

Puget Sound

# Health Alliance

Adoption of Processes and Tools  
to Advance Effective Patient Care

Clinical Performance Improvement Network  
February 15, 2011

## The 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 with chronic conditions
- Promoting prevention-related activities and healthy choices
- Reducing *avoidable* ER visits, ambulatory care-sensitive hospitalizations and readmissions



## 2010 Medical Group Survey

- Recommended by our Quality Committee in late 2009
- Survey primary care medical groups and clinics that are currently participating in the Community Checkup
- Collect and share information that describes whether or not activities and tools are being implemented within medical groups/clinics to enhance effective coordination of care
- Create a better understanding of current performance and areas of opportunity
- Stimulate improvement

## 2010 Medical Group Survey

- Sent to 53 primary care medical groups/clinics that are currently in the Community Checkup
- Survey completed by 33 medical groups (62%)
  - 290 clinic locations in total
  - 2,400 primary care providers (~85% of providers w/measure results)
  - 28 out of 33 have multiple locations (5/33 have one location)
  - 59% of survey respondents were medical directors/physicians
  - Information self-reported, unaudited
- 20 groups did not respond
  - 5 formally declined
  - 15 did not respond at all

## Survey Repondents - Thank You!

Bastyr Center for Natural Health	Multicare	Summit View Clinic
Country Doctor Community Health Center	Neighborcare	Swedish Physicians
Eastside Family Medicine Clinic	Northwest Physicians Network	The Doctors Clinic
Evergreen Healthcare	Pacific Medical Center	The Everett Clinic
Franciscan Health System	Pacific Walk-in Clinic	The Polyclinic
Group Health Cooperative	Providence Physician Group	UW Medical Center, Ambulatory Division
Harborview Medical Center	Public Health - Seattle King County	UW Physicians & Neighborhood Clinics
Healthpoint	Puget Sound Family Physicians	Valley Medical Clinic Network
Highline Medical Group	Sea Mar Community Health Center	Virginia Mason
International Community Health Services	Sound Family Medicine	Women's & Family Health Specialists
Minor & James Medical	Stevens Center for Internal Medicine	Yelm Family Medicine

### Invited, No Response

Bellevue Family Medicine Associates  
 Birth & Family Clinic  
 Cascade Valley Hospital  
 Eastside Internal Medicine  
 Family Care of Kent  
 Hall Health Primary Care  
 Interlake Medical Center  
 Lakeshore Clinic  
 Olympia Family Medicine  
 Peninsula Community Health Services  
 Seattle Indian Health Board  
 South Hill General Medical Clinic  
 Southlake Clinic  
 Totem Lake Family Medicine  
 Western Washington Medical Group

### Invited, Formally Declined

Big Rock Health Clinic  
 Community Health Care  
 Lake Serene Clinic  
 Overlake Internal Medicine Associates  
 Qliance

# 2010 Medical Group Survey

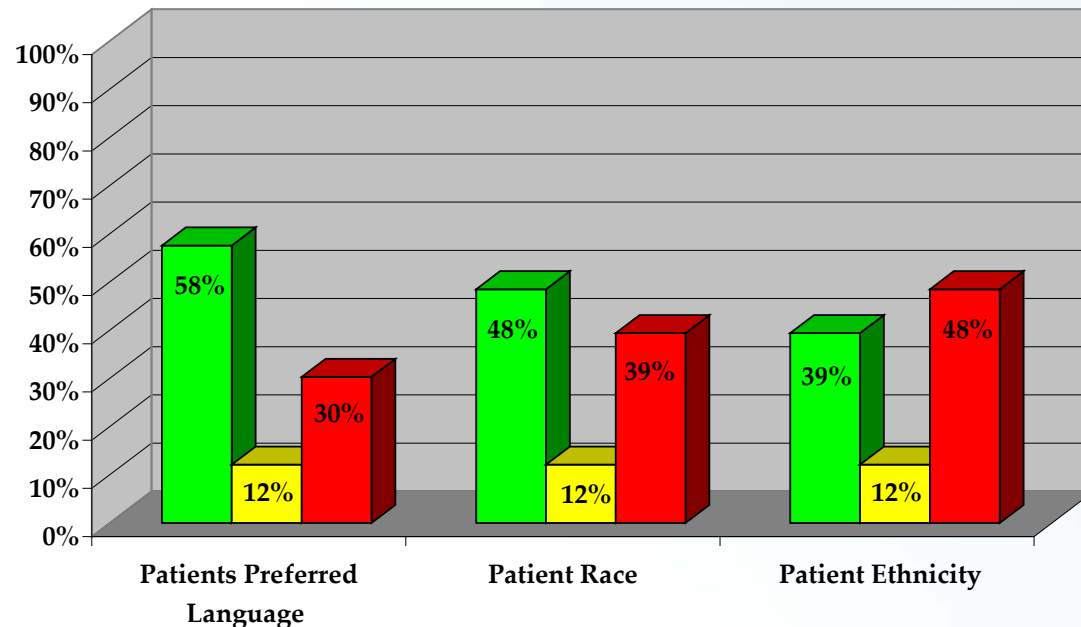
## Six Domains:

