August 2011

Puget Sound Community Checkup

An Ongoing Report to the Community on
Health Care Performance Across the Region

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

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August 9, 2011

Dear Community Member:

Welcome to the fifth Community Checkup report, the result of a collaborative effort to improve the quality and affordability of health care in our region. This report builds upon previous versions of the Community Checkup and includes results for 81 medical groups and more than 300 clinics of four or more clinicians as well as 30 hospitals within King, Kitsap, Pierce, Snohomish and Thurston Counties.
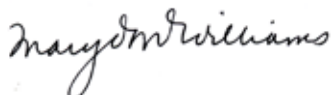
The Community Checkup supports the change that we seek to make through each of the four areas in which we work:

• **Performance Measurement and Public Reporting**—measuring and reporting variation in quality and cost
• **Consumer Engagement**—helping consumers make informed decisions
• **Payment Reform**—paying providers for value not just volume
• **Performance Improvement**—leveraging strategies to change results and improve value

By working in each of these four areas, the Alliance believes that it can achieve its strategic vision: by 2015, physicians, other providers and hospitals in the region will be in the top 10 percent in performance nationally in the delivery of quality, evidence-based care and in the reduction of unwarranted variation, resulting in a significant reduction in medical cost trends. This is a bold goal, but we believe that the Alliance community can reach it. The Community Checkup gives us a strong foundation upon which to build.

Many community members contributed to this report, especially medical groups, data suppliers and the members of our board and committees who guided this process. We extend our deep thanks to these individuals and organizations who contributed valuable time, resources, data, and other efforts to make this report possible.

Finally, we acknowledge the support of the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative in producing this report. AF4Q's ongoing commitment to transforming health care through community-wide efforts has been an invaluable contribution to our work.

Mary McWilliams

Mary McWilliams
Executive Director
Puget Sound Health Alliance

Table of Contents

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Results for Medical Groups

This section of the Community Checkup report presents performance results for medical groups in King, Kitsap, Pierce, Thurston and Snohomish Counties. The report measures how consistently patients receive high quality health care in several important areas, including prevention and care for chronic conditions.

The results in this section are based on the care that 1.6 million people, or nearly half of all the people who live in the Puget Sound region, received from their medical groups from July 2009 to June 2010. To be included in the report, medical groups of four or more practitioners must have at least 160 patients appropriate to each measure (for example, for a diabetes measure, a clinic must have at least 160 patients diagnosed with diabetes). The full report includes results for more than 80 medical groups with more than 300 clinic locations in the Puget Sound region.

The report includes 23 measures of care from medical groups in the following areas:

- Prevention (effectively screening for diseases)
- Appropriate use of services (when antibiotics and imaging are called for)
- Care for patients with diabetes, heart disease, asthma, depression, and Chronic Obstructive Pulmonary Disease (COPD)
- Use of generic prescription drugs
- Access to preventive care for adults, adolescents and children

A summary of the regional performance in each of these areas is presented in the pages that follow.

While the results of these measures are shown at the medical group or clinic level, they are the outcome from the decisions of everyone who participates in health care: doctors, patients, health plans, and employers or labor trusts. That's why this is called the Community Checkup.

This report shows whether doctors and other health professionals recommend the care to patients *and* whether patients follow through with that advice. There are many reasons that patients may not follow through to receive recommended care. The patient may not understand why the recommended care is important or there may not be coverage for the service through the health plan offered by the patient's employer. The purpose of this report is to help everyone make more informed decisions and encourage improvement in health care quality and value.

For each measure, this report presents the medical group results compared to the regional average for the privately insured (commercial) population. Where it is available, the results also include a national 90th percentile benchmark, which shows the performance level of the top 10 percent of health plans nationally. The data about performance at the national level are from the National Council on Quality Assurance (NCQA), a nonprofit organization dedicated to improving health care quality. NCQA uses a tool called the Healthcare Effectiveness Data and Information Set (HEDIS) to measure performance on important dimensions of care and service based on information from commercial health plans.

Unlike the past two Community Checkup reports, this report does not include data on the fee-for-service Medicaid population due to the need to further specify the categories of Medicaid patients suitable for these measures. Medicaid managed-care data is still included in this Community Checkup and can be accessed at www. WACommunityCheckup.org. The Alliance and the State of Washington hope to resolve the population anomalies and resume inclusion of Medicaid fee-for-service data in the next Community Checkup.

The graphs in this section show how each of the individual medical groups performs in terms of the number of above average, average and below average results for the 19 measures reported at the medical group level. (Two measures—"access to preventive care" and "beta blockers for heart disease"—are reported at the regional level only. Two addition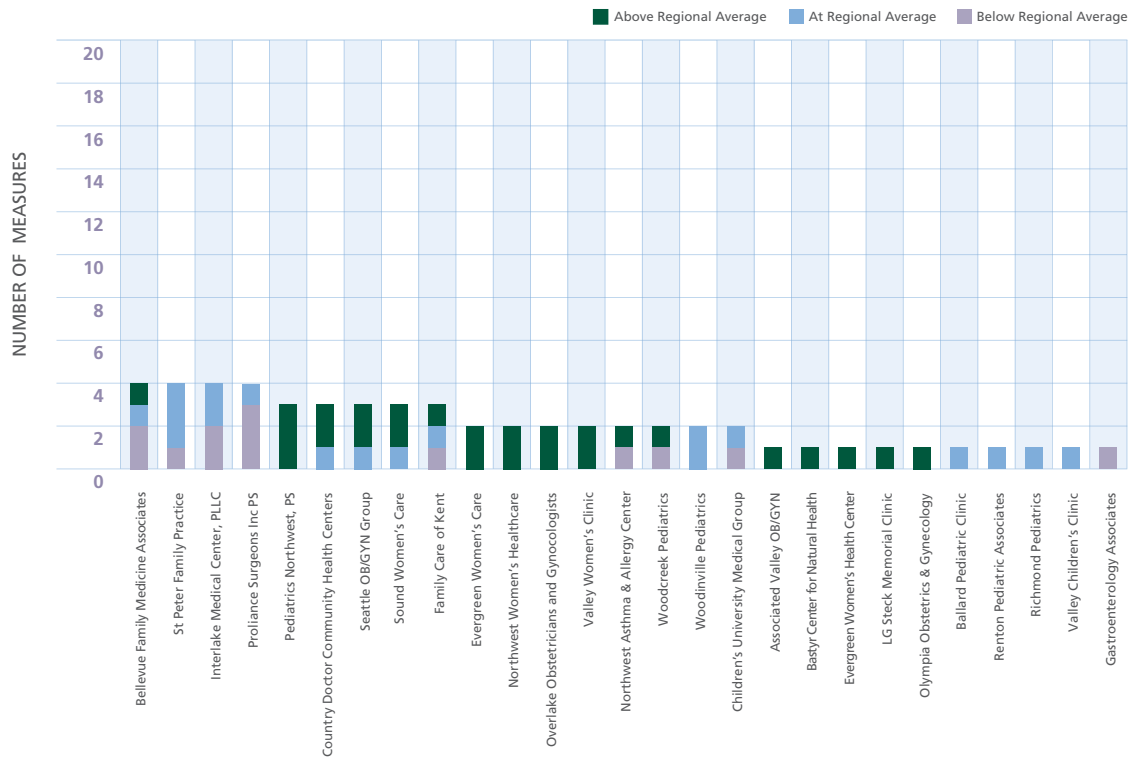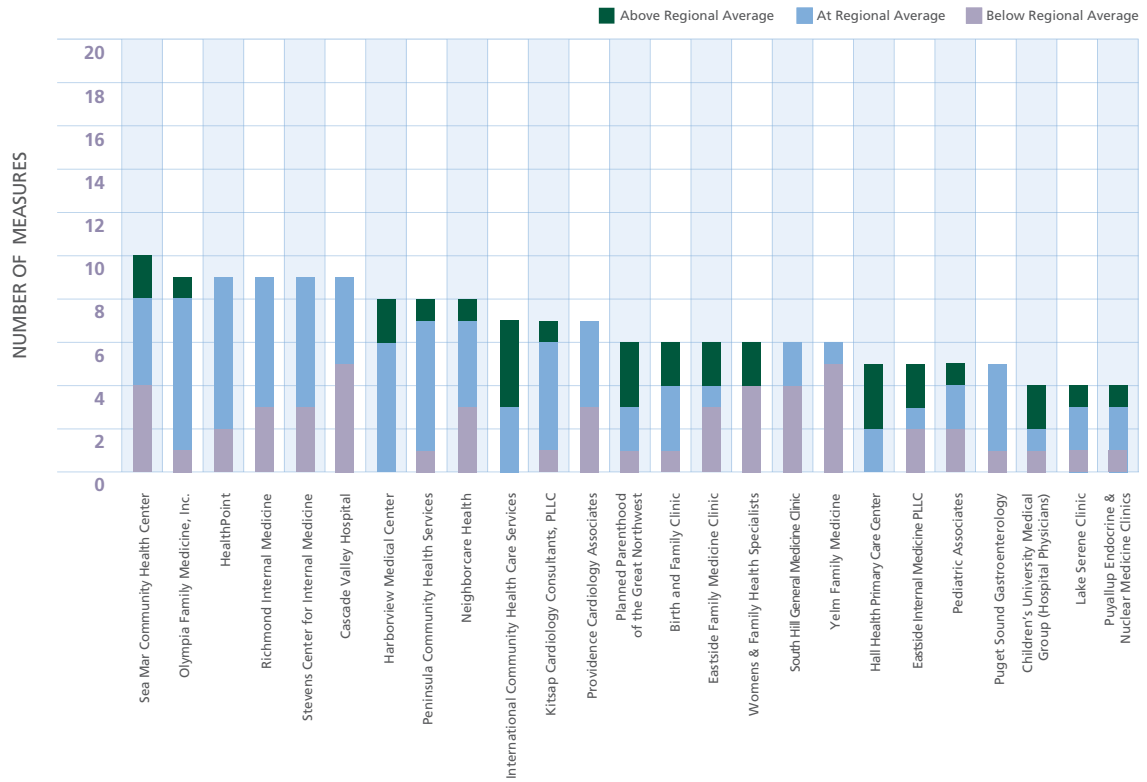al measures—"spirometry testing for COPD patients" and "adolescent well-care visits"—are also reported at the regional level only, in keeping with Alliance policy on how new measures are reported for the first time.)

Because results are reported at the medical group level only if the group has at least 160 patients for any given measure, most groups do not have results for all 19 measures. The graphs below start with those medical groups that report on 19 measures and then in clusters with the descending number of measures reported. Within each cluster, medical groups with the highest number of above average results are listed first. The purpose of these graphs is to provide a snapshot of the overall performance on the measures of the medical groups.

Additional details are available in the graphs in the pages that follow, which show the range of performance as well as the distribution of medical groups along the range. You will be able to see if most medical groups are performing at the same level, or whether there are some medical groups that perform significantly better or worse in certain areas.

To see specific medical group and clinic results please visit the Community Checkup website: *www.WACommunityCheckup.org*.

