 2007 to June 2008. Hospitals without reportable results in the '07-'08 period appear at the right side of the chart in alphabetical order.

Surgical Care



Note: These results come from data submitted by hospitals to the Centers for Medicare and Medicaid Services (CMS) for public reporting. Summary results are calculated by The Commonwealth Fund and reported at www.whynotthebest.org/.

What is Measured?

Surgical Care

A composite measure that includes performance on five measures of surgical care:

1. Antibiotic given within one hour before surgery
2. Correct antibiotic drug is given
3. Antibiotics are stopped within 24 hours after surgery
4. Treatment to prevent blood clots is given within 24 hours before and after surgery
5. Treatment to prevent blood clots is ordered

The composite rate is the sum of number of times a hospital performed the appropriate action for each of the five surgical care measures, divided by the number of opportunities the hospital had to provide appropriate care for that condition.

The graph displays that performance on this measure varies from 75 to 95 percent during the most recent measurement year, with high performance for multiple hospitals in our region. When looking at the results across three years, most hospitals have achieved significant improvement in results for surgical care demonstrated by the most recent rate in the green circle being the highest result for a particular hospital. Additionally, this may be another area of care where the sharing of best practices across the community could benefit regional performance.

Patient Experience

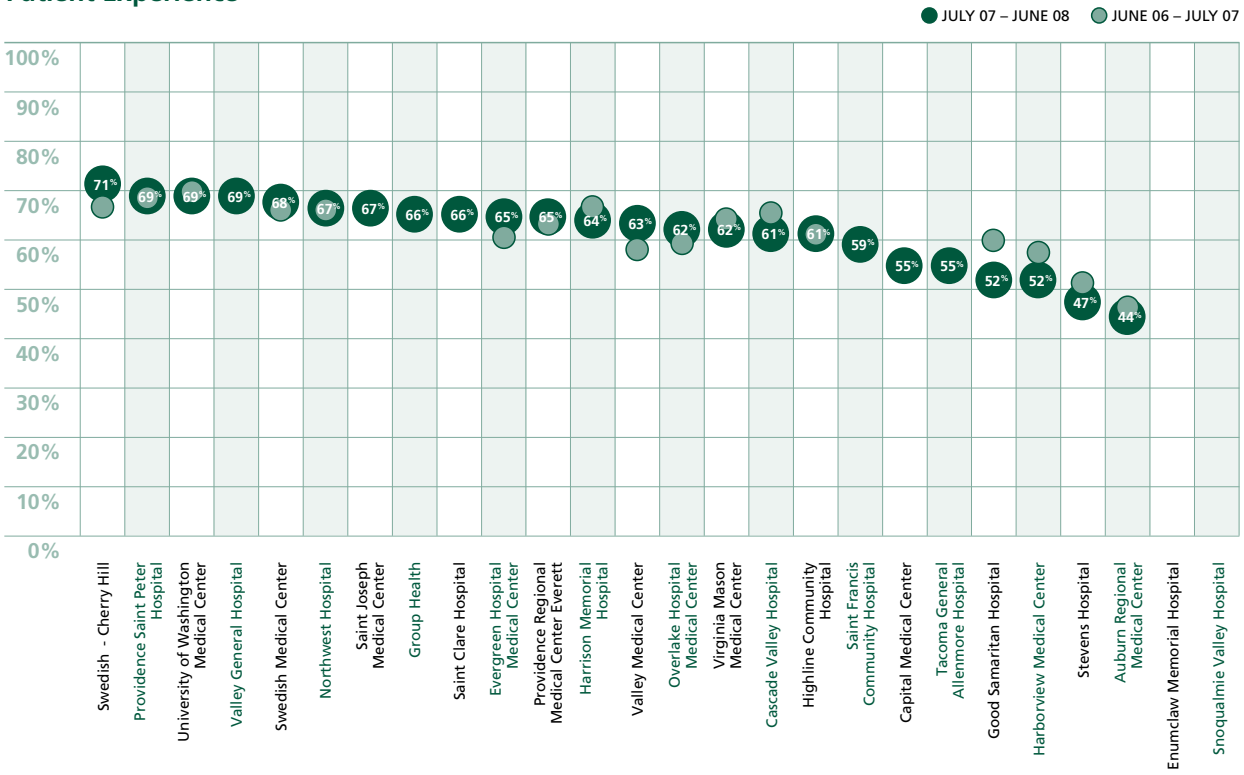
Patient experience refers to the patient's perspective about specific situations or events that happen from the time the patient enters a hospital until he or she leaves. During a hospital stay, patients should expect – and experience – the following things:

- The health care team, including doctors and nurses, should explain things in a way that the patient can understand, listen to the patient, and treat each patient with courtesy and respect.
- The health care team should explain any drugs that the patient needs to take,including why the drugs are needed, how and when the patient should take them, and any likely side effects.
- The hospital staff should do everything they can to help control the patient's pain.
- Patients should be able to get help when they need it.
- Patients' rooms and bathrooms should be kept clean.
- The area around the patient's room should be quiet at night.

