



Results for Medical Groups

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

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

Interpreting the Results.

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

- **July 2009 results not directly comparable to November 2008 results.** The results in this report reflect three additional data suppliers and are therefore not directly comparable to results in the November 2008 report¹. This Community Checkup report includes a special section comparing results across time periods based on a separate analysis that applied the same specifications to the same data suppliers across both time periods.
- **Results presented by payer population.** The results in this report and on the website are presented by population—patients with commercial insurance and patients covered through the Medicaid program. Several factors likely to impact the commercially-insured and Medicaid populations differently are described below.

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

- o **Commercially-insured population.** Data for the commercially-insured population represent information on care provided to individuals and their dependents in King, Kitsap, Pierce, Snohomish and Thurston counties who have at least one working member of the household who receives health care coverage through his or her employer. Commercially-insured individuals have health care coverage with a variety of benefit designs, such as health maintenance organizations (HMOs), traditional indemnity insurance, preferred provider plans, health savings accounts and high deductible plans.

- o **Medicaid population.** Medicaid is a program funded through the federal and state government that provides health insurance for low-income residents. In 2008, approximately 860,000 citizens depended on Medicaid for their health care coverage in Washington state. Medicaid/SCHIP generally covers all children in families with income up to 300 percent of the Federal Poverty Level (in 2008 the Federal Poverty Level for a family of four was income of \$21,200 per year). Populations covered by Medicaid include low-income families, children, pregnant women, and the elderly and disabled. Medicaid clients receive services through two types of programs: Medicaid managed care or Medicaid fee-for-service (FFS). Medicaid managed care primarily covers low-income families, pregnant women and children while Medicaid FFS primarily covers low-income elderly and disabled clients. The Medicaid population also displays greater racial and ethnic diversity than the general population. Based on 2007 data from the Washington State Department of Social and Health Services, whites are underrepresented and every other racial group is overrepresented within the Medicaid population when compared to the statewide population.

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

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

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

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

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

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

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

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

Prevention: Effectively Screening for Disease

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

- Breast cancer is the most frequently diagnosed cancer and the second leading cause of cancer death among Washington women – 5,401 new diagnoses and 791 deaths reported in 2005²
- In 2005, 63 women in Washington state died from invasive cervical cancer, which is often preventable with regular screening³
- Chlamydia is the most commonly reported sexually transmitted infection with 317 cases per 100,000 persons in 2008 in Washington⁴
- Colorectal cancer is the third most common cancer in Washington state with 2,776 cases diagnosed in 2004 and 942 people dying from colorectal cancer in 2005⁵

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

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

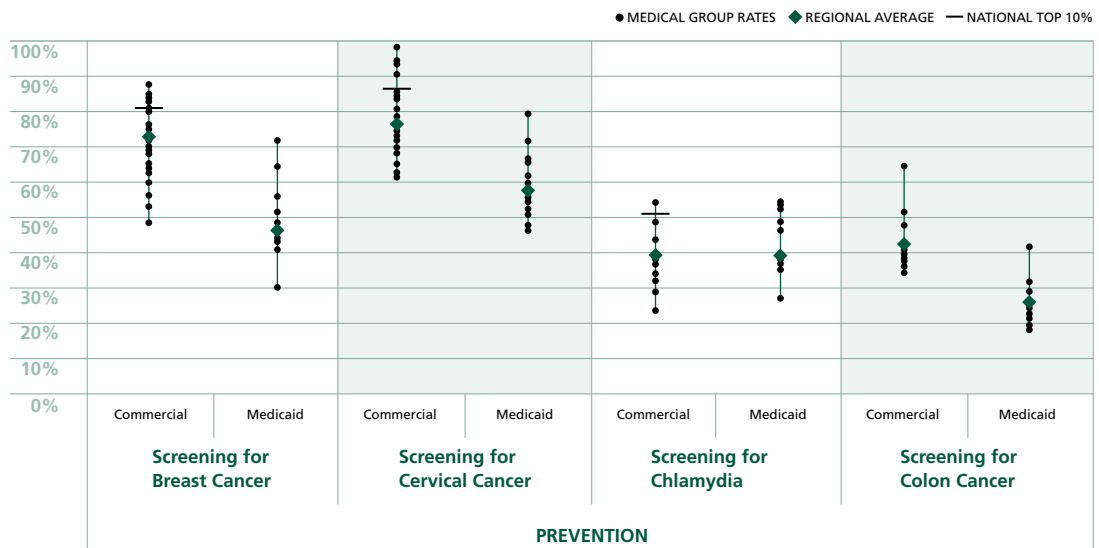
⁴ Washington State Department of Health, STI Fast Facts, 2008, available from <http://www.doh.wa.gov>; Internet; accessed 22 June 2009.