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Chart 1 legend: Above Regional Average | At Regional Average | Below Regional Average

NUMBER OF MEASURES

Y-axis: 0, 2, 4, 6, 8, 10, 12, 14, 16, 18, 20

X-axis labels:
Sea Mar Community Health Center
Olympia Family Medicine, Inc.
HealthPoint
Richmond Internal Medicine
Stevens Center for Internal Medicine
Cascade Valley Hospital
Harborview Medical Center
Peninsula Community Health Services
Neighborcare Health
International Community Health Care Services
Kitsap Cardiology Consultants, PLLC
Providence Cardiology Associates
Planned Parenthood of the Great Northwest
Birth and Family Clinic
Eastside Family Medicine Clinic
Womens & Family Health Specialists
South Hill General Medicine Clinic
Yelm Family Medicine
Hall Health Primary Care Center
Eastside Internal Medicine PLLC
Pediatric Associates
Puget Sound Gastroenterology
Children's University Medical Group (Hospital Physicians)
Lake Serene Clinic
Puyallup Endocrine & Nuclear Medicine Clinics

Chart 2 legend: Above Regional Average | At Regional Average | Below Regional Average

NUMBER OF MEASURES

Y-axis: 0, 2, 4, 6, 8, 10, 12, 14, 16, 18, 20

X-axis labels:
Bellevue Family Medicine Associates
St Peter Family Practice
Interlake Medical Center, PLLC
Proliance Surgeons Inc PS
Pediatrics Northwest, PS
Country Doctor Community Health Centers
Seattle OB/GYN Group
Sound Women's Care
Family Care of Kent
Evergreen Women's Care
Northwest Women's Healthcare
Overlake Obstetricians and Gynocologists
Valley Women's Clinic
Northwest Asthma & Allergy Center
Woodcreek Pediatrics
Woodinville Pediatrics
Children's University Medical Group
Associated Valley OB/GYN
Bastyr Center for Natural Health
Evergreen Women's Health Center
LG Steck Memorial Clinic
Olympia Obstetrics & Gynecology
Ballard Pediatric Clinic
Renton Pediatric Associates
Richmond Pediatrics
Valley Children's Clinic
Gastroenterology Associates

8

How to Interpret 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. Readers of this report should note the following:

- **Results not comparable with previous results.** The results in this report are not directly comparable to results in the July 2010 report. For example, some measures have been modified.

- **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.

- **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.

- **Claims data limits.** Some patients have a portion of their care provided by programs (e.g., grant-funded programs, etc.) that do not submit claims for certain services. This results in incomplete data feeding into the Alliance. Other services may occur as part of an inpatient stay and not get billed separately. This also results in incomplete data.

- **Individual patient needs.** Certain patient conditions and/or ages may exclude or prevent them from being a candidate for generic versus brand drugs. An example of this is that pediatric patients may require antacids in liquid form and equivalent generic antacids are only available in solid form.

- **Confidentiality issues.** There are confidentiality considerations, especially with the pediatric population. For example, a pediatric patient may not want to risk a bill or test results related to a chlamydia screening being opened by her parent/guardian so instead she seeks services outside of her normal PCP in a more anonymous setting. Services obtained through an alternative setting may be billed outside of a claims system and result in incomplete data capture at the Alliance.

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- **Benefit structures**. The benefit design of insurance policies may cause patients to seek or avoid certain services and treatments. These financially-based decisions are typically outside of the provider's influence.

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.

2011 Results

Access to Preventive Care

Access to preventive care services is a critical element of a high-performing health care system. 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 goal as a community is to ensure that patients in our community can get primary and preventive care when they need it.

The measures included in this report assess overall access to preventive care for both adults and children (those covered under commercial health insurance and those covered under Medicaid). For the first time, the Alliance is also including a measure on adolescent well-care visits, which is an important part of a wellness regimen for patients in that age range.

Highlights

- Regional performance is below the national 50th percentile for most measures

- New measure on adolescent well-care visits falls shorter of national benchmark than any other measure in Community Checkup

- Only access to care for adults ages 45 to 54 reaches the national benchmark
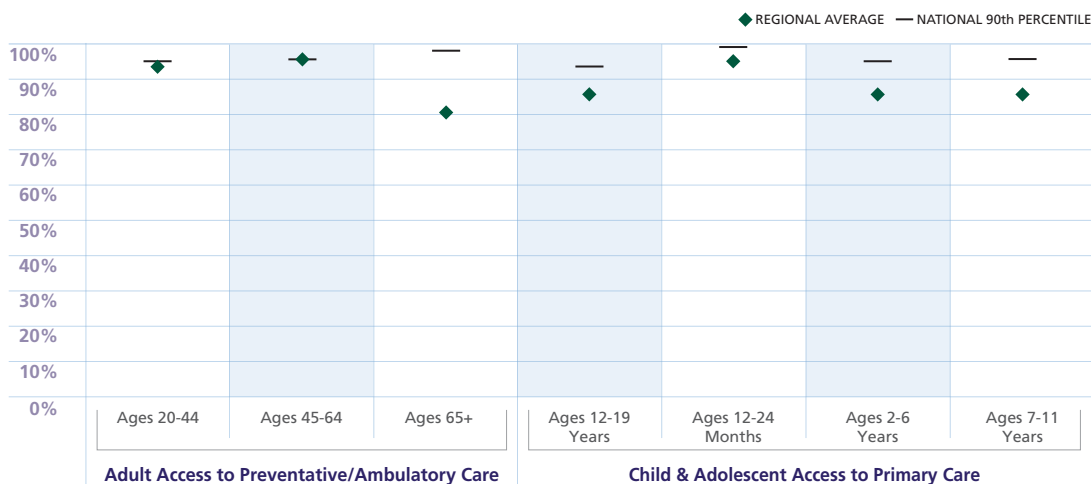
Our Performance

The adult, children and adolescent access measures in this category are reported at the regional level only, because they measure whether someone sought care anywhere. Adolescent well-care visits are reported by medical group.

On the adult, children and adolescent access measures, the region has room for significant improvement. In only one category—access to care for adults aged 45 to 54—does the regional performance match the national 90th percentile benchmark. In all other categories, it falls significantly short, failing even to meet the 50th percentile benchmark.

The region's performance on the new measure, adolescent well-care visits, is a particular disappointment. This is the only measure in the Community Checkup in which not a single medical group meets, let alone exceeds, the 90th percentile benchmark, which is only 57 percent. The regional performance for this measure falls shorter than the national benchmark than for any other measure we report. While many factors may contribute to this low level of performance, there is no question that the region should be looking for ways to better understand and address the barriers to adolescent well care visits.

Access to Care

◆ REGIONAL AVERAGE — NATIONAL 90th PERCENTILE

Adult Access to Preventative/Ambulatory Care — Child & Adolescent Access to Primary Care

Note: Access measures reported at regional level only: no medical group results available

Adolescent Well-Care Visits

● MEDICAL GROUP RATES ◆ REGIONAL AVERAGE — NATIONAL 90th PERCENTILE

Adolescent Well-Care Visits

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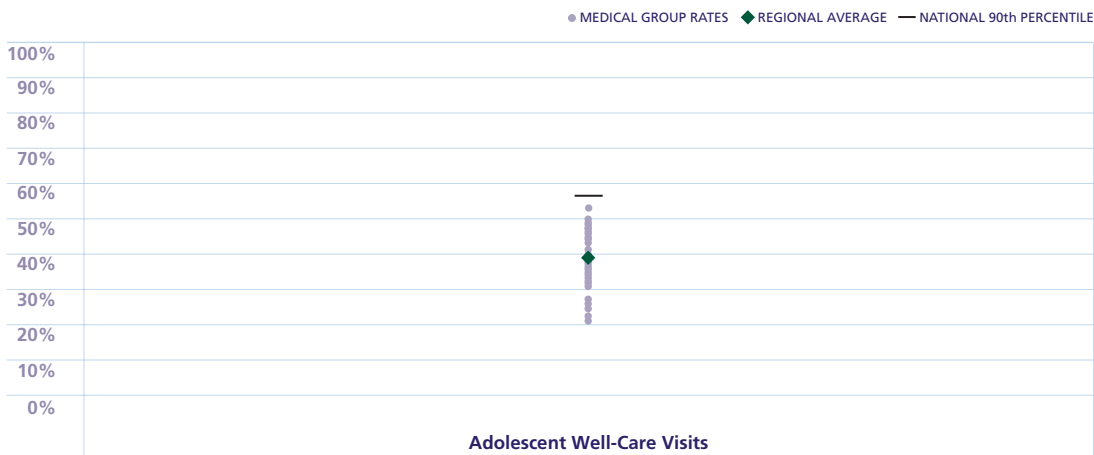
Cost Implications

Access to care for children and adolescents is important for preventing disease and promoting healthy behaviors at key periods of development. According to an extensive cost-benefit analysis by the U.S. Centers for Disease Control and Prevention, every dollar spent on childhood immunization saves $18.40 in direct and indirect costs, with an aggregate savings of $42 billion. (We currently do not measure immunization rates, but plan to do so at a future point.) Adolescent well-visits are an opportunity to identify and intervene in health-risk behaviors, such as tobacco and alcohol use and poor nutrition habits, which have long-term health and financial consequences.

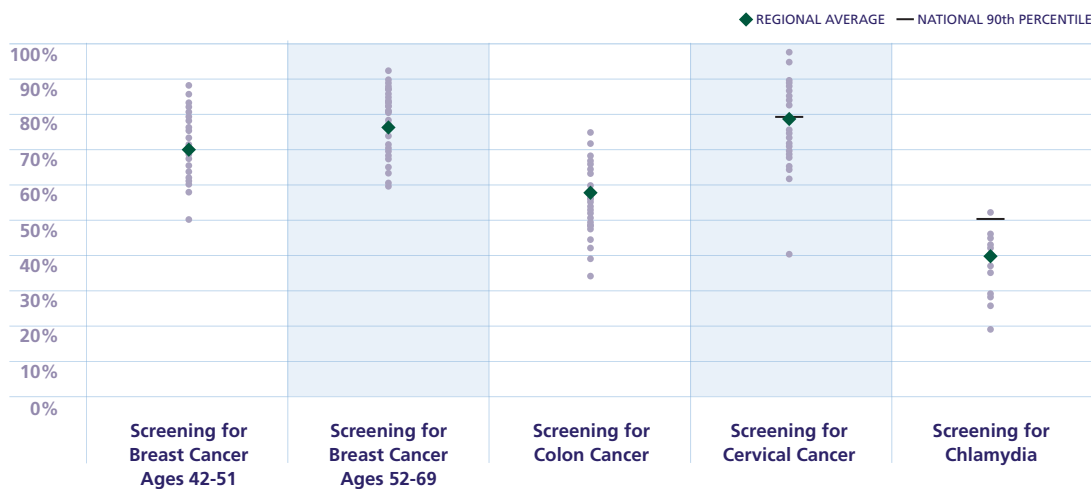| What is Measured?	Why Are These Measures Important?
• **Adults' Access to Preventive Health Services: Commercial**—The percentage of commercially insured adults 20 years and older who had a preventive care visit within the past three years.	• Selecting and developing a relationship with a primary care physician is an important step in a patient's commitment to health. • Access to primary care has been shown to correlate with reduced hospital use while maintaining the quality of care delivered. • Research demonstrates that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed patients and physicians.
• **Children's Access to Primary Care Practitioners (12–24 months, and 25 months–6 years)**—The percentage of children 12–24 months and 25 mo.–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 (12–21 years)**—The percentage of adolescents 12–21 years who had a visit with a primary care practitioner in the past two years. • **Adolescent Well-Care Visits (12–19 years)**—The percentage of adolescents 12–21 years who had a well-care visit with a primary care practitioner in the past year.	• Childhood and adolescence are important periods in a person's development. Through these years, children are developing physically, intellectually, Wand 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 and well-care 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.

Source: Agency for Healthcare Research and Quality

Prevention: Effectively Screening for Disease

Prevention is about taking steps to avoid disease or finding a disease early so it is easier and less costly to treat. Our goals as a community are to ensure: preventive care is a priority; that patients are informed and educated about the importance of recommended screening tests; delivery systems are designed to efficiently provide those services; and employers and health plans structure benefit packages to encourage preventive services. This report includes three measures of cancer screening and one measure of screening for Chlamydia.

