Puget Sound
Community Checkup

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

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Puget Sound
Health **Alliance**
An Aligning Forces for Quality Community

**Adoption of Processes
and Tools to Advance
Effective Patient Care**

**Medical Group
Survey Results
October 2012**

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Overview: 2012 Medical Group Survey

The Puget Sound Health Alliance is committed to strengthening our regional health care delivery system to enhance the ability of primary care providers to more effectively care for patients by improving quality improvement infrastructure. The Alliance promotes the use of evidence-based clinical guidelines, as well as tools and resources that are known to improve care, produce better outcomes within the ambulatory setting, and improve value for the system as a whole.

As a part of our ongoing quality improvement efforts, the Alliance conducted a survey of primary care medical groups and clinics that are currently participating in the Community Checkup (these are medical groups of four or more providers within the five-county region: King, Kitsap, Pierce, Snohomish and Thurston counties). The intent of the survey is to collect and share information that describes whether or not activities and tools are being implemented within medical groups and clinics to enhance effective coordination of care within the practice setting.

This is the second time the Alliance is conducting the survey. The first survey was in 2010 and the second survey was fielded earlier this year, in 2012. The findings offer a community-wide scan of the progress being made by primary care providers in adopting and using processes and tools known to advance effective patient care. The self-reported information is helpful in gaining a sense of those areas where the region is doing well and those areas where gaps in performance exist and there are opportunities to improve.

By sharing the survey results, the Alliance hopes to provide a broad view of overall clinic management and care coordination within the five-county region and to stimulate the adoption of processes and tools to advance effective patient care. In future years, the Alliance hopes to link the information collected on the specific characteristics of each clinic to its publicly reported performance measures in order to study the correlation between the two.

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Summary of Findings

The survey results highlight the following:

- Medical groups substantially improved in the ability to capture patients' preferred language, race, and ethnicity data. They also improved the use of <u>qualified</u> interpretive services, and increased staff training for (1) how to appropriately ask for race, ethnicity, and language information, and (2) cultural competency. While these areas showed improvement since 2010, some practices are still using family members for interpretive services.
- More than half of the time, extended hours on weeknights and weekends for patient appointments are not commonly available. This finding is consistent with the 2012 patient experience survey conducted by the Alliance which showed that "Getting Timely Appointments, Care and Information" was the area of patient experience in most need of improvement. When patients have access to their primary care provider they are less likely to make unnecessary trips to the emergency room or experience preventable hospitalizations.
- Consultation via secure email is not a common mode of communication with care teams (less than half of practices provide this service), which is a timely method of communication that patients value and an area that medical groups may be working to improve as they upgrade their EHR services.
- Diabetes registries remained the most common chronic condition registry followed by hypertension. Patient registries for the majority of other chronic conditions (e.g., depression, cancer, congestive heart failure, and chronic obstructive pulmonary disorder) are only used by about half of practices.
- Survey results indicate that there is room for improvement in the use of written care plans, which are important tools for assisting patients in remembering and understanding care instructions and next steps in their care process. Clinics use this tool up to two thirds of the time (17% for all clinics and 48% for some clinics), but not consistently or only in some clinics.

- Medical groups use multiple methods of patient reminders. Computer-prompted reminders at the point of care, postcards/letters and phone calls continue to be the most common means of communication with patients. Secure email contact for reminders is not commonly used.
- Care coordination and patient engagement improved compared to 2010 with better referral systems and outreach to patients who are seen in other facilities (i.e., hospital or emergency room). Shared goal setting and personalized coaching for self-management also increased in the region.
- The majority of practices do not have a dedicated care coordinator to proactively manage patients at high(er) risk due to multiple co-morbidities. Practices may be providing this service via other approaches that are not reflected in the survey.
- Medication reconciliation has improved since 2010 and surveyed providers reported that it is integrated into normal workflow policies and procedures including the EHR infrastructure.
- EHR adoption is improving in the region and it is encouraging to note the number of capabilities that medical groups are now using (compared to 2010). However, there are important EHR tools that are only partially implemented, suggesting that Meaningful Use standards are being minimally addressed. The community's readiness and/or capacity to fully use all capabilities of EHR systems is lagging. In the region, there is a gap in remote access capacity for patients such as online scheduling, reviewing medications, and ordering refills. Increasing remote access capacity is another opportunity to improve patient engagement and communication.
- Many clinics are conducting in-house patient experience/satisfaction surveys and using the feedback to improve care; however, the number of clinics measuring patient experience/satisfaction declined since 2010 and many (more than one third) are not using standardized national tools, but rather "homegrown" in-house produced tools. It is important to note that the Alliance conducted a patient experience survey and released results in 2012. This was the first time any organization in Washington state has systematically asked patients about their primary care experience and made comparable results publicly available.
- Eighty-eight percent of medical groups/clinics are aware of the Community Checkup. Almost two thirds of medical groups are aware of the secure portal to review their individual results, and 40% of medical groups actually use the portal for one or more purposes. This highlights the need for the Alliance to more proactively educate medical groups about the services the portal provides and how to use it.

These results offer an opportunity to view the progress providers in the region are making in adopting and using evidence-based tools to improve performance in the region. It is important to note that the survey tool is fluid and has and will be modified as evidence and systems change. We are hopeful that in the future the results of the survey may be used in tandem with the Community Checkup to better explain performance in the region and by medical group. The overarching goal of the Alliance is to improve health care quality and value in the region. We want the survey results to facilitate more discussion about the region's strengths and gaps in performance and to stimulate improvement activities.

Survey Design

The survey was designed to collect practice specific information on the current use of tools and other resources in order to assess the practice's strength in the following domains:

1. Addressing Healthcare Disparities
2. Access and Communication
3. Chronic Conditions Management
4. Care Coordination
5. Data Management
6. Improving Quality and Patient Experience
7. Community Checkup

During the first quarter of 2012, the Alliance sent the survey to 53 medical groups that are currently included in the Community Checkup and that are predominantly primary care-based or have a strong primary care component. The Alliance received survey responses from 42 medical groups (79% response rate) representing approximately 237 clinic locations and 1,475 primary care providers. During the 2010 survey we had responses from 33 medical groups (62% response rate). In 2012, of the 42 medical groups that participated, 32 have multiple locations including integrated clinic/hospital systems and independent practice associations, and 10 are individual clinics. See a listing on page 27.

Four practices declined to participate in the survey and seven did not respond. In conducting the survey, the Alliance asked that a healthcare professional (e.g., medical director, physician or clinic administrator/manager or a quality improvement (QI) director) complete the survey. Approximately 33% percent of survey respondents were medical directors or physicians, 24% were quality improvement staff, and 26% were clinic managers or group practice administrators. The information is self-reported and unaudited.

The 2010 survey tool was updated with guidance from local physicians who are members of the Alliance's Quality Improvement Committee. The majority of the questions are similar or the same as those asked in the 2010 survey. Some quality improvement questions were modified to reflect current research and/or changes in performance expectations since the previous survey.

It is important to note that the demographics of the respondents changed from 2010 to 2012. While there were more respondents, many represent smaller medical groups with fewer clinics or only one clinic. Also, some of the mid- to large-size medical groups did not respond this year.