1. Addressing Healthcare Disparities
2. Access and Communication
3. Management of Chronic Conditions
4. Care Coordination
5. Information Management
6. Improving Quality and Patient Experience

# Addressing Healthcare Disparities

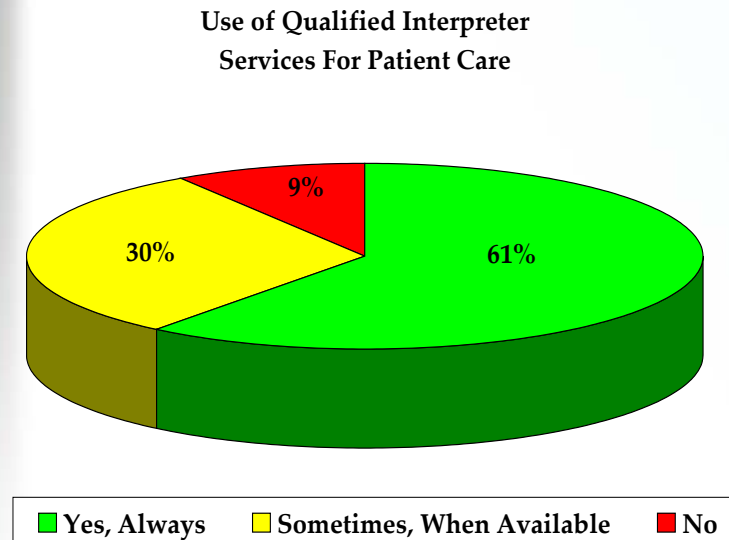
- An important starting point in reducing health disparities is to identify them through the collection of patient self-reported data on race, ethnicity and language. The information can be used to help shape a practice to be culturally responsive and to identify opportunities for improvement.

Is self-reported data collected from patients on language, race or ethnicity?