When discharging patients from the hospital, the goal of the health care team is to help patients take needed actions to get better and to prevent health problems in the future, including the need for re-hospitalization. Before a patient leaves the hospital, the patient should receive written instructions using plain language that the patient can understand about what to do during their recovery at home, including information about symptoms or problems to watch for.

The graph displays results for the patient's overall rating of the hospital for hospitals in our region over two years of measurement. The results are arrayed from highest to lowest for the most recent measurement period. Hospitals without reportable results in the '07-'08 period appear at the right side of the chart in alphabetical order.

Patient Experience



Note: These results come from data gathered using the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey tool and publicly reported by the Centers for Medicare and Medicaid Services (CMS).

What is Measured?

Patient Experience – Overall Rating	The percentage of patients who responded "9 or 10" to the following survey question: "Using any number from 0 to 10 where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital?"

The graph shows that results for this measure vary substantially across hospitals in our region – from a low of 44 percent to a high of 71 percent. The national best-performing rate for this measure is 97 percent for July 2007- 2008, indicating that very high achievement is possible for this measure and that there is considerable opportunity for hospitals in our region to improve. This measure also appears stable over the two time periods measured, although trends may emerge as results accumulate over time.

Never Events

The term "never events" refers to a list of 28 situations identified by the National Quality Forum (NQF) that should never happen. While rare, never events are serious problems that nearly always can be avoided, such as surgery on the wrong body part, death or disability from a fall or medication error at a health care facility, and using contaminated drugs or malfunctioning devices. In 1999, the Institute of Medicine reported that up to 98,000 Americans die every year from preventable medical errors in hospitals – making medical errors the 8th leading cause of death in the U.S. For a complete list of never events, go to *www.qualityforum.org/pdf/news/prSeriousReportableEvents10-15-06.pdf.*

In 2006, Washington State passed a law requiring hospitals to report to the Department of Health (DOH) when 'never events' occur in their facility. DOH collects this data on an ongoing basis and releases updated information quarterly. Hospitals must analyze why the event occurred and submit that to DOH as well.

The table below presents the number of 'never events' that occurred across all hospitals in Washington state between April 2008 and March 2009 which is the most recent four quarters of data available. Never events in Washington state are relatively rare, with only 200 such events reported statewide between April 2008 and March 2009. For context, these same hospitals reported nearly 645,000 discharges and 2.6 million patient days in 2007.

The table shows that more than half of the never events in the state fall in the category of care management, with a large majority of these events related to late stage pressure ulcers (i.e., serious and deep skin lesions generally caused by unrelieved pressure and/or friction). The second highest category is surgical events, making up 32 percent of the events with the largest number concentrated in retention of foreign objects after surgery.

	Apr-Jun 2008	Jul-Sept 2008	Oct-Dec 2008	Jan-Mar 2009	Total	%*
CARE MANAGEMENT EVENTS					105	53%
Patient death, serious disability from medication error	4	2	1	2	9	
Patient death, serious disability associated with a hemolytic reaction due to being given incompatible blood or blood products		1			1	
Maternal death or serious disability (low risk pregnancy)	2		1		3	
Stage 3/4 pressure ulcers	36	22	14	20	92	
SURGICAL EVENTS					64	32%
Surgery performed on the wrong body part	4	5	3	2	14	
Surgery performed on the wrong patient	1	1			2	
Wrong surgical procedure	1	1	3	1	6	
Unintended retention of foreign object post surgery/procedure	11	15	9	6	41	
Post-operative death in normal, healthy patient			1		1	
ENVIRONMENTAL EVENTS					19	10%
Patient death, serious disability associated with a fall	3	5	4	3	15	

	Apr-Jun 2008	Jul-Sept 2008	Oct-Dec 2008	Jan-Mar 2009	Total	%*
Patient death, serious disability associated with the use of restraints	1	2	1		4	
CRIMINAL EVENTS					5	3%
Care ordered by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider				1	1	
Sexual assault on a patient			1		1	
Death, significant injury of patient or staff from physical assault		1	1	1	3	
PRODUCT OR DEVICE EVENTS					4	2%
Patient death, serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended				1	1	
Patient death, serious disability associated with intra-vascular air embolism		2		1	3	
PATIENT PROTECTION EVENTS					3	2%
Patient suicide or attempted suicide resulting in serious disability	3				3	
Total (All Events)	66		39	38	200	