For purposes of this report, analysis focuses on: (1) why the area is important to address; (2) 2012 results; and, if applicable, (3) comparison to 2010. A summary of the survey findings, including a rationale for each area of focus, is presented on pages 7 to 26.
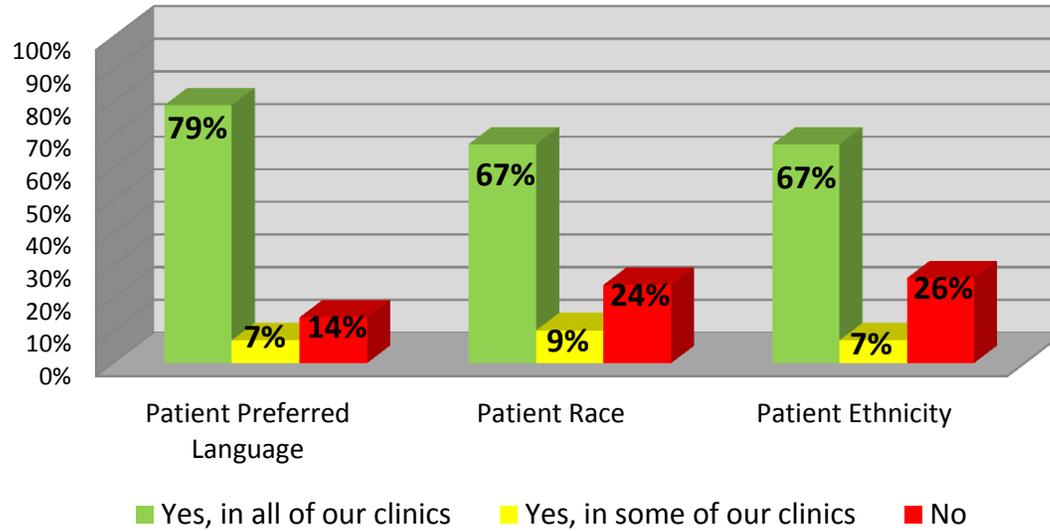
Results

Addressing Healthcare Disparities

Disparities in care are differences in the delivery of health care, access to health care services and medical outcomes based on ethnicity, geography, gender, socioeconomic status, insurance and other factors. Understanding and eliminating the causes of health care disparities is an ongoing effort of many groups and organizations. To identify and reduce health disparities it is important to be aware of the patient mix within a clinic.

Research suggests that an important starting point in achieving this goal is the collection of self-reported data (including race, ethnicity and preferred language) from patients. Systematically collecting and using the data to shape a practice is helpful in delivering care that is more responsive to the cultural and linguistic needs of patients, and to identify opportunities for improvement within clinics.

Disparities in health care are generally documented and information about disparities is sometimes available from public health data sources. But the lack of more specific data hinders our region's ability to assess gaps in care across race, language, ethnicity or socioeconomic characteristics locally. Puget Sound, specifically the Seattle-Tacoma-Bellevue region, is one of the more diverse regions in the nation. Therefore, understanding the nature of disparities in our region and then engaging in activities to reduce them is an important component of quality improvement.
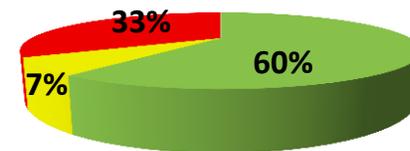
For which of the following elements does your clinic routinely collect self-reported data from patients (i.e., not gathered based on observation of staff)?

Patient Preferred Language: 79% Yes, in all of our clinics; 7% Yes, in some of our clinics; 14% No

Patient Race: 67% Yes, in all of our clinics; 9% Yes, in some of our clinics; 24% No

Patient Ethnicity: 67% Yes, in all of our clinics; 7% Yes, in some of our clinics; 26% No

- ■ Yes, in all of our clinics
- ■ Yes, in some of our clinics
- ■ No

Medical groups were asked if they collect self-reported race, ethnicity and language (R/E/L) information from patients (i.e., not gathered based on observation of staff). Medical groups/clinics have greatly improved their ability to capture this information from 2010. Currently, 79% of respondents collect language information and 67% collect race and ethnicity information. Increased rates of R/E/L may be a result of improved training in the region and/or uptake of Meaningful Use Core Objectives.
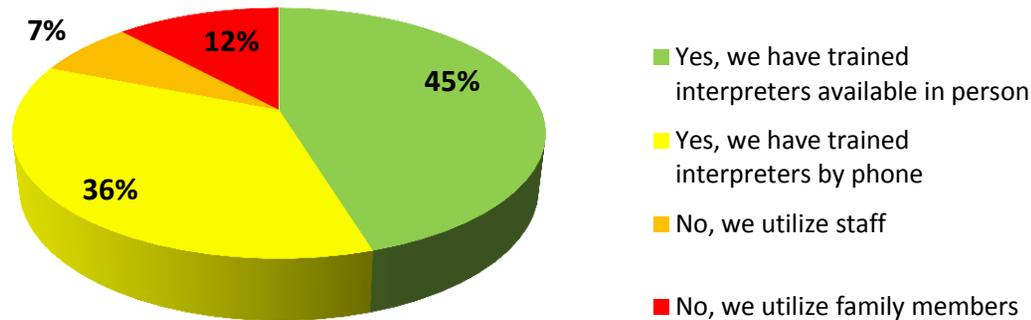
Approximately two thirds of respondents (67%) are training their staff how to collect race, ethnicity and language information in all or some of the clinics and over half (52%) are offering cultural competency training. It is encouraging to see the progress made to measure disparities in care and address the needs of patients. However, there is still an opportunity to improve training, data collection, and engagement, which will inform the work of practices in addressing the cultural needs of their patient populations.

Does your clinic train staff members on how to appropriately ask for race, ethnicity, and language information?

33% No; 7% Yes, in some of our clinics; 60% Yes, in all of our clinics

- ■ Yes, in all of our clinics
- ■ Yes, in some of our clinics
- ■ No

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Do you use qualified interpreter services (individuals who have had training in medical interpreting and have been certified) for limited English proficiency (LEP) and non-English speaking patients when needed?

- 🟩 Yes, we have trained interpreters available in person
- 🟨 Yes, we have trained interpreters by phone
- 🟧 No, we utilize staff
- 🟥 No, we utilize family members

7% 12% 45% 36%

Medical groups/clinics were asked if they use qualified interpretive services (individuals who have had training in medical interpreting and have been certified) for limited English proficiency (LEP) and non-English speaking patients when needed, in order to facilitate patient care. Eighty-one percent of respondents use qualified interpretive services either through trained interpreters available in person (45%) or trained interpreters by phone (36%). While the use of interpretive services is improving, some practices are still using staff (7%) and family members (12%), a practice that is not compliant with Joint Commission standards and may lead to misinformation and poor patient experience.

Of importance to medical groups looking forward is how successful they are at collecting the information and how they are using the information to improve care. The point of asking patients about their race, ethnicity, and language is not simply to amass data; the data is only worth collecting if they are used to help physicians and other health professionals achieve practical, applied goals.[1]

Comparison to 2010:

Areas showing improvement:

- Clinics improved their ability to capture preferred language, race, and ethnicity since 2010. Medical groups/clinics have improved substantially as 70% of 2012 respondents reported collecting data for all three categories for either all or some of their clinics compared to 26% in 2010.
- Roughly two thirds of clinics train staff how to appropriately ask for race, ethnicity and language data; this question was not asked in 2010.