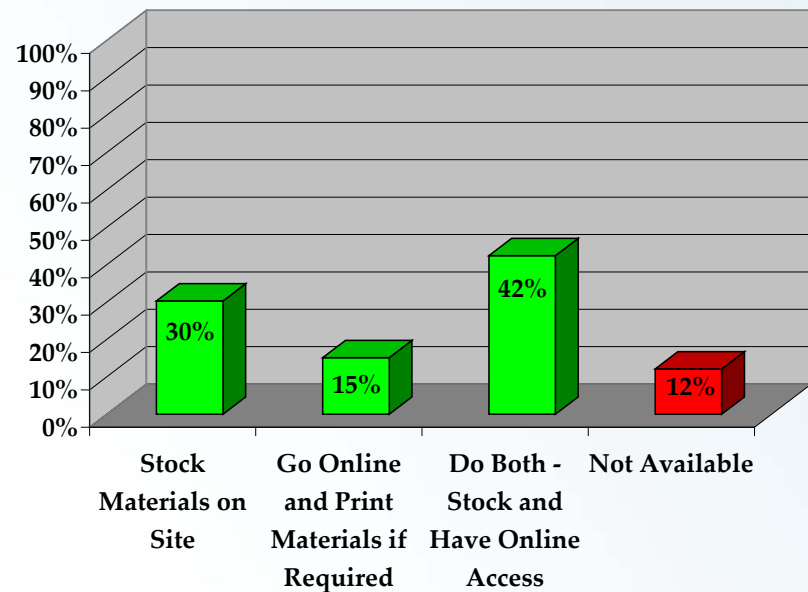


■ Yes, Collected @ All Clinics    ■ Yes, Collected @ Some Clinics    ■ Not Collected

- Use of qualified interpreters and educational materials in other languages is key to facilitating care and understanding for non-English speaking patients.

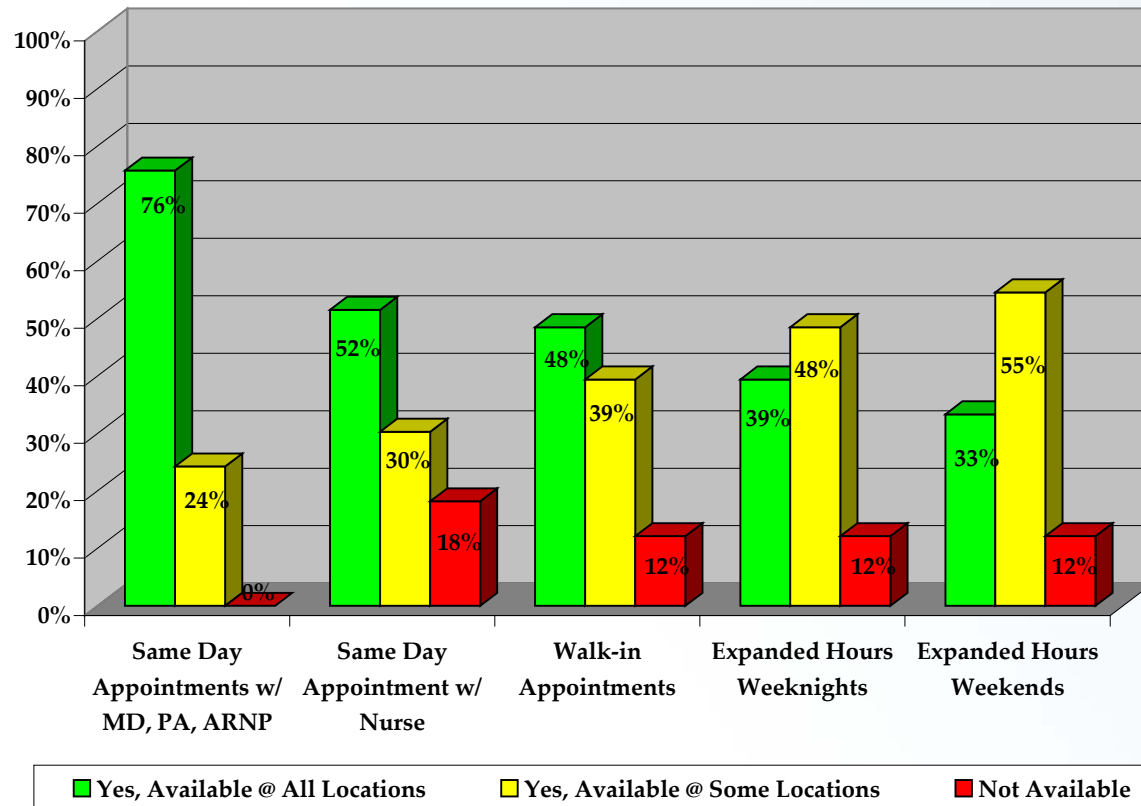


Availability of Written Resources for Non-English Speaking Patients in Other Common Languages