Highlights

- These measures show wide variation among medical groups

- Performance is below the national benchmark for those measures where a benchmark exists

- Chlamydia screening measure fails to reach an already modest benchmark

Prevention

♦ REGIONAL AVERAGE — NATIONAL 90th PERCENTILE

| | Screening for Breast Cancer Ages 42-51 | Screening for Breast Cancer Ages 52-69 | Screening for Colon Cancer | Screening for Cervical Cancer | Screening for Chlamydia |

Our Performance

As shown on the chart, there is wide variation among medical groups, a clear indication that there is room for performance improvement. In addition, for the two measures where there is a national benchmark—"screening for cervical cancer" and "screening for Chlamydia"—the region overall performs below the 90th percentile, significantly so in the case of chlamydia screening. The benchmark for chlamydia screening is relatively low to begin with, at just 51 percent, so the region's failure to match even this modest level is disappointing.

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Cost Implications

The value of prevention varies for each type of screening test. 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. Screening helps doctors identify conditions in their early stages, when treatment is far less expensive and more likely to succeed, reducing the potential financial and emotional burden for patients. For example, according to the National Business Group on Health's *Purchaser's Guide to Clinical Preventive Services*, the cost of treating a single case of early-stage cervical cancer averages $20,255, while the cost of treating a single case of the same disease in the late-stage averages $36,912 (both are year 2000 dollars). The *Guide* also states the cost of treating late-stage colon cancer is more than double the cost of treating it in early stages.

What is Measured?	Why Are These Measures Important?
• **Screening for Breast Cancer**—The percentage of women ages 42–69 who had at least one mammogram during the two-year measurement period. This measure is reported at the regional level for women age 42–51 and at the medical group level for women ages 52–69.	• Mammograms are currently the best way to detect breast cancer early, when it is most treatable. • Among women age 50 and older, more than 20 percent did not get a mammogram in the past two years. • Breast cancer is the most frequently diagnosed cancer among Washington women. • Screening could prevent 15–30 percent of deaths from breast cancer.
• **Screening for Cervical Cancer**—The percentage of women ages 21–64 who had at least one Pap test during the three-year measurement period.	• Invasive cervical cancer is one of the most preventable types of cancer due to the effectiveness of the Pap test. • Cervical cancer is no longer the leading cause of cancer death for women in the United States because many women get regular Pap tests.
• **Screening for Chlamydia**—The percentage of sexually active women ages 16–24 who had at least one test for Chlamydia during the measurement year.	• Chlamydia is the most commonly reported sexually transmitted infection. • 21,178 cases were reported in 2009. • About 75 percent of women and about half of men who have Chlamydia have no symptoms.
• **Screening for Colon Cancer for the Newly Eligible**—The percentage of adults ages 51–56 who had appropriate screening for colon or colorectal cancer.	• Colorectal cancer is the third most common cancer diagnosed in the U.S. and the second leading cause of annual cancer deaths. • Each year, nearly 1,000 people in Washington die from colorectal cancer. • Colon cancer is preventable. Colorectal screening can find abnormal growths in the colon before they turn into cancer. • If everybody age 50 or older had regular screening tests, up to 60 percent of deaths from colorectal cancer could be prevented.

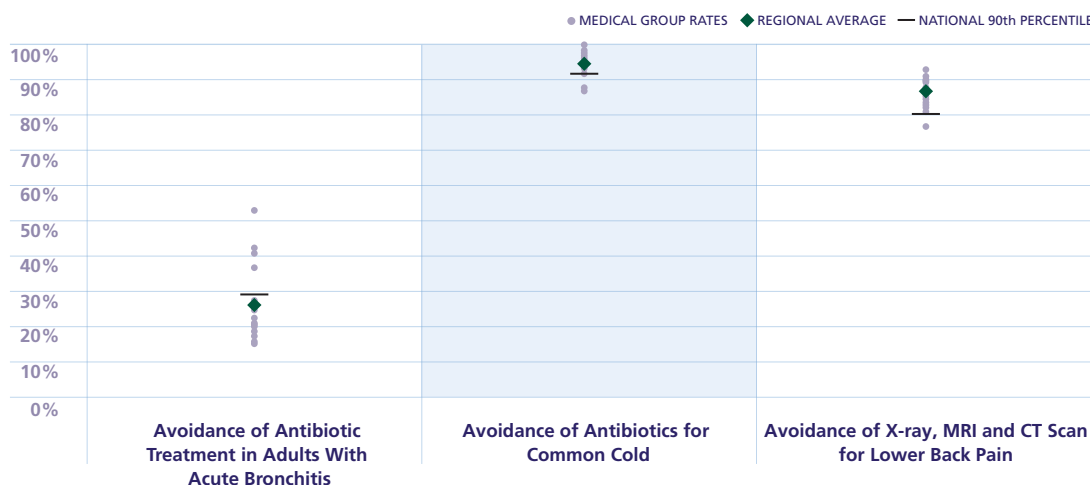Source: Washington State Department of Health

Appropriate Use of Services: Antibiotics and Imaging

In health care, some services are provided much more often than necessary. Despite what many people believe, more care is not always better care and in fact may cause harm by exposing patients to unnecessary risks or side effects. Our collective goal is to ensure both the delivery of needed health care services and the avoidance of unnecessary care that will not help patients. This report 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 for low back pain.

Highlights

- Disappointing results for avoidance of antibiotics for adults with acute bronchitis

- Performance for measure on avoidance of antibiotics for colds is above the national benchmark

- Region also does well in avoidance of imaging for low back pain

Appropriate Use of Care

● MEDICAL GROUP RATES   ◆ REGIONAL AVERAGE   — NATIONAL 90th PERCENTILE

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | Avoidance of Antibiotics for Common Cold | Avoidance of X-ray, MRI and CT Scan for Lower Back Pain

Our Performance

As shown in the chart, the region performs above the 90th percentile on both avoidance of antibiotics for the common cold and avoidance of imaging for low back pain. In both cases, only a few medical groups fall below the 90th percentile, and in the case of avoidance of antibiotics for colds, several medical groups approach a 100 percent compliance with the measure. By contrast, the region does not reach 90th percentile benchmark for avoidance of antibiotic treatment in adults with acute bronchitis even though the national benchmark performance is disappointingly low: only 29 percent. In fact, the bronchitis measure represents the lowest regional average out of all the measures in the Community Checkup. This

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translated into more than 12,500 consumers in our database receiving prescriptions for medication that would not improve their condition and that only served to add unnecessary cost to their care. Variation in this measure is also significant, with many medical groups performing below the regional average and a number above, a clear sign that improvement is possible.

Cost Implications

Low back pain is the most costly ailment in the workplace, averaging $8,000 per claim. Medical costs connected with low back pain are more than $25 billion per year in the U.S. When adding to that lost wages, disability payments, and retraining costs, total costs associated with back pain range between an estimated $50 billion and $100 billion per year. The use of imaging for low back pain when not medically indicated can identify abnormalities that are relatively common, not problematic and not the cause of patients' back pain, but once identified often drive additional imaging and surgical intervention that are unnecessary.

Inappropriate use of antibiotics for viral respiratory infections contribute to waste in the health care system and can make treating future bacterial infections more difficult when they become resistant to antibiotics because of overuse. Prescriptions for antibiotics to treat colds are estimated to cost $1.1 billion annually nationally.

What is Measured?	Why Are These Measures Important?
• **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.	• Upper respiratory infection (URI) is the most common reason people go to see their doctor and a major cause of lost days at school and work. • Colds are viruses, and antibiotics do not work for viral infections. Each year, about one out of five children with a cold gets unnecessary antibiotics. • Taking antibiotics when they are not necessary may put children at risk for the medicine's side effects. • If children use antibiotics too often, those drugs can be less effective for treating bacterial infections in the future.
• **Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis**—The percentage of adults age 18–64 diagnosed with acute bronchitis who were not dispensed an antibiotic prescription on or for three days after diagnosis.	• Acute bronchitis consistently ranks among the ten conditions that account for the most office visits to physicians in the U.S. • More than 90 percent of the time, cases of acute bronchitis are not caused by bacteria and therefore will not respond to antibiotics.

What is Measured?	Why Are These Measures Important?
• **Low Back Pain: (Avoidance of X-ray, MRI and CT Scan)—** The percentage of patients ages 18–50 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.	• Low back pain is one of the most common reasons for workers under age 45 to be on disability or workers' compensation. Almost two-thirds of all adults will have a problem with low back pain at some point. • Data show rapidly increasing use of imaging services (e.g., x-rays and MRIs) and associated costs without a demonstrated benefit to patients. In most cases, low back pain will go away or lessen within four to six weeks without medical attention. • 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.

Source: HEDIS and National Center for Immunization and Respiratory Diseases

Care for Patients with 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 can lead to other health problems such as heart disease, kidney disease, blindness and poor circulation, the last of which may lead to loss of limbs. People with diabetes have at least a two times a greater risk of heart disease and stroke than those without diabetes.
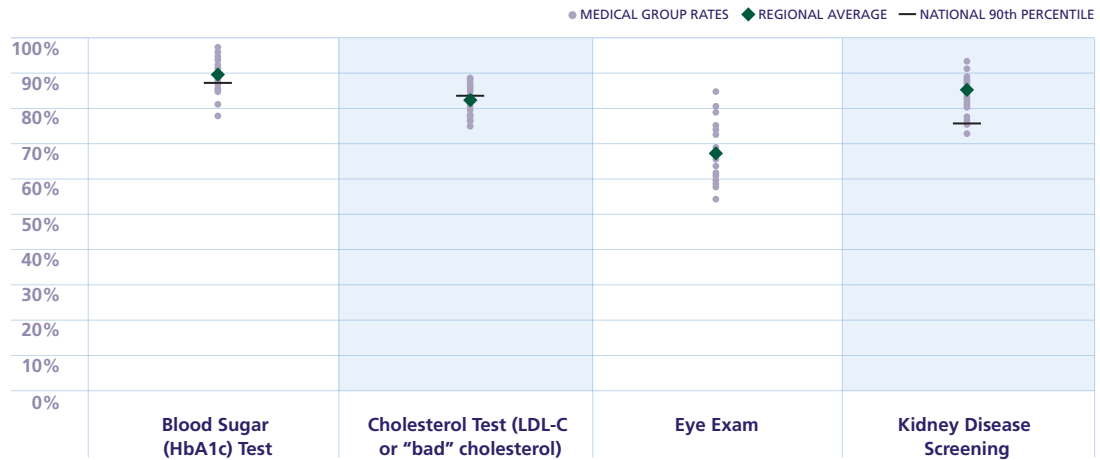
Diabetes is a rising threat to the health of Washington residents and a growing cost burden both to patients and the health care system overall. According to the Centers of Disease Control (CDC), the percentage of adults in the state with diabetes doubled between 1994 and 2009. Currently 7.2 percent of the State's adults have been diagnosed with the disease. Diabetes is the seventh leading cause of death in Washington.

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 measures included in this report that deal with regulating blood sugar (i.e., glucose) and cholesterol levels, and maintaining eye and kidney function.

Highlights

- The region generally performs well on the three measures with a national benchmark

- The diabetic eye exam measure displays comparatively greater variation among medical groups

- Even with a high performance, thousands of patients did not receive the recommended care during the reporting period

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Diabetes Care

Chart showing measures: Blood Sugar (HbA1c) Test, Cholesterol Test (LDL-C or "bad" cholesterol), Eye Exam, Kidney Disease Screening, with y-axis 0% to 100%.

Our Performance

The region performs above or near the 90th percentile benchmark on the three measures where a benchmark is available: blood sugar test, cholesterol test and kidney disease screening. The fourth measure (diabetic eye exam) has a lower regional average and displays greater variation than the other three measures. It is more difficult to capture these results as many claims for vision services are not submitted to the Alliance. The Alliance is working to increase the volume of eye exam data we receive.