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[1] Wynia M, Hasnain-Wynia R, Hotze T, Ivey SL. Collecting and using race, ethnicity and language data in ambulatory settings: a white paper with recommendations from the Commission to End Health Care Disparities. Chicago: American Medical Association; 2011.
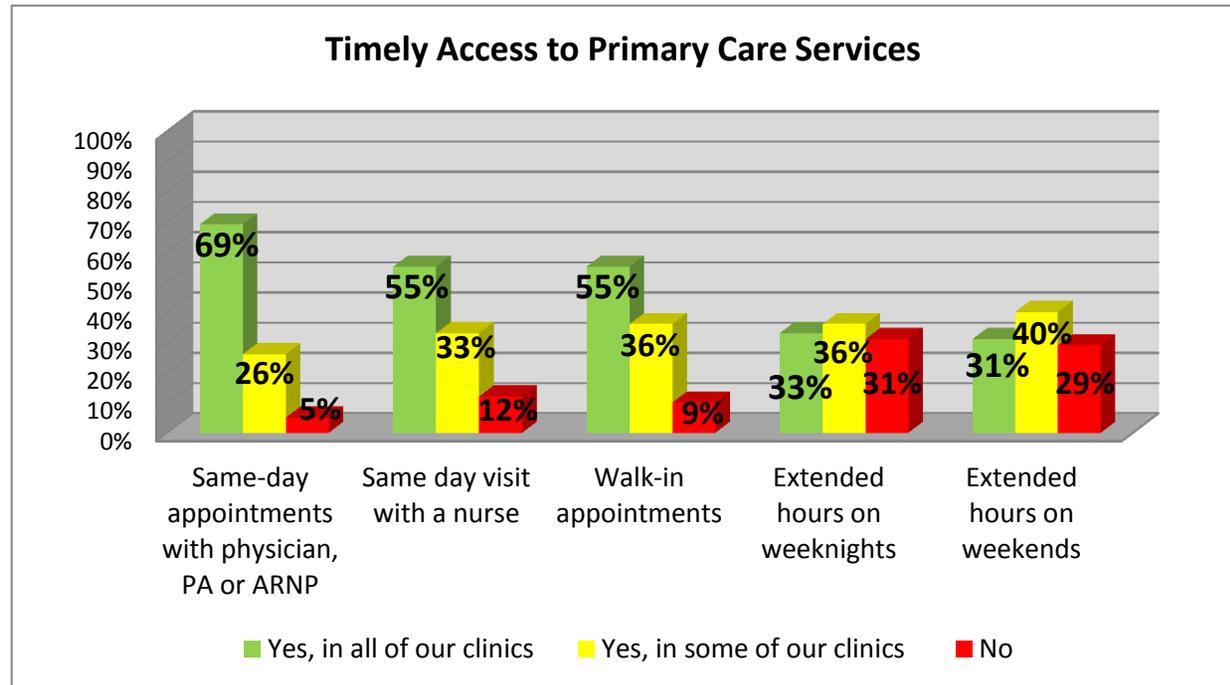
Access and Communication

Effective communication between providers and patients about their health and health care, as well as timely access to the health care team *when patients feel they need contact*, are both essential attributes of patient-centered care. Having clinic policies and strategies about improving seamless communication and patient access to the care team ensures that patients get care when and where they need it. Increased patient access to the primary care team is critical to effectively reducing *potentially avoidable* emergency room visits and avoidable hospitalizations. For medical groups/clinics, this means organizing the practice specifically to address demand and create a variety of ways for patients to access the care team. This may require additional investment of time, resources or tools in order to provide increased access.

In the survey, medical groups were asked about nine different elements of practice organization (related to access and communication) that are associated with stronger provider-patient relationships and that may lead to better health outcomes.

Medical groups were asked to indicate what methods their clinics have in place to promote easier access to the care team for patients:

- Approximately 69% of the medical groups/clinics have policies to support open scheduling (same day appointments with a physician, physician assistant (PA) or advanced registered nurse practitioner (ARNP)).
- 55% of medical groups/clinics routinely have options for a same-day visit with a nurse and/or walk-in services available.
- About one third of those surveyed do not offer any extended hours on weeknights and weekends.

Timely Access to Primary Care Services

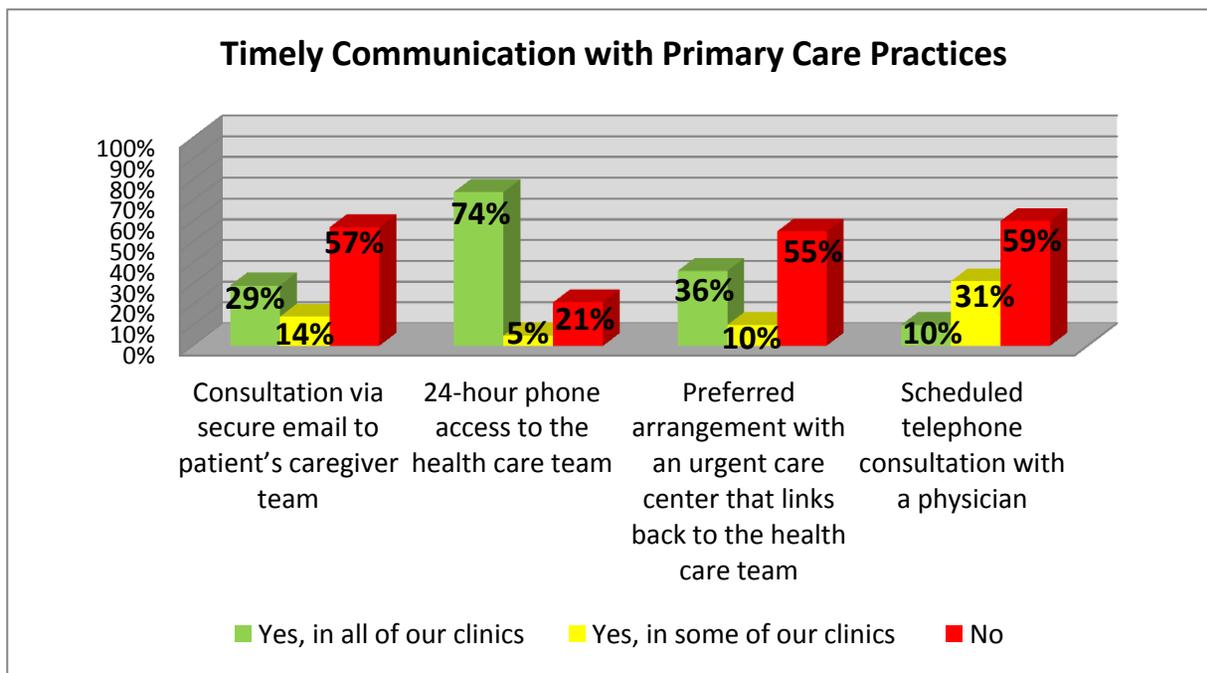|	Yes, in all of our clinics	Yes, in some of our clinics	No
Same-day appointments with physician, PA or ARNP	69%	26%	5%
Same day visit with a nurse	55%	33%	12%
Walk-in appointments	55%	36%	9%
Extended hours on weeknights	33%	36%	31%
Extended hours on weekends	31%	40%	29%

Timely access to primary care services in the region appears to be challenging and inconsistent. This identifies an opportunity for improvement as patients may seek emergency care if unable to access their provider or care team when needed. However, before a medical group offers these services, they usually will do an in depth analysis to determine if it is feasible to maintain the services and if patients are truly seeking service after regular business hours. Improving access is difficult to operationalize, particularly for small to mid-size practices, and improving communication may be more feasible than improving access hours.

Regarding timely communication, survey responses show:
- Seventy-four percent have 24-hour phone access (not including a health plan-related consulting nurse);
- Consultation via secure email is not a common form of communication in the region; and,
- The majority of primary care practices in the region do not provide scheduled telephonic visits with patients. This may necessitate an in-person visit for patients to have their needs met.

This year the Alliance asked about a preferred arrangement between the medical group and an urgent care center that links back to the health care team. Less than one half of medical groups have this arrangement in all or some of their clinics. This tool enables primary care providers the ability to better monitor their patients when they seek urgent care and provide better follow-up care to the patient.

Timely Communication with Primary Care Practices

	Consultation via secure email to patient's caregiver team	24-hour phone access to the health care team	Preferred arrangement with an urgent care center that links back to the health care team	Scheduled telephone consultation with a physician
Yes, in all of our clinics	29%	74%	36%	10%
Yes, in some of our clinics	14%	5%	10%	31%
No	57%	21%	55%	59%

The difficulties in improving timely access and communication are well documented and area medical groups in the region would like assistance in improving the gaps in the region.