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

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

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

Preventive Care: Commercial and Medicaid Results



What is Measured?

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

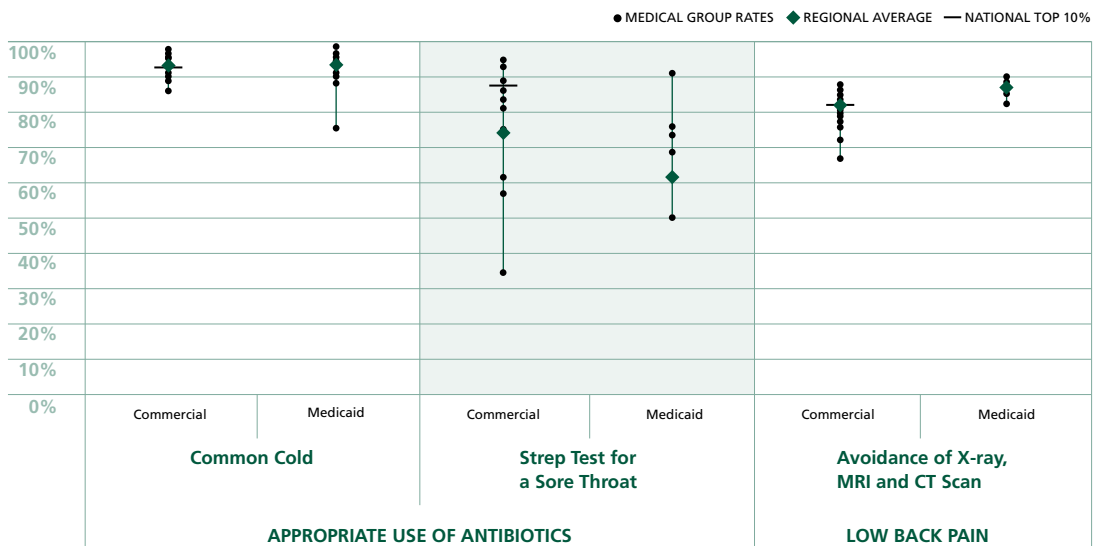
The graph shows the regional average is higher on screenings for breast and cervical cancer and lower on screenings for chlamydia and colon cancer within each population. For three of the prevention measures, the results for the commercial population are higher than the result for the Medicaid population.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

Appropriate Use of Services: Antibiotics and Imaging

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

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

Appropriate Use of Services: Commercial and Medicaid Results



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

What is Measured?

Appropriate Use of Antibiotics – Common Cold

The percentage of children ages 18 months to 18 years who went to the doctor for a common cold who were not prescribed an antibiotic for three days after the diagnosis.

Appropriate Use of Antibiotics – Strep Test for a Sore Throat

The percentage of children ages 2 to 18 who visited a doctor for a sore throat who received a “strep” test (group A streptococcus) before being prescribed an antibiotic.

Low Back Pain – Avoidance of X-ray, MRI and CT Scan

The percentage of patients ages 18 to 50 with a new diagnosis of low back pain who did not have an X-ray or other imaging study (MRI, CT scan) in the 28 days after they first visited a health care provider due to low back pain.