However, even for the measure where the regional performance is highest, the blood sugar test, more than 5,200 patients in our database may not, for whatever reason, have received the care in the measurement period that is recommended. With each additional measure, the number of patients not receiving optimal care grows. Given the increasing number of diabetes patients in the region, simply maintaining our present regional average would mean that an increasing number of patients would not be receiving the standard of care needed to treat their disease and help prevent complications.

Cost Implications

The estimated direct financial costs associated with diabetes in 2007 were $174 billion nationwide, and $2 billion in Washington State. The average annual cost of care for a person with diabetes is 2.3 times higher than the cost of care for a person without the condition. By managing their disease, patients can lower their risk for developing complications that can cause significant financial and emotional burdens.

What is Measured?	Why Are These Measures Important?
• **Blood Sugar (HbA1c) Test—** The percentage of patients ages 18–75 with diabetes who had an HbA1c test during the one-year measurement period.	• People with diabetes need to keep their blood sugar levels under control. HbA1c will be higher if there have been high levels of glucose in the blood. • In general, the higher the HbA1c, the higher the risk that an individual will develop problems such as eye disease, heart disease, kidney disease, nerve damage and stroke. This is especially true if a patient's HbA1c level stays high for a long time.
• **Cholesterol Test—**The percentage of patients ages 18–75 with diabetes who had a test for LDL cholesterol during the one-year measurement period.	• High levels of "bad" cholesterol (Low Density Lipoprotein Cholesterol or LDL-C) can harm blood vessels and lead to blood vessel damage or heart disease and eventually, possibly a heart attack or stroke. • Diet, exercise and medication can help control cholesterol; regular testing provides feedback on whether changes in these areas are needed.
• **Eye Exam—**The percentage of patients ages 18–75 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.	• High blood sugar can cause bleeding in the blood vessels in the eyes, which can lead to vision loss. • People with diabetes should have regular eye exams to watch for any signs of damage to the blood vessels in the eyes.
• **Kidney Disease Screening—** The percentage of patients ages 18–75 with diabetes who had a kidney disease screening test or were treated for kidney disease during the one-year measurement period.	• Diabetes can damage the kidneys and, over time, cause them to stop working, which requires dialysis treatment using a machine that cleans waste from the blood. • Regular screenings for kidney disease (nephropathy) can catch kidney damage early to improve the chances of preventing kidney failure.

Source: Washington State Department of Health

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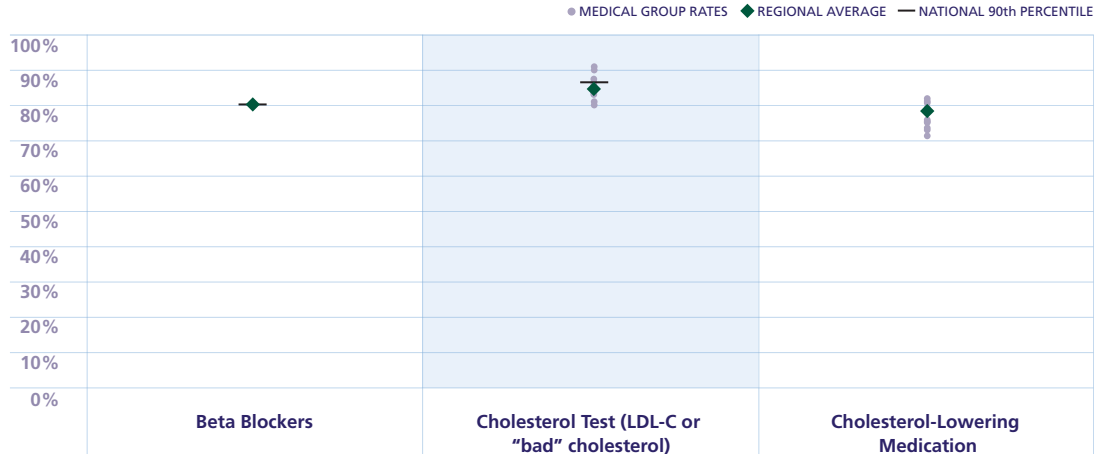
Care for Patients with Heart Disease

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 respectively the second and third leading causes of death in Washington State. 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.

Highlights

- The region performs near or at the national benchmark for the two measures where benchmarks are available
- Variation for the two measures reported at the medical group level is limited
- Despite good performance, many patients are still not receiving recommended care

Heart Disease Care

● MEDICAL GROUP RATES   ◆ REGIONAL AVERAGE   — NATIONAL 90th PERCENTILE

Beta Blockers | Cholesterol Test (LDL-C or "bad" cholesterol) | Cholesterol-Lowering Medication

Our Performance

As shown in the chart, the region performs at or near the national 90th percentile for the two measures for which there are benchmarks. (Because of the low numbers of patients per medical group, the beta blocker measure is reported at the regional level only.) Still, despite the relatively high performance, 20 percent of the patients who should be receiving beta blockers and 16 percent of the patients who should be having a cholesterol test are not. Variation for the measures on cholesterol tests

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and cholesterol-lowering medication is fairly limited, indicating more consistent performance across medical groups.

Cost Implications

The estimated direct and indirect costs associated with cardiovascular disease in the U.S. in 2010 are $503 billion, with heart disease accounting for $316 billion and coronary artery disease alone $177 billion. Indeed, the costs of cardiovascular disease continue to climb, even though the death rates for heart disease and stroke have decreased in recent decades. As the U.S. population ages, the economic impact of cardiovascular diseases on our nation's health care system will become even greater. By 2030, the estimated cost of heart disease is expected to triple, as more than 40 percent of U.S. adults are diagnosed with one or more forms of cardiovascular disease. Managing heart disease on a regular basis with routine monitoring and medications, according to the metrics above, as well as through diet and exercise, will mitigate that impact.

What is Measured?	Why Are These Measures Important?
• **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 months after being released from the hospital.	• Anyone who has had a heart disease is at a higher risk of having another heart attack or a stroke. • Medicines called beta-blockers help prevent a repeat heart attack or stroke. These drugs ease how hard the heart has to work.
• **Cholesterol-Lowering Medication—**The percentage of patients ages 18 to 75 with heart disease who had at least one prescription filled to lower cholesterol during the one-year measurement period.	• In addition to diet and physical activity, some prescription drugs can help lower cholesterol levels and help prevent problems related to heart disease.
• **Cholesterol Test—**The percentage of patients ages 18–75 who had at least one Low-Density Lipoprotein (LDL-C) in 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.	• If too much "bad" cholesterol (LDL-C) circulates in the blood, it can build up in the walls of the arteries that feed the heart and brain. Together with other substances, it can form plaque— a thick, hard deposit that can clog arteries and lead to a heart attack or stroke. • A high level of LDL-C (160 mg/dL and above) means an increased risk of heart disease.

Source: Washington State Department of Health

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Care for Patients with Asthma

Asthma is the irritation of the airways or tubes that carry air into and out of the lungs. Different things in the air can easily irritate and swell up the airways of people with asthma, making it hard to breathe. Symptoms may include cough, wheezing, and chest tightness. Our goal as a community is to assure that patients who have asthma receive the appropriate medication to manage the condition. The measure included in this report examines whether people who have asthma received these important long-term controller medications.

Highlights

- Region performs well, but does not reach 90th national percentile

- Range of performance among medical groups is relatively limited

Our Performance

As shown on the chart below, the region performs relatively well on the asthma measure. The range of performance among medical groups is relatively small and clustered above the regional average, indicating that most medical groups achieve high rates for this measure. However, the region as a whole does not reach the 90th national percentile, indicating that there is still room for improvement if the region is to achieve the Alliance goal of being a top performer nationally.

Asthma Care

● MEDICAL GROUP RATES ◆ REGIONAL AVERAGE — NATIONAL 90th PERCENTILE

Use of Appropriate Medication
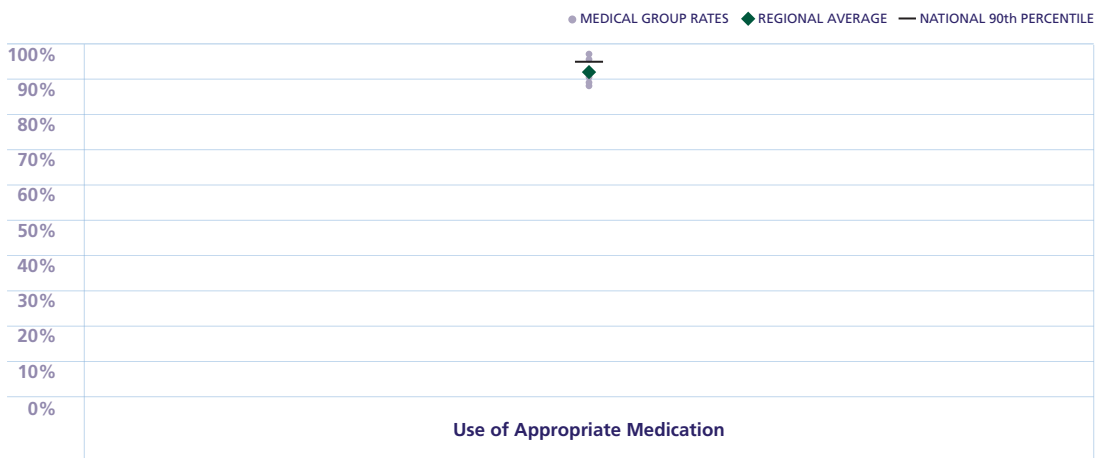
Cost Implications

The total cost of asthma in the United States is estimated to be more than $16 billion dollars per year, including health care costs and the costs of lost productivity at work and at home. The cost of asthma in Washington State is estimated to be more than $400 million annually in medical spending and lost productivity. About 48,000 adults with asthma in Washington make at least one emergency department visit per year and 100,000 make at least one urgent care visit for worsening asthma symptoms each year. Better control of a patient's asthma has the potential to reduce the need for emergency department visits and lost work days, as well as increasing quality of life.

What is Measured?	Why Are These Measures Important?
• **Use of Appropriate Medication**—The percentage of patients ages 5–50 identified as having persistent asthma and who filled a prescription for long-term controller medication during the measurement year.	• Washington state has one of the highest rates of asthma in the country, with almost one in ten Washingtonians suffering from asthma. • 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.

Source: Washington State Department of Health
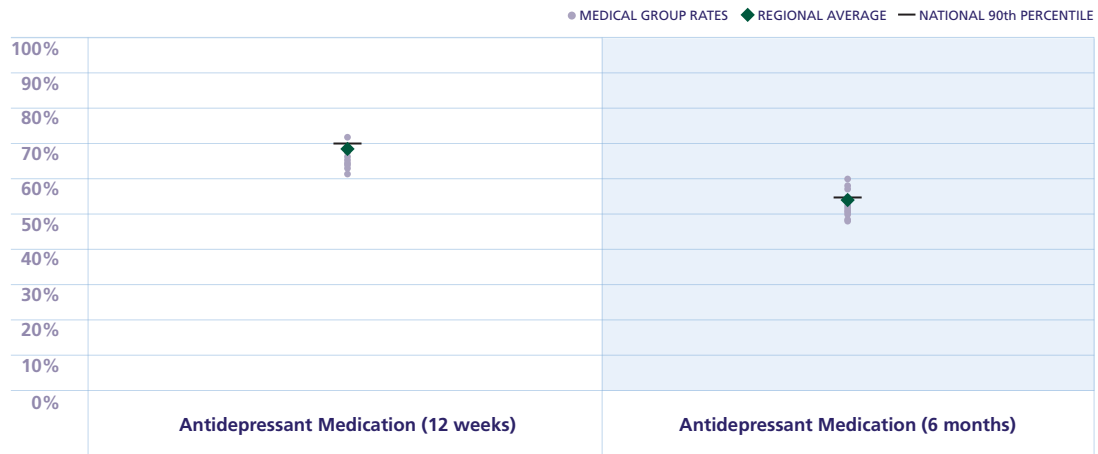
Care for Patients with Depression

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. Many people who have depression never seek treatment, which may include antidepressant medication and/or psychotherapy.