Some avenues to improvement include the following: careful consideration of patient demand; provider capacity; a shared electronic health record; systematic notification procedures and a broader practice approach to improving primary care

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access and continuity; and payer support is important to increasing patients' access to after-hours care.[2]

Comparison to 2010:

<u>Areas showing improvement:</u>

- Medical groups improved the use of consultation via email with the care team, which increased from 18% in 2010 to 29% in 2012.

<u>Areas of less progress in the community:</u>

- Timely access to primary care decreased in same-day appointments with providers from 76% in 2010 to 69% in 2012.
- Extended hours on weeknights and weekends decreased. In 2010, only 12% of medical groups had <u>no extended</u> weeknight hours. In 2012, 31% of respondents <u>did not have</u> extended weeknight hours. The results for expanded weekend hours decreased slightly from 33% to 31%.
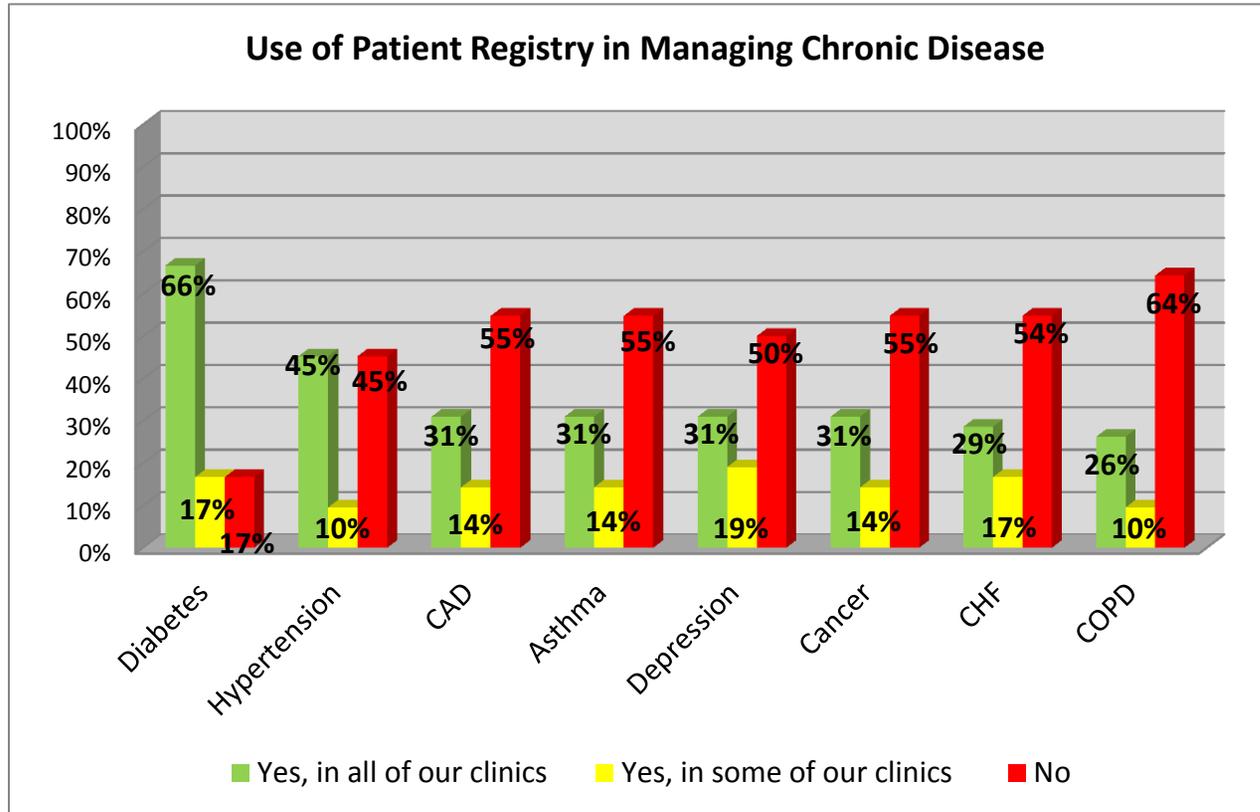
Management of Chronic Conditions

Chronic conditions are those that often require ongoing management by the affected person and regular interaction with the health care system. There is strong evidence that patient outcomes are improved if there is prompt assessment followed by management of these patients and their care over time. This includes the use of evidence-based guidelines for care delivery, planned care coordination including proactive follow-up with patients, and training for patients to manage their illness. The routine use of patient registries is an important component of planned care. A registry is essentially a list of patients with a given condition or disease that is continually maintained with updated information. This tool is used to track key measures and automatically remind both the patient and health care team when a patient needs certain tests or preventive services. Patient communication and planned care also includes the routine use of visit summaries, written care plans, and patient reminders, all evidence-based tools that improve management of chronic diseases and enhance overall patient care.

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[2] O'Malley AS, Samuel D, Bond AM, Carrier E. After-hours care and its coordination with primary care in the U.S. Washington, DC: Center for Studying Health System Change. J Gen Intern Med. 2012 Jun1.

Use of Registries

The Alliance recommends that providers routinely use a registry to assist them in being proactive in helping patients to manage their chronic conditions. Ideally, the registry resides within an electronic health record (EHR) with registry functionality, but may be a separate web-based tool or even a spreadsheet when an EHR is not available. Many practices modify and personalize their registries to reflect the needs of the practice and increase their ability to extrapolate the information for quality improvement.

Use of Patient Registry in Managing Chronic Disease

Disease	Yes, in all of our clinics	Yes, in some of our clinics	No
Diabetes	66%	17%	17%
Hypertension	45%	10%	45%
CAD	31%	14%	55%
Asthma	31%	14%	55%
Depression	31%	19%	50%
Cancer	31%	14%	55%
CHF	29%	17%	54%
COPD	26%	10%	64%

Most practices (88%) indicate that they use a patient registry (in varied formats) for one or more chronic diseases in all or some of their clinics. A patient registry is most commonly used for diabetes, with 66% of respondents reporting the use of a diabetes registry in all of their clinic settings. Hypertension is the second most common registry (45%).

The Alliance was also interested in learning if practices are using a registry for any other conditions (besides those specified in the survey); one practice indicated maintaining a registry for childhood obesity.
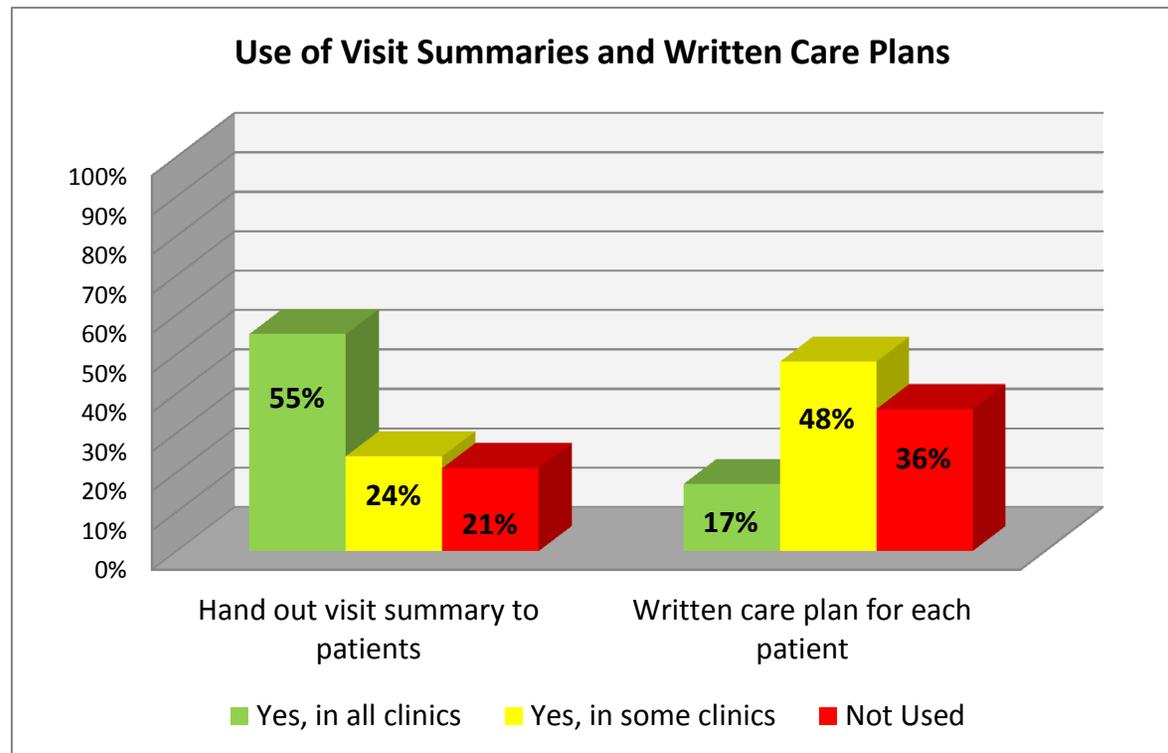
For those practices utilizing a patient registry, the most widely used format is the EHR embedded registry, followed by spreadsheets (Excel, Access or other database format). Paper-based or web-based registries are the least commonly used methods.