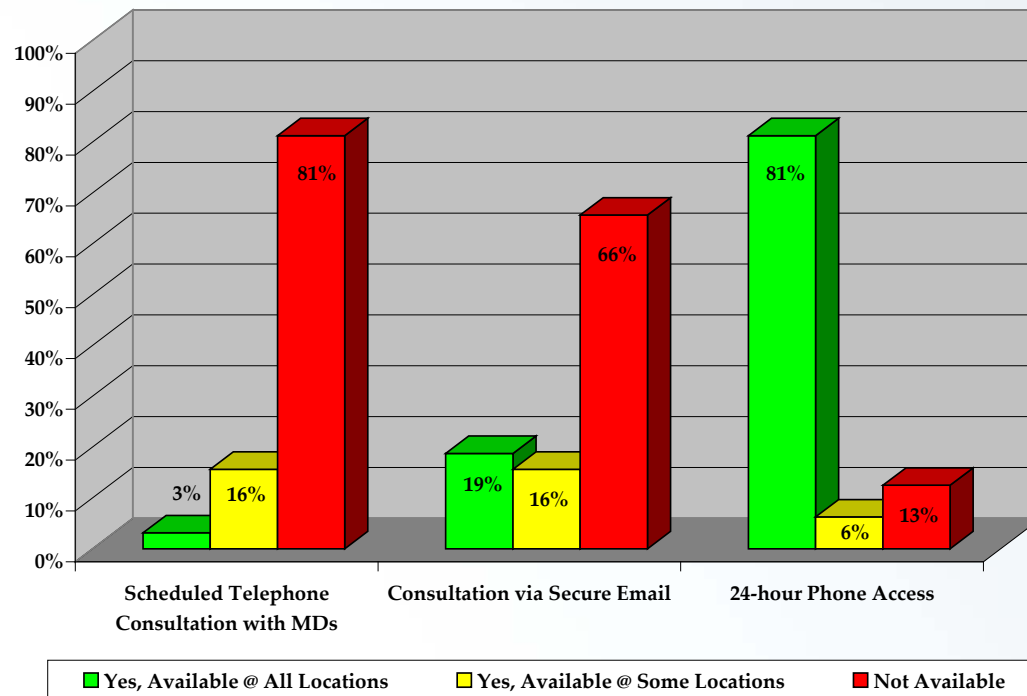
- Timely access to care (when the patient feels they need contact) is an essential component of effective care, and an important strategy in reducing avoidable ER visits and hospitalizations.

Timely Access to Primary Care Services



- There aren't many opportunities for patients to directly access their health care team via scheduled phone consults or email.

Timely Communication with Primary Care Practices



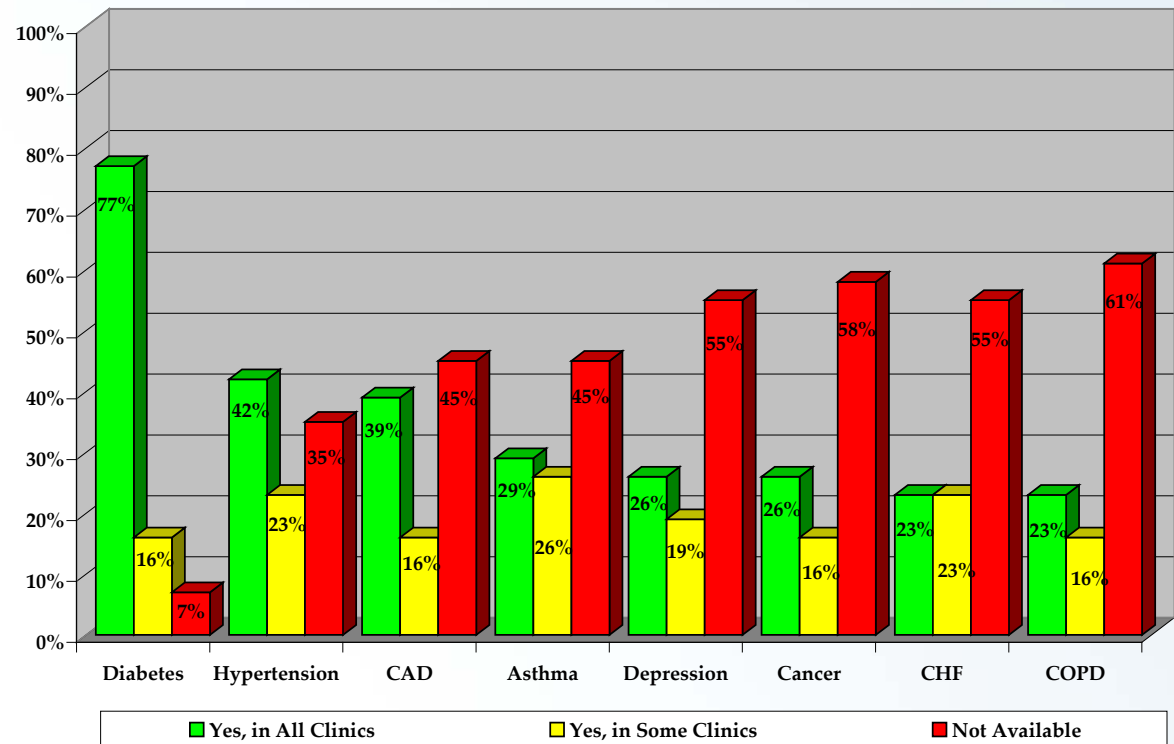
Note: The question re: 24-hr phone access specified access other than a health plan-related consulting nurse line.