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

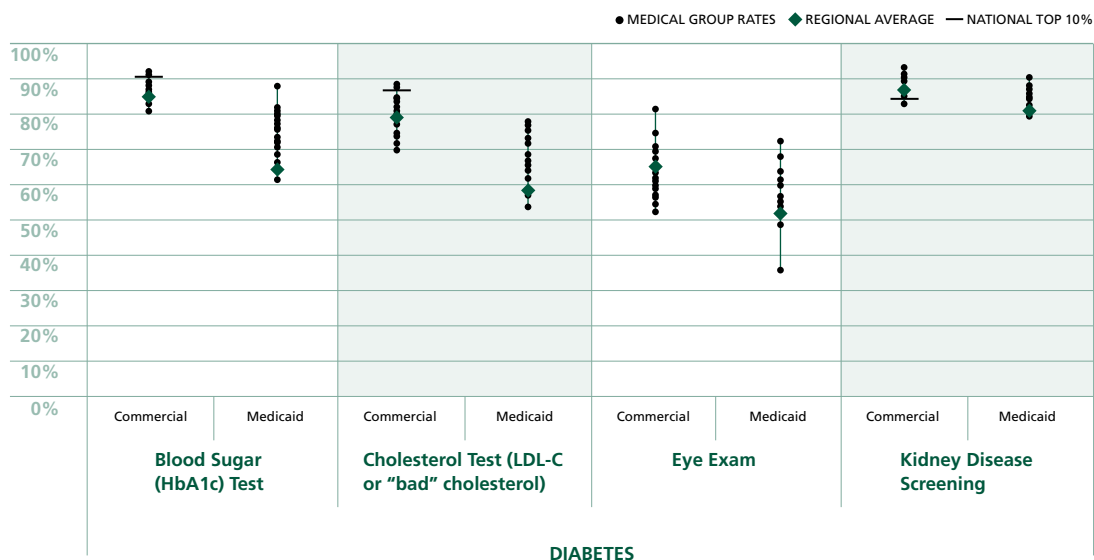
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Care For Patients Who Have Diabetes

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

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

Diabetes Care: Commercial and Medicaid Results



What is Measured?

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

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

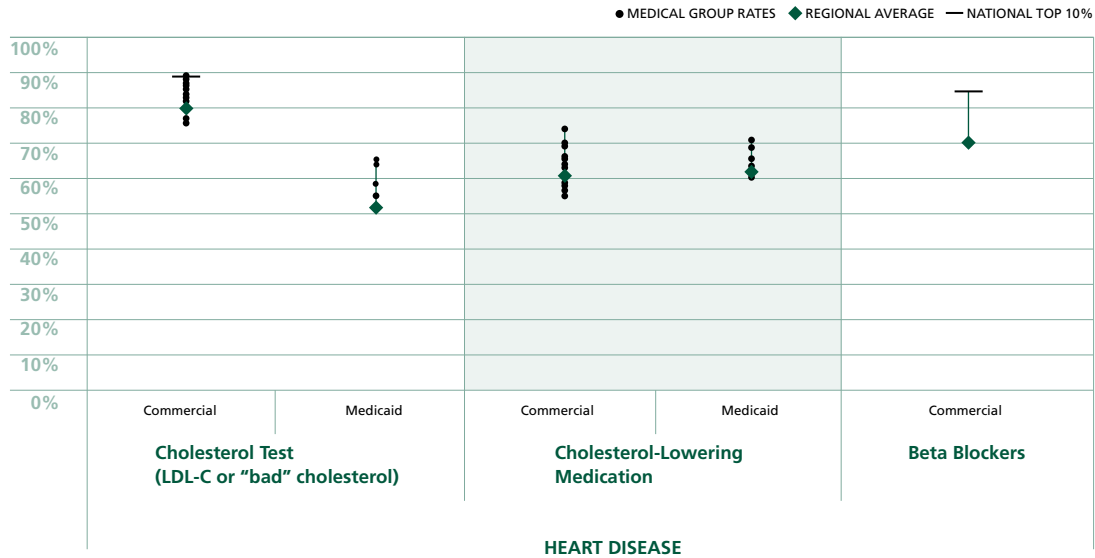
Care For Patients Who Have Heart Disease