Use of Visit Summaries and Written Care Plans
Survey results demonstrate that our region still has opportunities to improve the routine use of visit summaries and to improve written care plans to assist patients in remembering and understanding care instructions, medical advice and next steps in their care process. Among survey respondents, a little over half use visit summaries all of the time. Written care plans are consistently provided less than 20% of the time, which is a gap in performance in the region. However, written care plans are difficult to implement; many physicians are not taught how to construct and/or use them, and if a patient is affected by multiple chronic conditions a single care plan can be problematic for the health care team to produce.

Patient Reminders
An important component of effective disease management is timely and proactive outreach by the care team to patients who need follow-up care, medication management or lab work.

Use of Visit Summaries and Written Care Plans

	Yes, in all clinics	Yes, in some clinics	Not Used
Hand out visit summary to patients	55%	24%	21%
Written care plan for each patient	17%	48%	36%

Survey respondents were asked to indicate whether processes and systems are in place to support proactive management of patients with chronic diseases. Survey results indicate that several techniques are used in this region:

- Computer-prompted reminders at the points of care and outbound telephone reminders are the most commonly used methods;
- The use of secure email for specific reminders remains low.

Use of Patient Reminders	Point of Care Computer Prompt Reminder	Send Postcards/ Letters by Mail	Outbound Calls to Patients for Specific Reminders	Secure Email Contact for Specific Reminders
Yes, in All Clinics	62%	52%	62%	19%
Yes, in Some Clinics	19%	31%	29%	12%
Not Used	19%	17%	9%	69%

Processes to Educate Patients

When asked about processes used to educate and counsel patients with chronic conditions, 48% of the medical groups/clinics reported scheduling longer visits; 29% reported proactively calling patients to check and counsel; and, only 17% reported emailing or writing patients to educate them about their conditions.

Processes to Educate Patients with Chronic Health Conditions	Schedule Longer Visits for Counseling and Education	Proactively Call Patients to Check and Counsel	Proactively Email or Write to Patients
Yes, in All Clinics	48%	29%	17%
Yes, in Some Clinics	31%	33%	36%
Not used	21%	38%	47%

The Alliance also asked if clinics use other forms of patient education and respondents noted the following:

- Group visits
- Classes about chronic diseases
- Longer scheduled appointments for everyone (30–60 minutes in person, 15 minutes on the phone)

- Interactive voice reminders (IVR)
- Nurse education visits
- Appointments with a pharmacist, nurse or dietician as part of a provider visit or separate appointment

This is a gap in performance in the region. Patient activation is difficult for providers to accomplish, particularly during 15-minute visits. Medical groups may need to identify who within their practice is best trained to educate and serve the role of engaging patients. Often times it is a nurse, though it varies by practice.

Comparison to 2010:

Areas showing improvement:

- Medical groups/clinics improved the use of handing out visit summaries to patients (from 27% in 2010 to 55% in 2012).

Areas of less progress in the community:

- Medical groups are still unlikely to provide a written care plans (little change from 15% in 2010 to 17% in 2012, though a slight improvement).
- Use of email to contact patients for specific reminders and to proactively educate patients about their conditions remained low. In 2010, about a quarter of medical groups used email reminders (22%). In 2012, even less (19%) are using this tool. For education purposes, about 25% of clinics used email for proactive education in 2010, and in 2012 it is only used about 17% of the time.

Care Coordination

When patients who are at higher risk because of one or more chronic diseases receive evidence-based, coordinated support and medical interventions across different organizations and providers, they are more likely to have a better experience and improved health outcomes. Effective coordination of care comprises mechanisms that ensure patients and clinicians have access to, and take into consideration, information on a patient's conditions and treatments to ensure that the patient receives appropriate health care services. This helps to avoid gaps in care, duplication of tests or procedures, and reduce avoidable use of the emergency room and hospitalization. The number of Americans with one or more chronic diseases continues to rise. It is common for these individuals to receive care from different providers, often in different health-related organizations. Coordination of health care can be very complex and confusing at times unless medical groups/clinics have specific processes in place to reduce inconsistencies and engage patients in their own care management.

Care Coordination and Patient Engagement
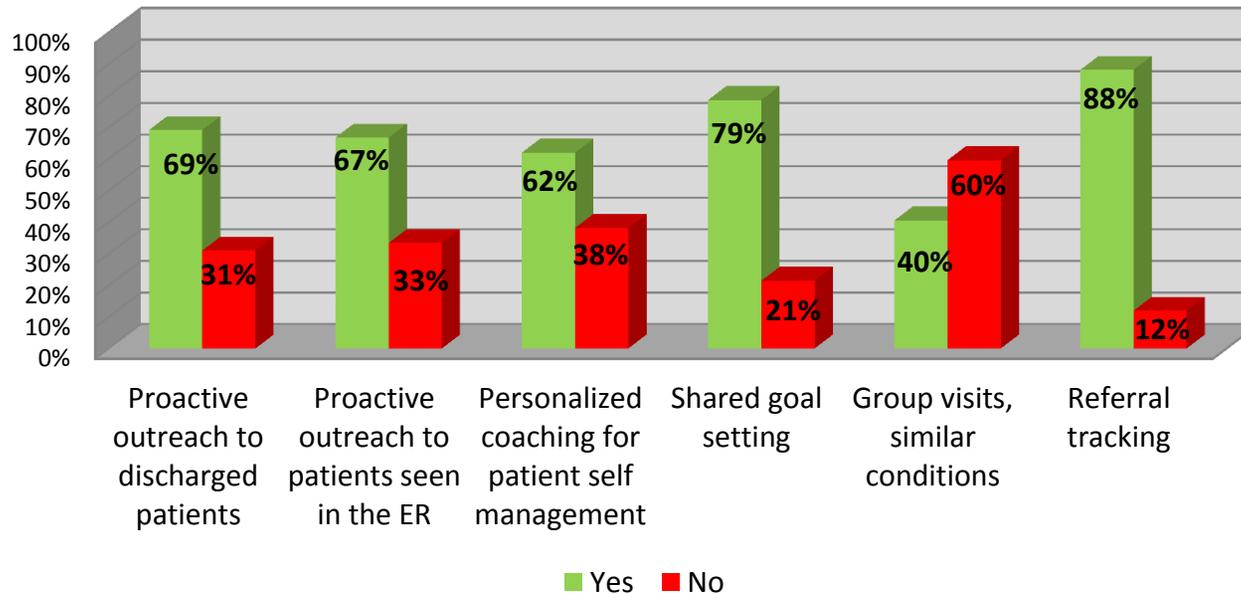
The survey asked several questions to assess current care coordination activities within the practices. Results indicate that 88% of respondents have protocols and processes in place to track referrals to other providers. Seventy-nine percent engage in shared goal setting as determined jointly by the provider and the patient. Ideally, these goals are documented in the patient medical record, easily accessed on a regular basis by the care team and patient, and used from one patient encounter to another. While these numbers are mainly positive it is worth noting that often a procedure or policy may be in place but not necessarily mean that the task is fully executed on a consistent basis. For example, for best results, referral tracking should include a "closed loop" where the patient is referred and tracked through the system by both physicians and feedback is received. This policy may be in place, but it would be best to note how often it actually occurs. An increase in policies is an important first step.