*Due to rounding, percentages do not sum to 100%
Only events with incidents during the last 4 quarters listed. For a more complete list, see *www.WACommunityCheckup.org*

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Looking Ahead

To further our goal of achieving a more effective and efficient health care system in the region, the Alliance intends to continue expanding the Community Checkup. For medical groups and hospitals, we will continue to add measures as they become available and develop new data sources (e.g., electronic medical records) when possible. We also have a commitment to finding ways to stratify performance results by race, ethnicity, and/or primary language so that, collectively, we may better understand health care disparities in our region. In addition to expanding our current reporting capability for medical groups and hospitals, future activities also include the following:

Health Plan Performance Reports from eValue8™.

The Alliance recently completed its second year of sponsoring the eValue8™ process in the Puget Sound area. eValue8™ is widely used by coalitions, their purchaser members, and national employers to assess and manage the quality of their health care vendors. The eValue8™ tool focuses on critical quality-related activities such as consumer engagement, provider performance, pharmacy management, prevention and health promotion, chronic disease management and behavioral health. The eValue8™ process permits purchasers to measure the relative performance of the health plans within their market and benchmark that performance to best practice nationally. The Alliance is currently one of 23 coalitions across the country that uses the eValue8™ tool - this number grows each year.

The Alliance strives to advance transparency of variation in performance to drive quality improvement in health care within the Puget Sound region. Our use of the eValue8™ tool is intended to:

1. Generate consistency in the assessment of health plans that enables transparency of performance and permits comparison within and across markets, including national benchmarks and best practices;
2. Stimulate improved performance from health plans, with a particular focus on information, systems and tools within the control of the plan that can be used to encourage and support improved performance from providers and delivery systems, as well as promote consumer behavior for wellness and informed decision-making;
3. Enable purchasers and health plans to work collaboratively to structure health insurance and benefit programs to reward value; and
4. Inform purchasers' procurement decisions about health insurance for their employees and dependents.

In 2008 and again in 2009, six health plans participated in eValue8™ in the Puget Sound market. The plans are: Aetna, CIGNA, Group Health Cooperative, Premera, Regence, and United Healthcare. By September, the Alliance intends to include the 2009 summary level results by health plan at www.WACommunityCheckup.org. Be sure to check for the new health plan tab.

Report on Resource Use in our Region

The Alliance will begin reporting on resource use in our region in 2009. Measuring resource use is an important step on the path to measuring value, a characteristic that includes both quality and resources. The resource reports are currently in development and we expect to release reports in the following areas over time:

- **Hospital Discharges, Costs, Service Intensity and Quality.** These reports will be drawn from publicly available data sources such as Centers for Medicare and Medicaid Services, Dartmouth Atlas, and the Washington State Department of Health.
- **Hospitalizations**.These reports will be generated from the dataset aggregated by the Alliance and will include information on the amount and type of care delivered during hospital stays by severity of the condition. The reports will include both professional and facility components of inpatient stays. Results will be summarized for each pairing of admitting hospital and active medical group.
- **Surgery Rates.** These reports will be modeled after the Dartmouth Atlas reports but will be generated from the Alliance dataset to present population-based rates of selected surgeries and procedures of interest in our region. Surgical treatments for conditions that also have non-surgical treatment options will be the focus.
- **Episodes of Care** We anticipate that these reports will be developed in the future. They will feature public domain episode of care specifications currently being developed nationally by the Quality Alliance Steering Committee. The initial wave of conditions likely to be featured will be Heart Attack, Congestive Heart Failure, Angina/Coronary Artery Disease, Diabetes, Chronic Obstructive Pulmonary Disease, and Asthma.

Report on Patient Experience

Patient experience data is currently available for the hospital setting through Hospital Compare and these results are included on the Community Checkup website. Although a number of medical groups in the area measure and review patient satisfaction with their practices, currently there is no process in place to standardize the measurement of patient experience with doctors' offices across the Puget Sound region and then share these results publicly. The Puget Sound Health Alliance has completed a proposal for fielding the Clinician and Group CAHPS survey in our community and publicly reporting results, and is currently seeking funding to proceed. Community agreement to measure patient experience using a common survey instrument and protocol would produce standard, comparable results for participating medical groups, similar to the quality measures already included in the Community Checkup. Adding measures of patient experience is very important, particularly to consumers of health care, and would be a significant advancement for transparency and health care quality in our region.