# Management of Chronic Conditions

- The use of a patient registry is fairly well established for patients with diabetes. Survey findings highlight an opportunity to extend the routine use of registries for other chronic conditions.

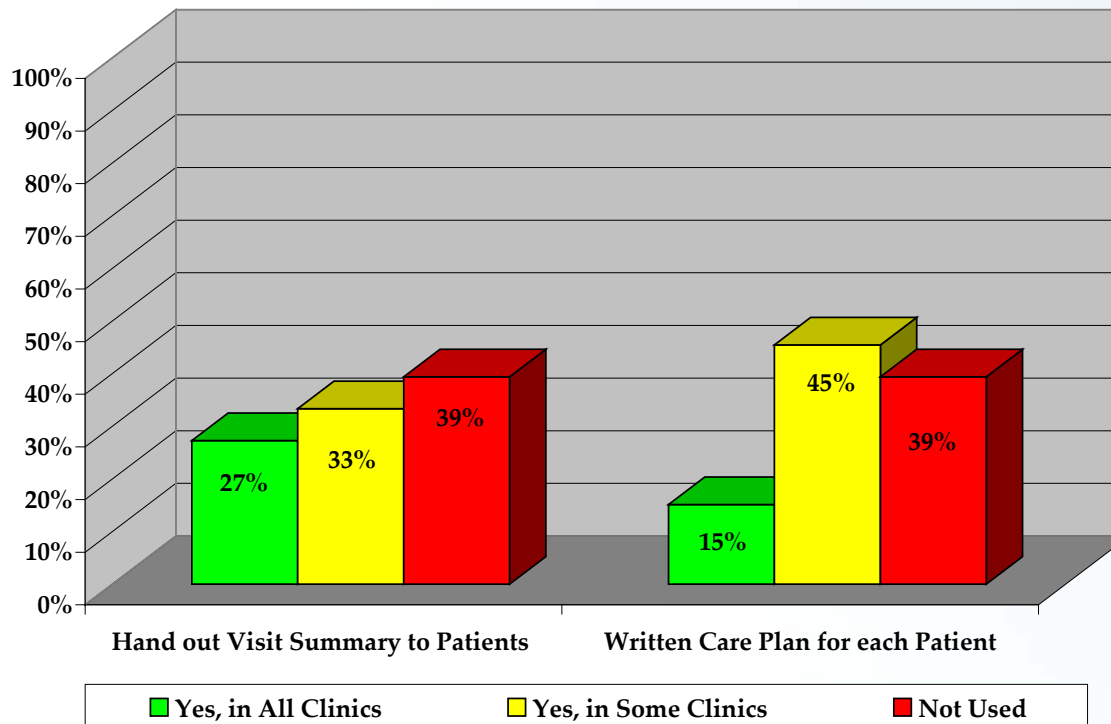
For those practices utilizing a patient registry, the most used format is the EHR-embedded registry (57%), followed by spreadsheets (excel, access or database format) (17%), and web-based registries (13%). About 7% still use paper-based registries.