About two thirds of practices have processes to ensure proactive outreach to patients who have been recently discharged from the hospital or seen in the ER when they know that patients where in the ED/Hospital. Evidence suggests that improving transitions in care, specifically getting patients in touch with their primary care team immediately following discharge, is correlated with lower rates of readmission. Medical groups are only able to follow-up when they become aware that their patients visited the ER or were admitted to the hospital.

Improving communication methods between hospitals and providers would strengthen overall care coordination. The use of personalized coaching for patient self-management ranked lower at 62% and less than half of medical groups offer group visits for similar conditions (40%).

The use of *dedicated* care coordinators within the practice setting is an important element of planned care for patients with one or more co-morbidities who are at the highest risk. Care coordinators devote their time to proactive outreach to patients, planning care, coaching and coordination of services to support the medical management of patients with chronic conditions.

Dedicated Care Coordination Resources Within the Practices

- No Dedicated Care Coordination 59%
- Dedicated Care Coordination Resources, All Locations 17%
- Dedicated Care Coordination Resources, Some Locations 24%

Fifty-nine percent of medical groups/clinics report that they do not have any dedicated resources for care coordination (e.g., one or more members of the health care team). The majority of care coordinators were RNs (65%). Other backgrounds of care coordinators were LPN or MA.

Prevention is important for both patients with chronic conditions as well as healthy individuals. The survey asked respondents to report on their use of patient reminders in the area of prevention. Survey results indicate that patient reminders continue to be most commonly sent by medical groups for breast cancer screening (90%). Use of reminders for flu vaccines greatly increased to 81% from 58% in 2010. Keep in mind these are reminders not actual services. It would be important to note how often theses preventive services occurred as a result of the reminder.

Patient Reminders for Preventive Services	Breast Cancer Screening	Colorectal Cancer Screening	Cervical Cancer Screening	Flu Vaccine	Pneumococcal Vaccination	Well Child Visit
Yes	90%	71%	79%	81%	67%	81%
No	10%	29%	21%	19%	33%	19%

Medication reconciliation is an essential component of safe care, particularly for patients with multiple chronic conditions (and who may be on multiple medications) and those patients recently discharged from the hospital. It is encouraging to see that over 74% of practices are conducting medication reconciliation at each visit. It is also positive that the percent of practices with no processes in place decreased to 17% from 24% in 2010. Respondents indicated that their practices use the following processes and systems for medication reconciliation:

- Include as part of standard medical assistant workflow with confirmation by a provider
- Greater use of EHR functionalities
- Documentation of review at each visit
- Review medications patients bring to the office

Process to Ensure Medication Reconciliation	Response
Yes, at each visit, all clinics	74%
Yes, at each, some clinics	9%
No process in place	17%

Comparison to 2010:

Areas showing improvement:

- Eighty-eight percent of respondents have protocols and processes in place to track referrals to other providers compared to 78% in 2010.
- Proactive outreach to patients who have been recently discharged from the hospital greatly improved from less than 50% in 2010 to 69% in 2012.
- Practices improved medication reconciliation from 55% in 2010 to 74% in 2012.
- Survey results indicate that patient reminders continue to be most commonly sent by medical groups/clinics for breast cancer (90%), up ten percent from 2010. Use of reminders for colorectal and cervical cancers both improved by almost 10% from 2010. Flu vaccines greatly increased from 58% in 2010 to 81% in 2012 as well as for pneumococcal vaccination.

Area of less progress in the community:

- Medical groups designating a dedicated care coordinator services decreased from 26% in 2010 to 17% in 2012.

Data Management

Key information is generated in the delivery of care (e.g., vital signs, problem lists, medications, procedures and test results). Providers and other members of the health care team need to have real-time access to medical information for patients as well as tools to help ensure the quality and safety of the care provided. Implementation of an Electronic Health Record (EHR) is an important step in enhancing patient care and enabling more ready access to the information for all members of the health care team to support planned and coordinated care.

The Alliance supports the recommendation that providers install and utilize an EHR system that adheres to Meaningful Use standards. A strong EHR system includes the following components: capturing health information in a standardized format; registry capability; reporting services; imbedded clinical guidelines; reminder systems for both the care team and patients; and improving quality improvement. Sixty-nine percent of respondents indicated that they currently have a fully functioning EHR in all of their clinics. To meet the definition of a fully functioning EHR, the medical groups/clinics had to have the ability to use various components of the electronic data system for entering and retrieving clinical data to drive practice improvements for their entire clinic population. The Washington and Idaho Regional Extension Center (WIREC) assists practices in EHR implementation and Meaningful Use standards in the region. These percentages are in alignment with what WIREC is experiencing.

EHR Implementation	Response
Yes, all clinics	69%
Yes, some	14%
No, underway	5%
No, planned	10%
Not considered now	2%

The majority of practices are working with Epic, NextGen, Centricity and/or a combination of these or other EHR platforms.
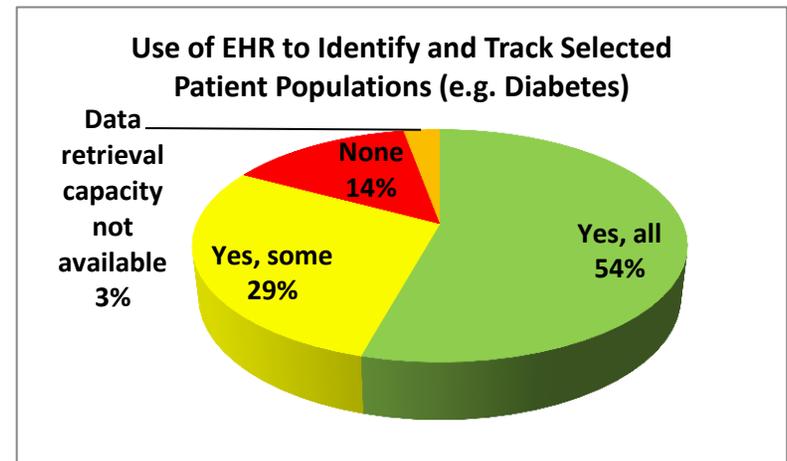
The survey gathered information about the actual capabilities of the EHRs used by the 35 practices indicating full or partial EHR implementation, and also asked about how fully the EHR is being implemented (i.e., capability plus use) within the clinic(s). Of interest were both clinical and administrative tasks that are linked together for an individual patient in the EHR system. See below for detailed results.

Provider Elements of an EHR System			
	Yes in all Clinics for all patients	Partial Implementation*	Not Implemented
Patient appointment scheduling	86%	14%	3%
Clinical documentation of each visit	83%	17%	0%
Standardized problem lists	77%	23%	0%
Documentation of current medication lists	83%	17%	0%
Medication prescription ordering with ability to highlight drug interactions and correct dosing	74%	23%	3%
Order entry for lab and diagnostic testing	68%	29%	3%
Laboratory results reporting	86%	14%	0%
Radiology results reporting	63%	20%	17%
Alerts regarding abnormal values	71%	20%	9%
Clinician alerts based on evidence based care	46%	34%	20%
Secure patient portal (i.e. patient electronic access) to the majority of the EHR plus secure email capabilities automatically captured in EHR	31%	20%	49%
Patient reminders for needed tests or follow-up care	46%	43%	20%
Decision support tools (providers ability to access clinical guidelines or protocols at the point of care)	51%	38%	11%
Access to clinical documentation and reports from emergency rooms	46%	31%	23%
Access to clinical documentation and discharge reports from inpatient stays	46%	31%	23%

*Partial implementation indicates that the EHR functionality is present in some clinic locations and/or for some patients but not all.