Highlights

• Region performs near the national 90th percentile on both measures

• However, many patients are not receiving and complying with the recommended treatment

Our goal as a community is to assure that people seeking care for depression receive and comply with recommended treatment. 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.

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Depression Care

● MEDICAL GROUP RATES ◆ REGIONAL AVERAGE — NATIONAL 90th PERCENTILE

Antidepressant Medication (12 weeks)   **Antidepressant Medication (6 months)**

Our Performance

As shown in the chart, the region performs slightly below the national 90th percentile in these two measures. As good as this performance is, there is still plenty of room for improvement. Nearly 30 percent of the patients diagnosed with depression in our region do not remain on antidepressant medication for the first 12 weeks of their diagnosis and more than 40 percent don't maintain treatment for six months. This means that a large number of patients may not see the relief from their depression or prevention of its return that they might if they remained on their medication. Given the number of patients with depression in the Alliance database—11,300—more than 3,000 patients in the commercially insured population in our database are not receiving and/or complying with the recommended treatment.

Cost Implications

Depression is the most common cause of disability in the U.S. and annually costs an estimated $80 billion in direct and indirect costs. People with depression are more likely to be absent from work or less productive when they are at work. Early and effective treatment of employee depression can lower employers' health care costs and boost workers' productivity and quality of life.

| What is Measured?	Why Are These Measures Important?
• **Anti-depressant Medication (12 weeks)**—The percentage of patients age 18 and older who were newly diagnosed with depression and prescribed an anti-depressant and remained on an antidepressant for 12 weeks after the diagnosis.	• One way of treating depression is with antidepressants. • Patients typically feel relief from their depression within two to six weeks after beginning to take antidepressants. • However, it can take as long as eight to twelve weeks for the medications to have an effect.
• **Anti-depressant Medication (6 months)**—The percentage of patients age 18 and older who were newly diagnosed with depression and prescribed an anti-depressant and continued taking an antidepressant for a least 180 days (6 months) after the diagnosis.	• Evidence shows that treatment using antidepressant medication should continue for six to nine months after a patient starts to take antidepressants in order to help eliminate all symptoms and prevent the depression from coming back. • About half of the people who take antidepressants incorrectly or do not finish all of their medicine

Care for Patients with Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema, chronic bronchitis and in some cases asthma. Symptoms include breathlessness, chronic coughing, and wheezing. People who smoke or have smoked are much more likely to develop COPD than people who have never smoked. The measure, which is included in this report for the first time, examines the use of spirometry testing to confirm the diagnosis of COPD in new patients.

Highlights

- Region fails to meet national 90th percentile benchmark.

- Overall, fewer than half the patients newly diagnosed with COPD in our database are receiving the recommended testing.

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COPD Care

**Use of Spirometry Testing in
the Assessment and Diagnosis of COPD**
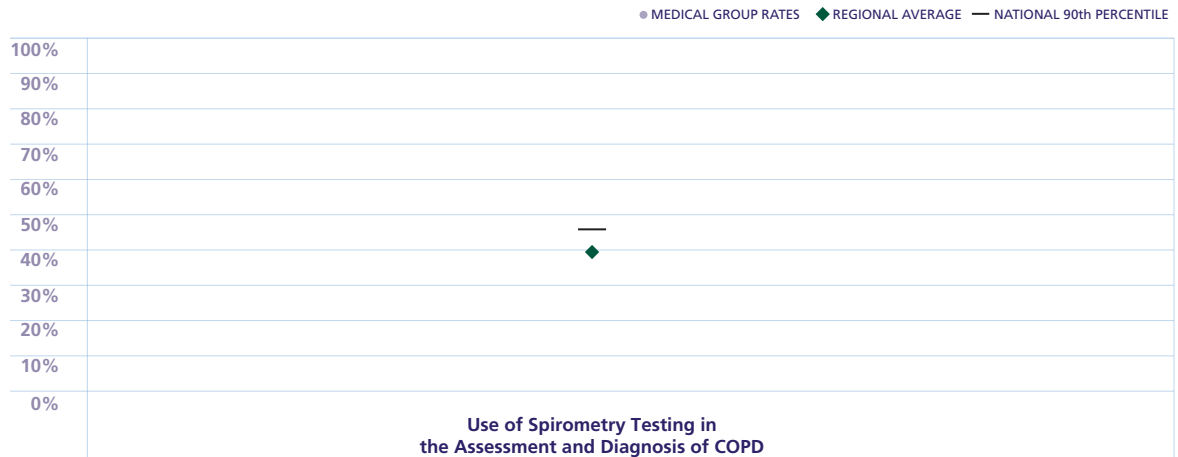
Our Performance

Spirometry testing for COPD is an example of underuse in our health care system. Although the value of spirometry testing is well recognized, the national 90th percentile for this measure is less than 50 percent. Our region performs considerably below that modest level, indicating a clear opportunity for improvement. That means that more than 2,000 patients newly diagnosed with COPD in our database who could have benefited from spirometry testing did not receive it. Because only a few clinics have enough data to report publicly, this measure is reported at the regional level only.

Cost Implications

COPD is the third leading cause of death in the U.S., and a serious long-term disability. An estimated 12 million people in the U.S. are diagnosed with COPD, and an additional 12 million probably have the disease but have not been diagnosed with it. In 2008, there were about 822,500 hospital stays for COPD, costing $6.1 billion. Another 3.8 million hospital stays included COPD as a secondary, or complicating, condition. Thus, nearly one out of five patients 40 years or older in U.S. hospitals has a diagnosis of COPD. Better control of COPD can enhance a patient's quality of life while reducing the risks and costs of hospitalization.

What is Measured?	Why Are These Measures Important?
• **Use of Spirometry Testing in Assessment and Diagnosis**—The percentage of patients age 40 and older with a new diagnosis of COPD who had appropriate spirometry testing to confirm diagnosis.	• COPD is relatively easy to diagnose using a spirometry machine, a simple, noninvasive breathing test that measures the amount of air and speed with which a person can blow it out of his or her lungs. • The spirometry reading can help provider determine the best course of treatment for a patient. Early detection of COPD might change its course and progress.

Source: Washington State Department of Health

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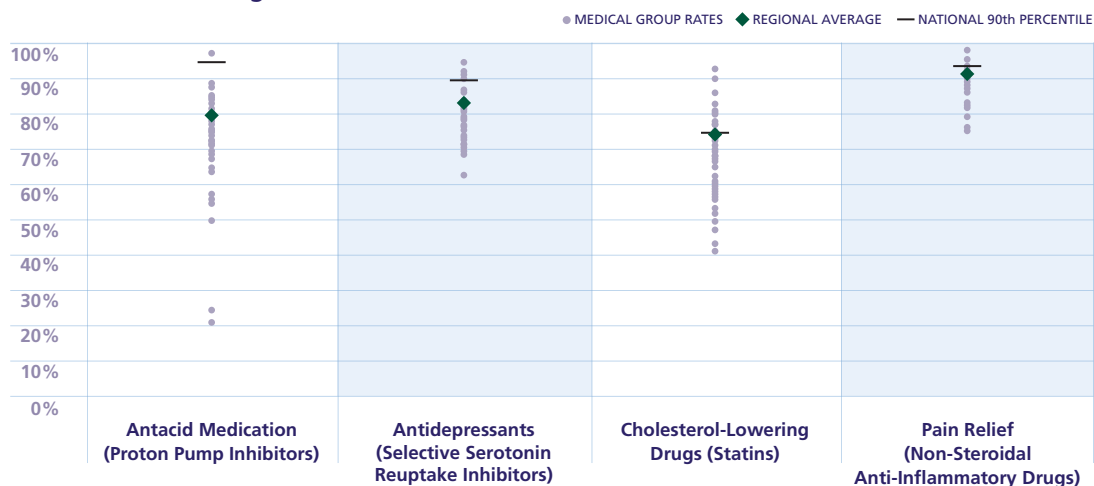Health Alliance

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Use of Generic Prescription Drugs

Generic prescription drugs have the same chemical composition and, for most people, work as well as brand-name drugs. Generic drugs have an added benefit: they usually cost less than their brand-name counterparts. 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. This report includes four measures of generic prescribing rates. All of these measures are important for the same reason. For the majority of patients, when taken in equivalent doses, most generic drugs work as well as brand-name drugs, but at significantly less cost.

Highlights

- The region performs below the Alliance benchmark in three out of four of the measures

- This category shows the greatest amount of variation among medical groups

- Results may be affected by availability of over-the-counter or discounted generic drugs not captured by Alliance claims database

Use of Generic Drugs

● MEDICAL GROUP RATES   ◆ REGIONAL AVERAGE   — NATIONAL 90th PERCENTILE

Antacid Medication (Proton Pump Inhibitors) | Antidepressants (Selective Serotonin Reuptake Inhibitors) | Cholesterol-Lowering Drugs (Statins) | Pain Relief (Non-Steroidal Anti-Inflammatory Drugs)

Our Performance

In 2007, the Alliance assessed potential savings from increasing the use of generic prescriptions across the four class of drugs measured, in which generic drug options are widely available. The Alliance estimated that more than $2.5 million could be saved each year in the Puget Sound region for each percentage point increase in the "generic fill rate" in these four classes of drugs. The generic fill rate is how often a prescription is filled with a generic rather than a brand name drug when a generic equivalent is available. The Alliance also established achievable benchmarks for performance in each of the four drug classes.

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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 from retail stores affects the measures. The rates may also be influenced by a number of other factors, including the patient population at particular clinics.

Still, by the Alliance's estimates, the region continues to miss a significant savings opportunity by failing to sufficiently increase the generic fill rate. In three out of the four drug classes the regional average falls below the Alliance benchmark. Only in a single class—statins—does the regional standard approximate the benchmark. In all the categories, the amount of variation is striking, by far the greatest amount of variation among any of the Alliance measures For the antacid measure, the difference between the lowest performer and highest performer is more than 70 percentage points. Variation to the degree shown in all four categories is unwarranted, which is why the Alliance intends to focus increased attention on this issue in the coming year.

Cost Implications
The health care system saved an estimated $140 billion in 2009 by using generic instead of brand-name drugs. Moreover, when drugs are more affordable, patient adherence to complete the course of treatment or stay on a chronic disease medication is likely to be higher, resulting in better health and avoidance of costly complications of noncompliance. Thus, cost and quality go hand in hand.

What is Measured?	Why Are These Measures Important?
• **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.	• Chronic stomach or gastric acid can cause pain, ulcers, and injury to the stomach, esophagus or throat. • Occasional, mild heartburn in patients not diagnosed with gastroesophogeal reflux disease may respond to lifestyle changes or over-the-counter medications.
• **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.	• Antidepressants help treat symptoms of major depression and other psychiatric conditions.
• **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.	• Statins reduce Low-Density Lipoprotein (LDL, or "bad") cholesterol levels in the blood.
• **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.	• Non-steroidal anti-inflammatory drugs (NSAIDS) are used to relieve pain and swelling for conditions such as arthritis, low back pain, and headaches.