Use of Patient Registry in Managing Chronic Disease



- There is room for improvement in the *consistent* use of visit summaries and written care plans to assist patients in their understanding and ability to remember outside of the provider's office.

Use of Visit Summaries and Written Care Plans



# Management of Chronic Conditions

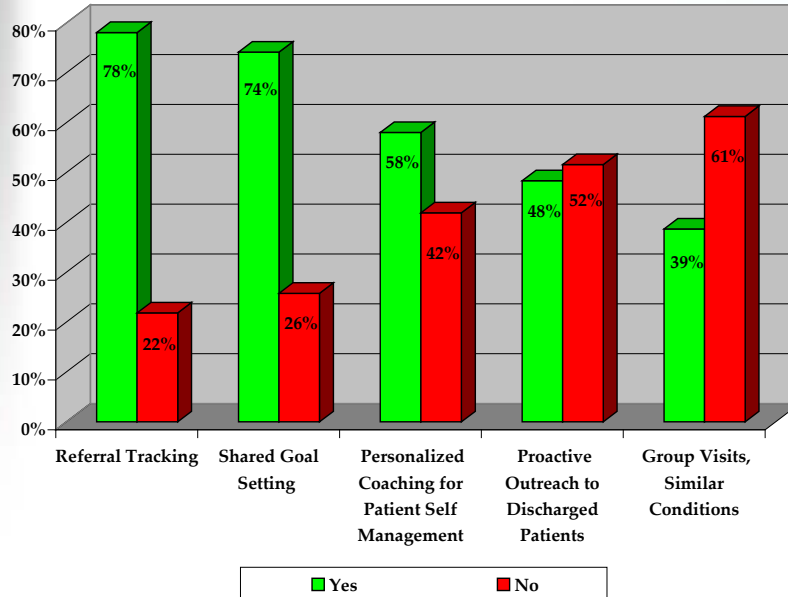
- Systematic and proactive outreach to patients who need follow-up care, medication management and/or lab work is an important part of chronic disease care. Point of care reminders are used most often, but this technique only reaches those patients who make an appointment and are seen in person.

Use of Patient Reminders	Point of Care/ Computer Prompt Reminder	Send Post Cards/ Letters by Mail	Outbound Calls to Patients for Specific Reminders	Secure Email Contact for Specific Reminders
Yes, in All Clinics	63%	59%	56%	22%
Yes, in Some Clinics	13%	25%	25%	16%
Not Used	25%	16%	19%	63%

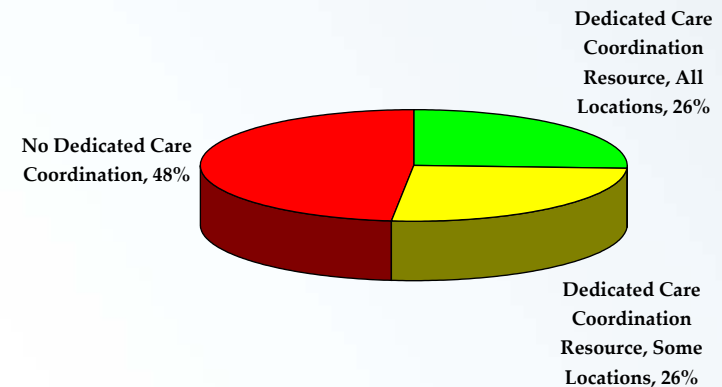
Processes to Educate Patients with Chronic Health Conditions	Schedule Longer Visits for Counseling & Education	Proactively Call Patients to Check and Counsel	Proactively Email or Write to Patients
Yes, in All Clinics	47%	31%	25%
Yes, in Some Clinics	38%	34%	28%
Not Used	16%	34%	47%

- Effective care coordination helps to avoid gaps in care and duplication of tests or procedures, and reduce avoidable use of the ER and hospitalization. Shared goal setting, personalized coaching and outreach to recently discharged patients are the most effective in engaging patients.