Patient's Access to Online Medical Records			
	Yes, in All Clinics	**Yes, in Some Clinics**	**None of the Clinics**
Direct online scheduling of appointments (where patients can choose their appointment time directly online and schedule themselves)	14%	6%	80%
Online appointment requests (form requesting appointment)	29%	11%	60%
Problem list	20%	6%	74%
Laboratory results	31%	9%	60%
Radiology results	20%	9%	71%
Biometric measurement results	14%	9%	77%
Ability to review existing medications and order refills	26%	9%	65%
Chart notes	6%	6%	88%
Immunization records	20%	9%	71%
After-visit summaries	20%	11%	69%

Offering access to electronically based information is important for patient engagement. Few medical groups report having an EHR with the capacity to provide remote access to patients, which is helpful for patients seeking online scheduling of appointments, ordering prescriptions refills, and accessing records and after visit summaries. Patients with access to chart notes written by their doctors feel more in control of their care and report a better understanding of their medical issues, improved recall of their care plan, and being more likely to take their medications as prescribed.[3] More than one half of the medical groups/clinics that have implemented an EHR retrieve data to analyze and track for selected patient populations in all or some of their medical groups/clinics.

Use of EHR to Identify and Track Selected Patient Populations (e.g. Diabetes)

Data retrieval capacity not available 3%

None 14%

Yes, some 29%

Yes, all 54%

[3] Delbanco T, Walker J, Bell SK, Darer JD, Elmore JG, Farag N, Feldman HJ, Mejilla R, Ngo L, Ralston JD, Ross SE, Trivedi N, Vodicka E, Leveille SG. Inviting Patients to Read Their Doctors' Notes: A Quasi-experimental Study and a Look Ahead. Annals of Internal Medicine. 2012 Oct; 157(7): 461-470.

The majority of services in active use by providers represent minimum Meaningful Use standards. Hopefully as the next stages of Meaningful Use go into effect, the community will slowly implement more of the capabilities of EHR systems.

Comparison to 2010:

Areas showing improvement:

- Medical groups implemented fully functioning EHR systems in all clinics from 55% in 2010 to 69% in 2012.
- Medical groups improved in the use of the following EHR capabilities from 2010 to 2012:
    o Patient appointment scheduling improved from 75% to 86%
    o Clinical documentation of each visit improved from 71% to 83%
    o Standardized problem lists improved 64% to 77%
    o Medication prescription ordering improved from 68% to 74%
    o Order entry lab and diagnostic testing improved from 61% to 74%
    o Laboratory results reporting improved from 79% to 86%
    o Secure patient portal improved from 21% to 31%
   o Patient reminders for needed tests or follow-up improved from 39% to 46%.

Areas of less progress in the community:

- There is a gap in the following EHR capabilities (from 2010 to 2012):
    o Clinician reminders/alerts based on evidence based care needs decreased from 54% to 46%.
    o Use of decision support tools decreased from 61% to 51%
    o Access to clinical documentation and reports from emergency rooms decreased from 57% to 46%.
    o Access to clinical documentation and discharge reports from inpatient stays decreased from 54% to 46%.
- Patient's access to online medical records saw little improvement; online scheduling remained constant at 14%; problem lists went from 29% in 2010 to 20% in 2012; and the ability to order prescription refills went from 29% in 2010 to 26% in 2012.

Improving Quality and Patient Experience

You can't improve what you don't measure. The ability to continuously improve quality is, in part, based on an ability to routinely measure what is happening within the practice. This enables a practice to identify patterns and opportunities for improvement, and create systems within the practice to prevent errors or gaps in care from reoccurring.

Use of PDSA for Making Continuous Improvement

None
24%

Yes, some
24%

Yes, all
52%
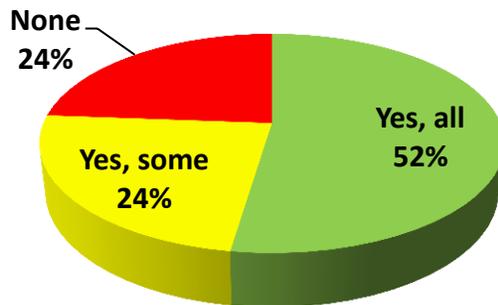
Quality improvement (QI) is a commitment to *continuously* doing things better than before with a focus on standards *as well as* improving health outcomes, patient experience and provider/team experience. QI efforts rely extensively on data collected about processes and outcomes. The PDSA (Plan-Do-Study-Act) cycle is a tool that is used by many healthcare organizations to conduct rapid cycle testing and make continuous improvements in their unique settings. Practices were asked whether they use the PDSA cycle to assist QI efforts.

It is not possible to be a patient-centered practice without understanding the patients' perception of their care and focusing continuous quality improvement on enhancing patient experience within a practice. Of the 42 medical groups/clinics that responded to this survey, 86% are measuring patient satisfaction or patient experience in all or some of their practice locations. Of those practices that do measure patient satisfaction/experience, 58% report that they conduct continuous measurement (i.e., monthly), 22% measure semi-annually, 11% measure on an annual basis, and 9% measure every other year or more.

There is a significant difference between measuring patient satisfaction and patient experience. The former measures *how satisfied* a patient was with the care process or with how he or she was treated, and is generally considered more a measure of business loyalty than quality. The latter, patient experience, asks patients to report their experiences (*how often* something happens) in areas research has shown patients value and that are tied to improved clinical outcomes, including but not limited to availability of information, communication with clinicians, responsiveness of the care team and coordination between care providers.

The "homegrown" measurement tool – most likely focusing on patient satisfaction – is the most widely used followed by "other" tools (not defined), Press Ganey and then the CG-CAHPS tool. There is a mix of tools noted with some focused on patient satisfaction and others on patient experience (e.g., CG-CAHPS).

**Tools Used to Measure Patient Experience or Patient Satisfaction**
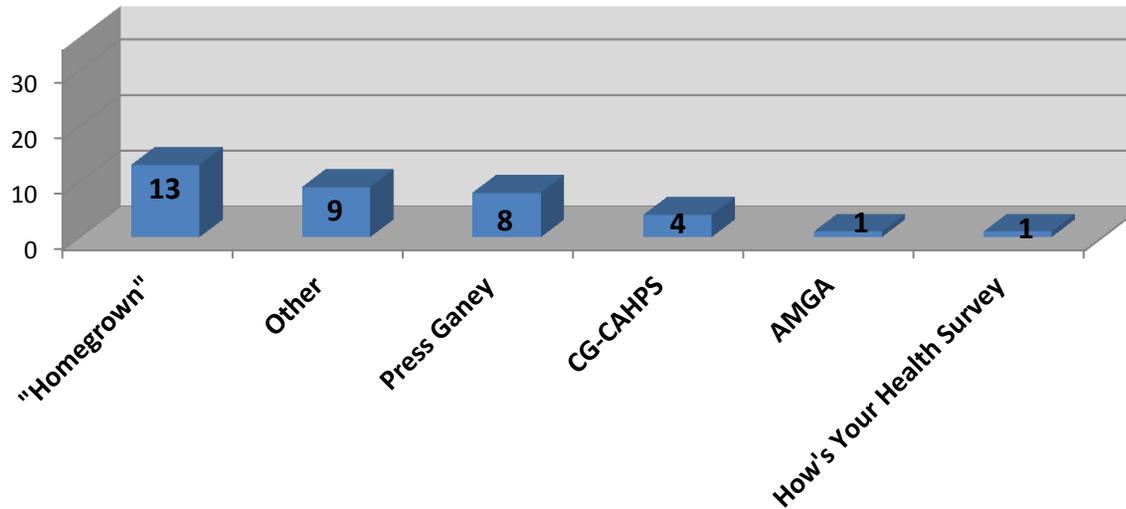
Very few, if any, practices share their results publicly other than selectively through various marketing efforts. And, with so much variation among the different survey tools and implementation methods (mailing, phone, web-based, at point of service), it is impossible to accurately compare results *across* medical groups/clinics to stimulate improvement, and enhance patient understanding and choice. The Alliance conducted and released results of the first regional Patient Experience Survey in May 2012. This report provides an opportunity for consumers and medical groups alike to compare patient experience with primary care practices across the region. You can see results at www.wacommunitycheckup.org

The Alliance also asked medical groups/clinics to indicate whether they have processes in place to routinely use patient opinion, gathered through several sources, to make improvements within their practices.