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Medical Group 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 single report on health care information 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
- King County (via Aetna)
- Molina Healthcare of Washington
- Premera Blue Cross
- Recreational Equipment Inc. (via Aetna and Group Health)
- Regence Blue Shield
- Sound Health and Wellness Trust (via Zenith Administrators)
- Snohomish County (via Regence)
- United Healthcare
- Vision Service Plan
- Washington State Health Care Authority Uniform Medical Plan (via Aetna, ODS and FIServ)
- 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 1.6 million people within the Puget Sound region, which is nearly 50 percent of the total regional population. The dataset does not include data reflecting care to people who have individual insurance policies or who are uninsured. It also does not feature 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 multistep 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 ensured the correct submission of the data. Another 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 a secure online clinic roster application. Because measure results were attributed first to practitioners and secondarily 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 both 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.

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Results for Hospitals

The hospital results in this report reflect 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 highlights hospital care results for our five-county region in the areas of heart failure care, pneumonia care, surgical care, and patient experience. It is intended to build community understanding so that we can work together to improve the safety, effectiveness and affordability of local hospital care.

Highlights

- Several hospitals perform particularly well on this measure

- Results have shown substantial improvement for most hospitals over the five-year measurement period

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To see complete hospital results, including performance information for heart attack care, pneumonia care, heart care mortality (death) rates, serious adverse events, patient safety, and meeting standards associated with better outcomes for high-risk care, please visit the Community Checkup website: *www.WACommunityCheckup.org*.

Overall Performance

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 when they 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.

- **Care has improved over time.** The results demonstrate that what gets measured, gets managed. The time series shown for hospitals' performance generally shows improvement. This is impressive, particularly considering that CMS standards are being raised.

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 the oxygen and nutrients that the body needs.

When you go to the hospital to be treated for heart failure, you should expect your doctor or health care team to take the following steps at admission: check to see how your heart is pumping by doing a test called a left ventricular systolic (LVS) function assessment, and give you medicines to improve how your heart is pumping. When you leave the hospital, you should receive instructions for what to do to reduce the risk of more complications, and get counseling or advice to quit smoking.

Our goal as a community is to ensure that patients in our community consistently receive care for heart failure that evidence shows is effective to manage the disease. The measure included in this report assesses whether four key actions were taken.

Heart Failure Care

Legend: JULY 09 – JUNE 10 | JULY 08 – JUNE 09 | JULY 07 – JUNE 08 | JULY 06 – JUNE 07 | JULY 05 – JUNE 06

Hospital values (July 09 – June 10):
- Virginia Mason Medical Center — 100%
- Swedish - Cherry Hill — 98%
- Northwest Hospital — 98%
- Overlake Hospital Medical Center — 97%
- Swedish Medical Center — 96%
- Valley General Hospital — 96%
- Highline Medical Center — 96%
- Providence Everett Medical Center — 95%
- University of Washington Medical Center — 95%
- Valley Medical Center — 94%
- Harborview Medical Center — 94%
- Saint Clare Hospital — 93%
- Evergreen Hospital Medical Center — 92%
- Providence Saint Peter Hospital — 91%
- Good Samaritan Hospital — 91%
- Stevens Hospital — 91%
- Harrison Medical Center — 89%
- Saint Francis Community Hospital — 89%
- Capital Medical Center — 89%
- Auburn Regional Medical Center — 89%
- Saint Joseph Medical Center — 89%
- Tacoma General Allenmore Hospital — 87%
- Enumclaw Regional Hospital — 86%
- Cascade Valley Hospital
- Snoqualmie Valley Hospital

Our Performance

This category is a composite measure of care for heart failure that includes performance on the four measures listed below. The composite rate is 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 86 percent to 100 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 five years measured with many hospitals demonstrating consistent year-over-year gains.

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Cost Implications

There are an estimated 5.7 million people in the U.S. with heart failure. According to a study conducted by the Commonwealth Fund, there were large variations in hospitals' costs for treating congestive heart failure (CHF), with care for a typical CHF patient varying from $1,522 in the lowest-cost hospital to $18,927 in the highest-cost hospital. Hospitals in the highest-cost quartile had higher quality-of-care scores and lower mortality. The risk of readmission within 30 days for patients with CHF ranged from 22 percent to 24.7 percent.

What is Measured?	Why Are These Measures Important?
• **Test of how the heart is pumping (LVS function) is given**—The percentage of patients who have heart failure who received a test of the heart's ability to pump (Left Ventricular Systolic or LVS function).	• Heart failure occurs when the heart can't pump enough blood throughout the body. The right treatment for heart failure depends on the area of the heart affected. The test called the left ventricular systolic (LVS) function assessment checks how the heart is pumping so health care providers can see if the heart is pumping properly.
• **Medicines given to improve heart function**—The percentage of a hospital's heart failure patients who were given special medicines, either an ACE (angiotensin converting enzyme) inhibitor and/or ARB (angiotensin receptor blocker) to improve how the heart is pumping to treat Left Ventricular Systolic Dysfunction (LVSD).	• ACE inhibitors and ARBs are medicines to lower blood pressure and reduce the work the heart has to perform by limiting the effects of a hormone that narrows blood vessels. These medicines are particularly beneficial in patients with decreased function of the left side of the heart.
• **Patients advised to stop smoking**—The percentage of patients who have heart failure who, before they were discharged from the hospital, were advised or counseled to stop smoking.	• Smoking increases the risk for developing blood clots and inhibits circulation, which can result in worsened heart failure, a heart attack or stroke.
• **Instructions given when patient is released from the hospital**—The percentage of patients with heart failure who were given appropriate instructions when they were released from the hospital.	• Heart failure is a chronic condition that needs to be managed over time to reduce the risk of more complications. Hospital staff should provide information to patients to help them manage their heart failure symptoms after they leave the hospital.

Pneumonia Care

Pneumonia is a serious lung infection that causes breathing trouble, fever, cough and tiredness. It is a leading cause of death among the elderly and people who have ongoing illnesses.

When you go to the hospital to be treated for pneumonia, your health care team should follow these guidelines to help you get better: test your blood to find out what germs caused your pneumonia, give you the right type of antibiotics to treat the pneumonia, give you the first dose of antibiotics within six hours after you get to the hospital, test how much oxygen is in your blood within 24 hours after you get to the hospital, and give you a pneumonia vaccine if you have not already had one.
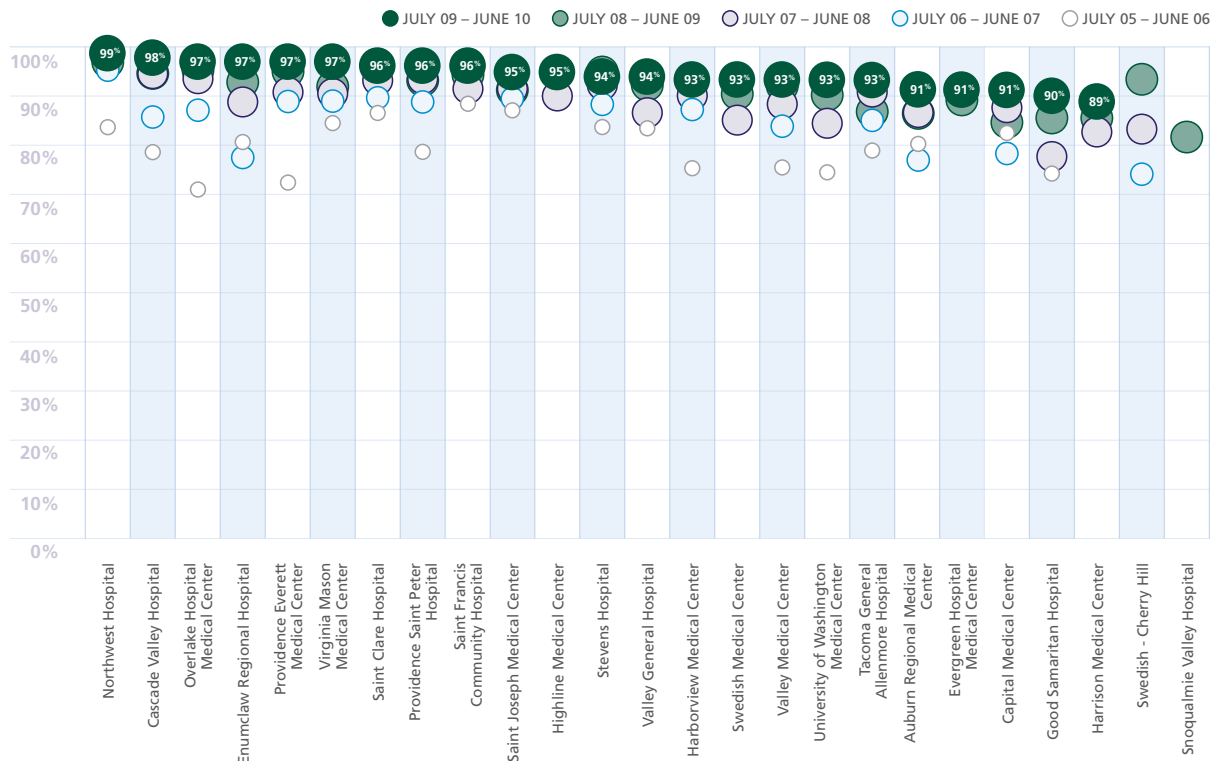
When you leave the hospital, your health care team should take the following steps to help cure or manage your pneumonia to keep it from causing more health problems: give you a flu shot if you have not already had one that year, and give you counseling or advice to quit smoking.

Our goal as a community is to ensure that patients in our community consistently receive care for pneumonia that evidence shows is effective. The six measures included in this report assesses whether six key actions were taken.

Pneumonia Care

Legend: ● JULY 09 – JUNE 10 ● JULY 08 – JUNE 09 ○ JULY 07 – JUNE 08 ○ JULY 06 – JUNE 07 ○ JULY 05 – JUNE 06

Hospitals (left to right): Northwest Hospital (99%), Cascade Valley Hospital (98%), Overlake Hospital Medical Center (97%), Enumclaw Regional Hospital (97%), Providence Everett Medical Center (97%), Virginia Mason Medical Center (97%), Saint Clare Hospital (96%), Providence Saint Peter Hospital (96%), Saint Francis Community Hospital (96%), Saint Joseph Medical Center (95%), Highline Medical Center (95%), Stevens Hospital (94%), Valley General Hospital (94%), Harborview Medical Center (93%), Swedish Medical Center (93%), Valley Medical Center (93%), University of Washington Medical Center (93%), Tacoma General Allenmore Hospital (93%), Auburn Regional Medical Center (91%), Evergreen Hospital Medical Center (91%), Capital Medical Center (91%), Good Samaritan Hospital (90%), Harrison Medical Center (89%), Swedish - Cherry Hill, Snoqualmie Valley Hospital

Our Performance

The graph shows that performance from this measure varies from 89 percent to 99 percent in the current year. Since the data was first reported publicly, the hospitals have generally made strides in improving their results for pneumonia care, with some hospitals that were among the lowest performers when their performance was first reported now among the highest performers. As with other measures, this may be another area of care where sharing of best practices across the community has been a benefit to the region's performance.