Care Coordination and Patient Engagement

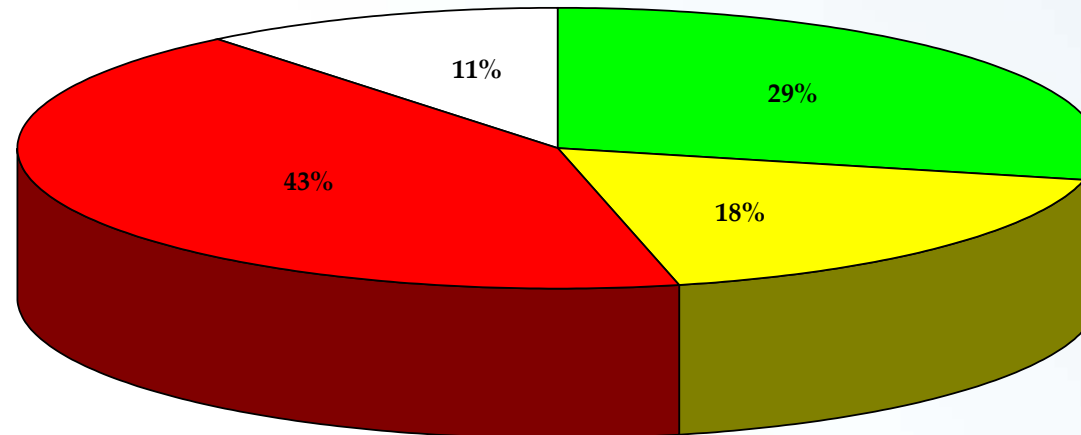


Dedicated Care Coordination Resources Within the Practice



- The timely exchange of accurate information between the hospital and primary care team for patients recently discharged from the hospital is an important component of care coordination and patient safety.

Ability to Connect Clinic EMR Directly to the EMR at Hospital(s)  
Primarily Used by Physicians and Patients



- EHR adoption is increasing. These results are encouraging and will continue to improve under the banner of the ARRA HITECH Act and Meaningful Use.

EMR Implementation	Response
EMR is fully functioning for <i>all</i> clinics	55%
EMR is fully functioning for <i>some</i> clinics	21%
EMR implementation is underway for all clinics	9%
No, but it is being considered for the near future (within the next 2 years)	15%
No, and it is not being considered at this time	0%

The majority of practices are working with Epic, NextGen, GE or Cerner.

# Utilizing the Capabilities of EHRs

- Even though EHRs are being implemented, there is room to more fully maximize various capabilities.

	Yes in <i>all</i> Clinics for <i>all</i> patients	Partial* Implementation	Not Implemented
Patient appointment scheduling	75%	14%	11%
Clinical documentation of each visit	71%	25%	4%
Medication prescription ordering with ability to highlight drug interactions and correct dosing	68%	28%	4%
Standardized Problem Lists	64%	32%	4%
Order entry for lab and diagnostic testing	61%	28%	11%
Laboratory results	79%	17%	4%
Radiology results	64%	22%	14%
Alerts re: abnormal values	68%	21%	11%
Documentation of medication lists	79%	17%	4%
Clinician reminder/clinical alerts based on evidence based care needs	54%	32%	14%
Secure patient portal for communication and exchange of information	21%	25%	54%
Patient reminders for needed tests or follow-up care	39%	29%	32%
Decision support tools	61%	32%	7%