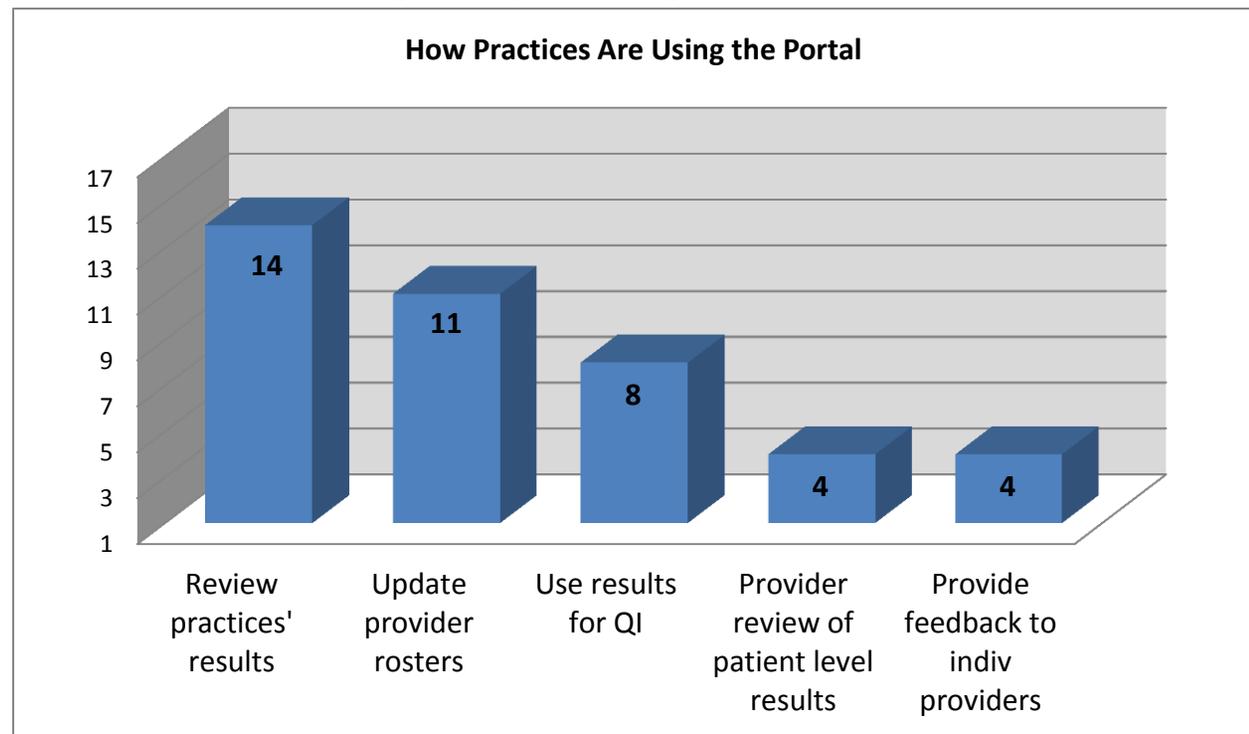**Clinic Use of Patient Feedback to Improve Care**

25
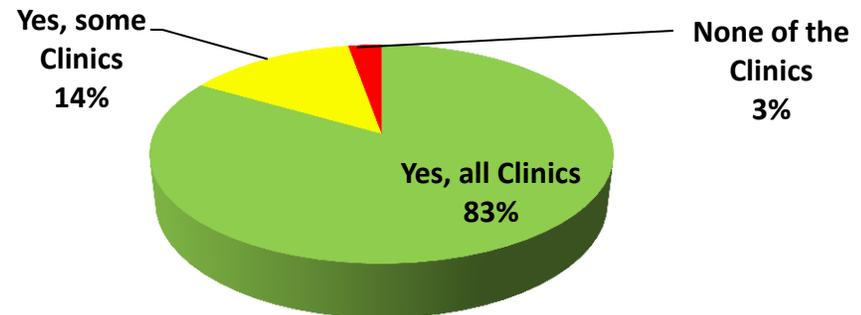
Community Checkup

The Community Checkup (www.wacommunitycheckup.org) is the regional go-to source for a comprehensive overview of health care performance in the Puget Sound region. The Community Checkup provides results by medical group and clinic for over 25 nationally vetted ambulatory care performance measures, and compares local results with national benchmark performance. The Alliance offers a secure portal for registered medical groups to review individual practice level results, perform patient verification ensuring results are correct at the patient level, and update provider rosters.

The survey asked questions to assess awareness of the Puget Sound Health Alliance Community Checkup. The majority (88%) of survey respondents are aware of the Community Checkup. Respondents were also asked about whether they are aware of the secure portal that allows registered providers access to Community Checkup individual practice results.

Only 64% of respondents are aware of the secure portal and only seventeen (40%) of medical group use the portal. Those that are aware of and using the portal noted that they use the portal primarily for reviewing practices' results and updating provider rosters.

How Practices Are Using the Portal

Category	Value
Review practices' results	14
Update provider rosters	11
Use results for QI	8
Provider review of patient level results	4
Provide feedback to indiv providers	4

Appendix – Survey Invitees and Responders

Survey Respondents – Thank You!		
Bastyr Center for Natural Health*	LG Steck (Big Rock Health Center)	Sound Family Medicine*
Birth & Family Clinic	Minor & James Medical*	South Hill General Medical Clinic
Cascade Valley Hospital	MultiCare*	Southlake Clinic
Community Health Care	Neighborcare*	Stevens Center for Internal Medicine*
Country Doctor Community Health Center*	Northwest Physicians Network*	Summit View Clinic*
Eastside Family Medicine Clinic*	Olympia Family Medicine	Swedish Physicians*
Evergreen Healthcare*	Overlake Internal Medicine Associates	The Everett Clinic*
Family Care of Kent	Pacific Medical Center*	UW Medical Center, Ambulatory Division*
Franciscan Health System*	Peninsula Community Health Services	UW Physicians & Neighborhood Clinics*
Group Health Cooperative*	Providence Physician Group*	Valley Medical Clinic Network*
Hall Health Primary Care	Public Health – Seattle King County*	Virginia Mason*
Harborview Medical Center*	Qliance	Western Washington Medical Group
Healthpoint*	Sea Mar Community Health Center*	Women's and Family Health Specialists*
International Community Health Services*	Seattle Indian Health Board	Yelm Family Medicine*

Invited, No Response

Eastside Internal Medicine

Interlake Medical Center

Lake Serene Clinic

Lakeshore Clinic

Highline Medical Group*

Richmond Internal Medicine

The Doctors Clinic*

Invited, Declined

Bellevue Family Medicine Associates

Pacific Walk-In Clinic (now U.S. HealthWorks)*

Puget Sound Family Physicians*

The Polyclinic*

*Participated in Alliance 2010 Medical Group Survey