Cost Implications

According to a Commonwealth Fund study of Medicare patients, the cost of care for a typical patient of pneumonia can vary widely from hospital to hospital, with a low of $1,897 to a high of $15,829. Pneumonia patients had a between a 17.3 percent and a 17.9 percent chance of being readmitted to the hospital within 30 days of being discharged.

| What is Measured?	Why Are These Measures Important?
• **Antibiotic given within 6 hours of arrival to hospital**—The percentage of patients with pneumonia who were given an antibiotic within 6 hours of arriving at the hospital. (Patients who come down with pneumonia while they are hospitalized are not counted in this measure).	• For people with pneumonia caused by bacteria, early treatment with antibiotics can cure the pneumonia and reduce the chance of complications.
• **Blood test done before an antibiotic is given**—The percentage of patients who had a blood test before being given the first dose of antibiotics.	• A blood test can help doctors find out which bacteria may have caused the pneumonia. Different antibiotics work for different types of bacteria, so knowing the type of bacteria allows doctors to pick the right antibiotic for each patient.
• **Correct antibiotic drug is given**—How often patients get the right antibiotic drug, based on the type of bacteria that caused the pneumonia.	• If the patient's pneumonia is caused by bacteria, hospitals can treat the infection with antibiotics. Different bacteria are treated with different antibiotics.
• **Flu shot (influenza vaccination) is given**—The percentage of patients with pneumonia who were checked for, and if appropriate, given a flu shot (influenza vaccination).	• Flu shots lower the risk of influenza, a serious and sometimes deadly lung infection that can spread quickly in a hospital or community. Health care teams should make sure that patients with pneumonia, particularly those 50 or older, get a flu shot during flu season to protect them from another lung infection and to help prevent the spread of influenza.
• **Patients advised to stop smoking**—The percentage of patients with pneumonia who, before they were discharged from the hospital, were advised or counseled to stop smoking.	• Smoking increases patients' chances of getting pneumonia or lung diseases like emphysema and bronchitis. It is important for patients to get information before they leave the hospital to help them quit smoking. Quitting reduces patients' chances of getting pneumonia again.
• **Pneumonia vaccine (pneumococcal vaccination) is given**—The percentage of patients with pneumonia who were checked for, and if appropriate, given a pneumonia vaccine (pneumococcal vaccination).	• The vaccine for pneumonia may help prevent or lower the risk of problems from pneumonia caused by bacteria. Even patients who already have pneumonia should be asked if they have been vaccinated recently for pneumonia. If not, they should be given the vaccine.

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Surgical Care

Surgical care is the care you get before, during and after surgery. According to the Committee to Reduce Infection Deaths, about one in every 20 patients in U.S. hospitals gets an infection, and hospital infections cause more than 100,000 patient deaths per year.

Surgery involves many steps taken by doctors, nurses and others. To lower the chance that you will get an infection or blood clots, you should expect your doctor or health care team to take the following steps, based on national guidelines for safe practices: give you an antibiotic during the hour before the surgery begins (before "surgical incision"), give you the right antibiotics depending on what kind of surgery you are having, remove hair appropriately (if necessary), and give you treatment to reduce the risk of blood clots. After surgery, you should expect your doctor or health team to: stop antibiotics within 24 hours after surgery, control your blood sugar, and give you treatment to reduce the risk of blood clots.

Highlights

- Multiple hospitals perform at very high-levels for this measure

- Over the five-year reporting period, most hospitals have made significant improvements

Surgical Care

Legend: JULY 09 – JUNE 10 · JULY 08 – JUNE 09 · JULY 07 – JUNE 08 · JULY 06 – JUNE 07 · JULY 05 – JUNE 06
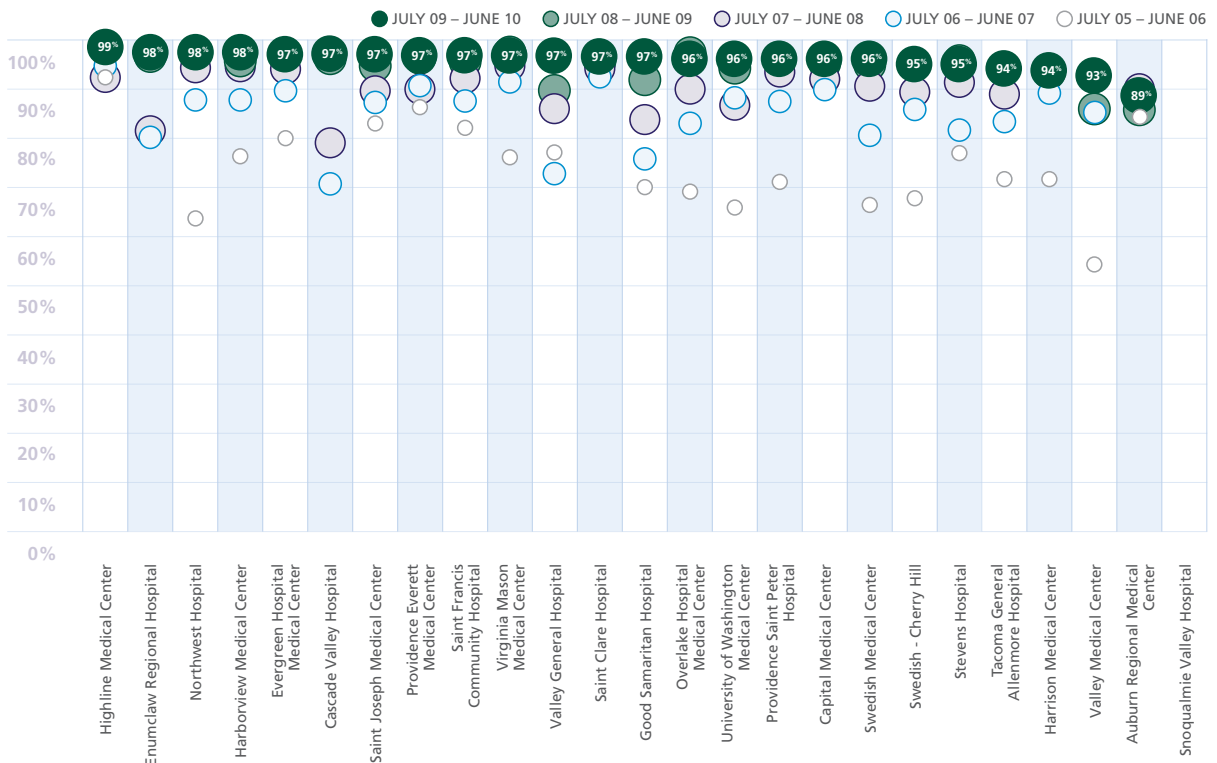
Our goal as a community is to ensure that patients in our community consistently receive safe, effective care in the hospital. The measures included in this report look at certain steps that are important to reduce the risk of developing problems like blood clots and infections.

Our Performance

The graph displays that performance on this measure varies from 89 to 99 percent during the most recent measurement year, with very high performance for multiple hospitals in our region. When looking at the results across five years, most hospitals have achieved significant improvement in results for surgical care, with some achieving dramatically better results of 20 percentage points or more.

Cost Implications

Of the estimated 30 million surgeries performed each year, approximately 500,000 patients develop surgical site infections, at an estimated national annual cost of $1.5 billion. Preventing surgical site infections and blood clots would not only improve the recovery of patients, it would also reduce the costs of treating such problems, including the potential of longer hospitalizations.

What is Measured?	Why Are These Measures Important?
• **Antibiotic given within one hour before surgery**—How often hospital teams give patients antibiotics within one hour before surgery..	• Research shows that surgery patients who get antibiotics within the hour before their operation are less likely to get wound infections. Getting an antibiotic earlier, or after surgery begins, does not work as well.
• **Antibiotics are stopped within 24 hours after surgery**—How often hospital teams stop giving antibiotics to patients within 24 hours after surgery.	• While antibiotics can lower the chances of infection after surgery, it is usually not necessary to continue the drugs for more than 24 hours after routine surgery, and doing so can increase the risk of side effects. Patients should talk with their doctors if they have questions about how long they should take antibiotics after surgery.
• **Correct antibiotic drug is given**—How often patients get the right antibiotic drug, based on the type of surgery, to prevent a surgical wound infection.	• Certain antibiotics are recommended to help prevent infection for particular types of surgery. By following the guidelines for the correct antibiotic drugs, hospitals can reduce a patient's risk of getting a wound infection after surgery.
• **Treatment to prevent blood clots is ordered**—How often doctors order treatments for patients to prevent blood clots from forming after certain surgeries.	• Treatment(s) to prevent blood clots must be given at the right time to prevent blood clots from forming after selected surgeries. A number of factors can increase a patient's risk of developing blood clots, but doctors can order treatments, called "prophylaxis," to reduce the risk. Such treatments may include blood thinning drugs, elastic support stockings, or mechanical air stockings that help blood circulation in the legs.

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What is Measured?	Why Are These Measures Important?
• **Treatment to prevent blood clots is given within 24 hours before and after surgery—** How often patients actually received treatment(s) to prevent blood clots within 24 hours (before or after) certain surgeries.	• Certain types of surgery can increase the risk of blood clots forming because patients do not move much during and, usually, after some surgeries. Treatments called "prophylaxis" should be provided at the right time. Approaches may include blood thinning drugs, elastic support stockings, or mechanical air stockings that help circulation in the legs.
• **Blood sugar control—** How often heart surgery patients had their blood sugar (blood glucose) kept under good control in the days right after surgery	• Even if heart surgery patients do not have diabetes, keeping their blood sugar under good control after surgery lowers the risk of infection and other problems. "Under good control" means their blood sugar should be 200 mg/dL or less when checked first thing in the morning.
• **Appropriate hair removal—** How often surgery patients who needed hair removed from the surgical area before surgery had hair removed using a safer method (electric clippers or hair removal cream – not a razor)	• Preparing a patient for surgery may include removing body hair from skin in the area where the surgery will be done. Medical research has shown that shaving with a razor can increase the risk of infection. It is safer to use electric clippers or hair removal cream.

Patient Experience – General

Patient experience refers to important things that happen to you from when you enter a hospital until you leave. During a hospital stay, you should expect the following things:

- Your health care team, including doctors and nurses, should explain things in a way that you can understand, listen to you, and treat you with courtesy and respect.

- Your health care team should explain any drugs that you need to take, including why you need to take them, how and when you should take them, and what side effects the drugs might have.

- The hospital staff should do everything they can to help control your pain.

- You should get help when you need it.

- Your room and bathroom should be kept clean.

- The area around your room should be quiet at night.

Highlights

- This measure shows significant opportunity for improvement

- Results have not shown progressive improvement over time

Our goal as a community is to ensure that patients in our community consistently receive effective, respectful care when they are in the hospital. The measure included in this report assesses how hospitals are rated by patients on the following key aspects of patient experience.

Patient Experience

Legend: ● JULY 09 – JUNE 10   ● JULY 08 – JUNE 09   ○ JULY 07 – JUNE 08   ○ JULY 06 – JUNE 07   ○ JULY 05 – JUNE 06

Hospitals (left to right): Evergreen Hospital Medical Center (76%), Swedish – Cherry Hill (74%), University of Washington Medical Center (73%), Providence Saint Peter Hospital (72%), Virginia Mason Medical Center (70%), Cascade Valley Hospital (69%), Saint Francis Community Hospital (69%), Swedish Medical Center (68%), Overlake Hospital Medical Center (68%), Northwest Hospital (67%), Providence Everett Medical Center (67%), Saint Joseph Medical Center (67%), Saint Clare Hospital (66%), Valley Medical Center (66%), Highline Medical Center (65%), Valley General Hospital (64%), Harborview Medical Center (63%), Harrison Medical Center (60%), Tacoma General Allenmore Hospital (60%), Capital Medical Center (59%), Stevens Hospital (53%), Good Samaritan Hospital (53%), Auburn Regional Medical Center (47%), Enumclaw Regional Hospital, Snoqualmie Valley Hospital

Our Performance

Of all the hospital measures highlighted in this report, patient experience is the one where there is the most room for improvement. The graph shows results for the patients' overall rating of the hospital for each hospital in our region over a four year period. Variability in the region is high, with the most current results ranging from 76 percent to 47 percent, virtually unchanged from last year's results. Unlike other areas, we don't see the same progressive improvement over time, suggesting that it is harder to move these results than it is for other measures. The Alliance will be supplementing this information with a patient experience survey of ambulatory care, which will be released in 2012.