- Use of EHRs to Track Health Indicators, Populations

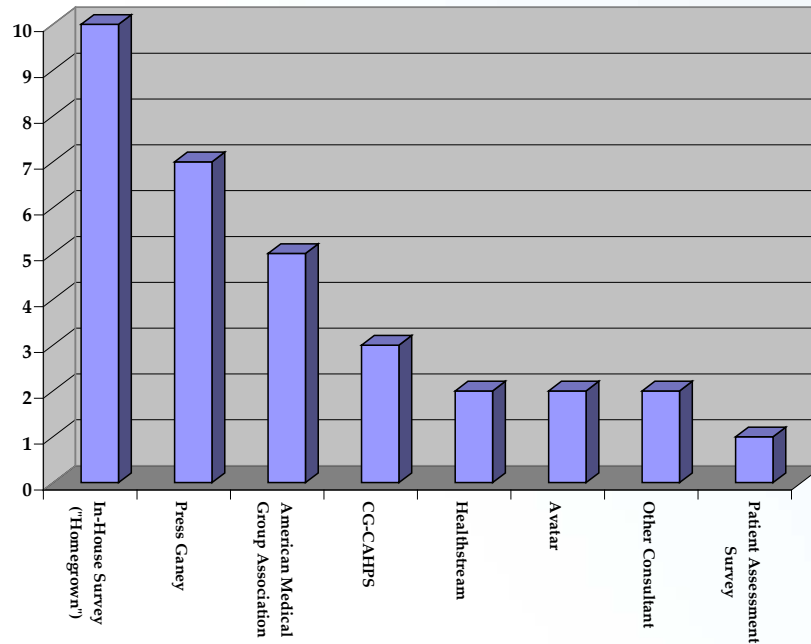
	Use of EMR to identify and track selected health indicators and outcomes (e.g. blood pressure)	Use of EMR to identify and track selected patient populations (e.g. diabetes)
Yes, in all clinics	57%	64%
Yes, in some clinics	21%	29%
None implemented	18%	7%
Data retrieval capacity not available	4%	0%

- Electronic Access to Information for Patients

	Direct Online Scheduling of Appointments (patients choose and schedule their appointment time)	Online Appointment Requests (fill in form <i>requesting</i> appointment)	Laboratory and other Biometric Measurement Results	Ability to Review Existing Medications and Order Refills
Yes, in All Clinics/Clinic	14%	25%	29%	29%
Yes, in Some Clinics	7%	14%	11%	11%
None Of the Clinics	79%	61%	61%	61%

# Measuring and Using Patient Experience to Improve Care

Tools Used to Measure Patient Satisfaction or Patient Experience



88% of medical groups report some type of measurement. There is a lot of variation in how practices learn about their patients' experience and level of satisfaction with the care they receive.

	Assessment of Patients Needs and Expectations	Assess Patient Complaints to ID Patterns and Prevent Recurring Problems	Use Survey Results to Improve Care
<b>Strongly Agree</b>	38%	45%	31%
<b>Agree</b>	48%	48%	55%
<b>Disagree</b>	10%	7%	14%
<b>Strongly Disagree</b>	3%	0%	0%

- ✓ EHR adoption is increasing, at least among medical groups of four or more in the Puget Sound region
- ✓ A majority of medical groups work to increase access to their clinics via open scheduling, extended hours and walk-in appointments
- ✓ Practices are likely to focus on understanding and addressing language barriers
- ✓ Many groups report using a registry to help them manage the care of patients with diabetes
- ✓ Most medical groups report having some mechanism for measuring patient satisfaction and agree that they use results to improve care

- ✓ Collection of patient self-reported data on race, ethnicity and language AND use of this information to understand disparities and target improvements
- ✓ Use of secure email and scheduled phone appointments to improve ease of communication
- ✓ Enabling patients to access their information electronically (e.g., labs, medications)
- ✓ Use of patient registries for chronic conditions other than diabetes (depression, CAD, asthma, COPD, CHF)
- ✓ Routine use of patient reminders (for follow-up care, lab work, etc), after-visit summaries and written care plans
- ✓ Dedicated care coordination embedded in the care team, with ability to share information with the hospital
- ✓ Focus on patient experience (rather than satisfaction) and functional status

Thank you!

Susie Dade

Director, Performance Improvement

Puget Sound Health Alliance

206-448-2570, ext. 116

[sdade@pugetsoundhealthalliance.org](mailto:sdade@pugetsoundhealthalliance.org)

Peter McGough, MD

Chair, Alliance Quality Improvement Committee