What is Measured?

- **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?"

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Appendices

Appendix I: Medical Group Measures and Sources

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 at *www.WACommunityCheckup.org*.

Medical Group Measures and Sources		
CATEGORY OF CARE	MEASURE DESCRIPTION	MEASURE SOURCE
Access to Preventive Care	Adults' Access to Preventive Health Services – Commercial	HEDIS ®
	Adults' Access to Preventive/Ambulatory Health Services – Medicaid	
	Children's Access to Primary Care Practitioners – 12-24 month and 25 months to 6 years	
	Children's Access to Primary Care Practitioners – 7-11 years	
	Adolescent's Access to Primary Care Practitioners – 12-19 years	
	Adolescent Well-Care Visits – 12-19 years	
Prevention – Effectively Screening for Disease	Screening for Breast Cancer	HEDIS ®
	Screening for Cervical Cancer	
	Screening for Chlamydia	
	Screening for Colon Cancer for the Newly Eligible	
Appropriate Use of Services – Antibiotics and Imaging	Appropriate Use of Antibiotics – Common Cold	HEDIS ®
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	
	Low Back Pain – Avoidance of X-ray, MRI and CT Scan	
Care for Patients with Diabetes	Blood Sugar (HbA1c) Test	HEDIS ®
	Cholesterol Test	
	Eye Exam	
	Kidney Disease Screening	
Care for Patients with Heart Disease	Cholesterol Test	HEDIS®
	Beta Blockers	HEDIS®
	Cholesterol-Lowering Medication	American College of Cardiology and American Heart Association

Medical Group Measures and Sources, continued		
CATEGORY OF CARE	MEASURE DESCRIPTION	MEASURE SOURCE
Care for Patients with Asthma	Use of Appropriate Medications	HEDIS®
Care for Patients with COPD	Spirometry Testing	HEDIS®
Care for Patients with Depression	Antidepressant Medication – 12 weeks	HEDIS®
	Antidepressant Medication – 6 months	
Use of Generic Prescription Drugs	Antacid Medication	Puget Sound Health Alliance
	Antidepressants	
	Cholesterol-Lowering Drugs	
	Pain Relief	

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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 Alliance modified the list of medications used to calculate this measure to include the most complete list of current cholesterol-lowering medications available. 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.*

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). The HEDIS benchmarks contained herein are owned and copyrighted by NCQA and are included in this publication with the permission of NCQA. The HEDIS benchmarks pertain to performance measured at the health plan level and do not represent any standard of medical care. The benchmarks are provided "AS-IS" without any warranty of any kind including but not limited to any warranty of accuracy or fitness for a particular purpose. © National Committee for Quality Assurance. All rights reserved.

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Appendix II: Hospital Measures and Sources

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

Hospital Measures and Sources		
CATEGORY OF CARE	MEASURE DESCRIPTION	MEASURE SOURCE
Heart Attack Care	Aspirin given at arrival to hospital	Hospital Compare (CMS)
	Aspirin given at discharge from hospital	
	Blood pressure medicine prescribed at discharge from hospital	
	Medicine to reduce blood clots given within 30 minutes of arrival at hospital	
	Medicines given to improve heart function	
	Patients advised to stop smoking	
	Procedure to open blocked blood vessels done within 90 minutes of arrival at hospital	
Heart Failure Care	Test of how the heart is pumping (LVS function) is given	Hospital Compare (CMS)
	Medicines given to improve heart function	
	Patients advised to stop smoking	
	Instructions given when patient is released from the hospital	
Heart Care Mortality (Death) Rates	Hospital 30-day death (mortality) rates from heart attack	Hospital Compare (CMS)
	Hospital 30-day death (mortality) rates from heart failure	
	Hospital 30-day death (mortality) rates from pneumonia	
Pneumonia Care	Antibiotic given within 6 hours of arrival to hospital	Hospital Compare (CMS)
	Blood test done before an antibiotic is given	
	Correct antibiotic drug is given	
	Flu shot (influenza vaccination) is given	
	Patients advised to stop smoking	
	Pneumonia vaccine (pneumococcal vaccination) is given	

Hospital Measures and Sources, continued

CATEGORY OF CARE	MEASURE DESCRIPTION	MEASURE SOURCE
Surgical Care	Antibiotic given within one hour before surgery	Hospital Compare (CMS)
	Antibiotics are stopped within 24 hours after 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	
	Blood sugar control	
	Appropriate hair removal	
Surgical Care (Other)	Urinary catheters removed on the first or second day after surgery	Hospital Compare (CMS)
Hospital Readmission Rates	Hospital 30-Day Readmission Rates for Heart Attack	Hospital Compare (CMS)
	Hospital 30-Day Readmission Rates for Heart Failure	
	Hospital 30-Day Readmission Rates for Pneumonia	
Early Elective Deliveries	Electively scheduled deliveries by either cesarean section or induction between 37 weeks and 38 weeks and 6 days of a healthy pregnancy	The Leapfrog Group
Patient Experience – Communication	Communication with doctors	CMS Hospital Compare (HCAHPS patient survey)
	Communication with nurses	
	Medicines explained	
Patient Experience – General	Cleanliness	CMS Hospital Compare (HCAHPS patient survey)
	Discharge information	
	Pain control	
	Quiet at night	
	Timely assistance from hospital staff	
Patient Experience – Overall	Overall rating	CMS Hospital Compare (HCAHPS patient survey)
	Overall recommendation	
Serious Adverse Events	Serious adverse events	The Leapfrog Group Washington DOH

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Hospital Measures and Sources, continued		
CATEGORY OF CARE	MEASURE DESCRIPTION	MEASURE SOURCE
Patient Safety	Preventing medication errors	Leapfrog Group Annual Hospital Quality and Safety Survey
	Appropriate staffing in the Intensive Care Unit (ICU)	
	"Never Events" policy	
Meeting Standards Associated with Better Outcomes for High-Risk Care	Heart bypass surgery (coronary artery bypass graft)	Leapfrog Group Annual Hospital Quality and Safety Survey
	Heart angioplasty (percutaneous coronary intervention)	
	Abdominal aortic aneurism repair	
	Aortic valve replacement	
	Pancreatic resection (removal of part of the pancreas)	
	Esophageal resection (removal of part of the esophagus)	
	Bariatric surgery	
	High-risk births	

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.

Appendix III: Hospital Quality Improvement Initiatives

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

Robert Wood Johnson Foundation National Collaboratives

Aligning Forces for Quality: Hospital Quality Network

Allenmore Hospital, Tacoma General Hospital and Good Samaritan Hospital of the MultiCare Health System, as well as Providence St. Peter Hospital and Overlake Hospital, are participating in collaboratives to improve the quality and safety of patient care, identify potential disparities and craft plans to ensure equity. The network is addressing three separate QI initiatives: Reducing Readmissions, Increasing Throughput, and Improving Language Services. The Collaborative offers a national learning network of institutions that develop and exchange quality improvement (QI) tools, strategies, and lessons learned.

Initiative	QI Tools, Strategies, and Lessons Learned
Reducing Readmissions	• Hospitals are working to reduce 30-day readmission rates following heart failure hospitalizations. • Standardize the collection of race, ethnicity, and language data • Identify potential disparities in t the quality of care and develop plans to ensure equity as a core component of quality.
Increasing Throughput	• Hospitals are working to improve select emergency department (EDs) performance measures.
Improving Language Services	• All hospitals are required to provide interpreter services to patients who speak limited English, but there is little guidance on the most effective, efficient ways to implement these requirements. • Hospitals are working to ensure all their LEP (limited English proficiency) patients receive the assistance of a qualified language services provider for initial assessment and discharge instructions, as well as for all additional critical communication.

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 work with the hospitals to understand their successes and help share lessons learned and other insights about the new regional quality improvement innovations.

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Foundation for Health Care Quality Initiatives

The Puget Sound Health Alliance supports the SCOAP Surgical Checklist Program, which promotes the use of the SCOAP Surgical Checklist in all operating rooms in every hospital in Washington State. The Alliance also supports the concept of both the SCOAP and COAP programs.

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.

The Clinical Outcomes Assessment Program (COAP) is physician-led quality improvement activity aimed at improving the quality of care for patients with heart disease who are treated in Washington hospitals.

COAP recently started publicly reporting benchmarks for Percutaneous Coronary Interventions (PCI) and Coronary Artery Bypass Graft (CABG) surgeries. The Foundation recently launched the new Obstetrics Clinical Outcomes Assessment Program (OBCOAP) this year.

Washington State Hospital Association (WSHA) Initiatives

Eliminating Hospital Acquired Infections

Washington hospitals are working together to improve patient safety by eliminating hospital acquired infections by 2012. The goal is supported through WSHA's Patient Safety Program and WSHA staff- provided toolkits to help hospitals implement evidence-based practices. Targeted infections and infection control practices include: Catheter Associated Urinary Tract Infection, Central Line Associated Blood Stream Infections, Hand Hygiene, Healthcare worker influenza immunization, Methicillin Resistant Staphylococcus aureus (MRSA), Pneumonia Care, Surgical Site Infection (SSI), and Ventilator Associated Pneumonia (VAP). The WSHA website shares hospital infection summaries, which lists hospitals, infections rates, and infection prevention measures. Infection rates currently publicly reported are ventilator pneumonia infections, central line infections, cardiac surgery, orthopedic surgeries, and hysterectomy.

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. The aim is to reduce statewide 30-day rehospitalization rates by 30 percent and to improve patient and

family satisfaction with care coordination. 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 transparent measurement of rehospitalization so that all stakeholders may better understand the magnitude of the problem and track improvement over time. Ideally, we would be able to track readmissions not just by hospital, but also 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.

Early Elective Deliveries

Early Elective Deliveries are deliveries by either cesarean section or induction between 37 weeks and 38 weeks and 6 days of a healthy pregnancy. This time period is critical to the development of the baby, but a growing number of newborns are "electively" scheduled for delivery before the 39th week of pregnancy for no medical reason. Early deliveries can lead to unnecessary risk for the newborn and increase the cost of care. WSHA invited hospitals to participate in a collaborative to reduce elective deliveries prior to 39 weeks. This is a state-wide collaborative opportunity supporting providers and hospitals to achieve the ACOG recommendation not to perform elective deliveries prior to 39 weeks in order to avoid iatrogenic prematurity. The Alliance began publicly reporting this measure in the spring of 2011. The measure was developed by The Leapfrog Group, an employer-led hospital quality organization that publicly reports voluntarily reported measures, and has been endorsed by the National Quality Forum, an organization that develops national measures of hospital quality and safety.

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Acknowledgements

As a multi-stakeholder organization, the Puget Sound Health Alliance is the place where those who give, get and pay for health care can come together to help change the system for the better. We believe that everyone has a role to play in improving health care in our region.

The Alliance is guided by its Board of Directors, whose members reflect the range of stakeholders that compose the Alliance membership. The Board, under the chairmanship of Steve Hill, guides the Alliance in its vision and strategy. The Board's work for the Alliance is a testament to its ongoing dedication to the importance of the Alliance's mission and the value that each member places in the Alliance's goals.

Our work is also made possible by our participating organizations and the many members who work on our committees. Thanks to their commitment and tireless efforts, the Alliance has been able to achieve much and to set ambitious goals for the future with confidence.

Finally, the Alliance is grateful to the Robert Wood Johnson Foundation for its continuing support of our efforts. As a member of the Aligning Forces for Quality network, the Alliance has profited from the assistance that the Foundation has supplied as well as been inspired by its vision of how local efforts can affect change in the community.

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American Heart Association

King County Medical Society

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Puget Sound Regional Council

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About the Alliance

The Puget Sound Health Alliance was formed in 2004 as a nonprofit, nonpartisan 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.

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*.