Heart disease refers to conditions that affect the heart's ability to pump blood. The measures in our report focus on coronary artery disease (CAD) and stroke which are the second and third leading causes of death in Washington state. Together they accounted for almost 11,000 deaths in 2005 in Washington state⁷. CAD, also called coronary heart disease (CHD), involves the narrowing of blood vessels that supply blood to the organs and tissues, including the heart. Our collective goal is to help people who have heart disease keep their condition from getting worse. The keys to this effort are to monitor cholesterol levels and effectively manage patients' cholesterol and blood pressure levels.

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

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

Heart Disease Care: Commercial and Medicaid Results



What is Measured?

Heart Disease – Cholesterol Test

The percentage of patients ages 18 to 75 who had at least one LDL cholesterol screening test in the year after they were discharged from the hospital for heart attack, coronary artery bypass graft, percutaneous transluminal coronary angioplasty (PTCA), stroke or aneurysm.

Heart Disease – Cholesterol-Lowering Medication

The percentage of patients ages 18 to 75 who have heart disease who had at least one prescription filled to lower cholesterol during the one-year measurement period.

Heart Disease – Beta Blockers

The percentage of patients with a diagnosis of heart attack (acute myocardial infarction) that filled a prescription for beta blocker drugs (to improve the heart's ability to pump) for six month after being released from the hospital.

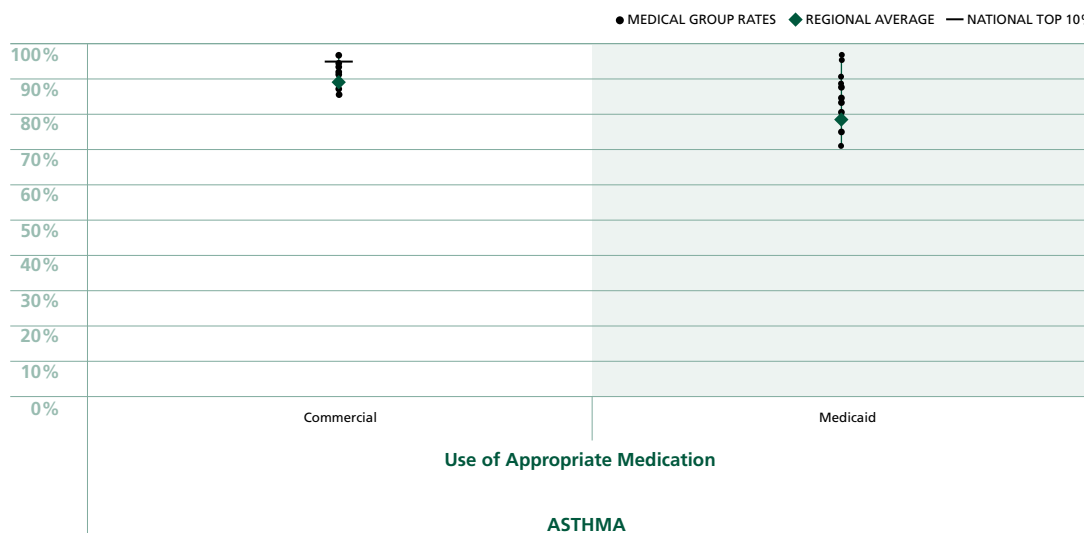
As shown in the graph, the region performs higher on cholesterol test for the commercial population compared to the Medicaid population. Because of low numbers of patients per medical group, the beta blocker measure is reported at the regional level only. For cholesterol-lowering medication for the Medicaid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

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

Care For Patients Who Have Asthma

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

Asthma Care: Commercial and Medicaid Results



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

What is Measured?

Asthma – Use of
Appropriate Medication

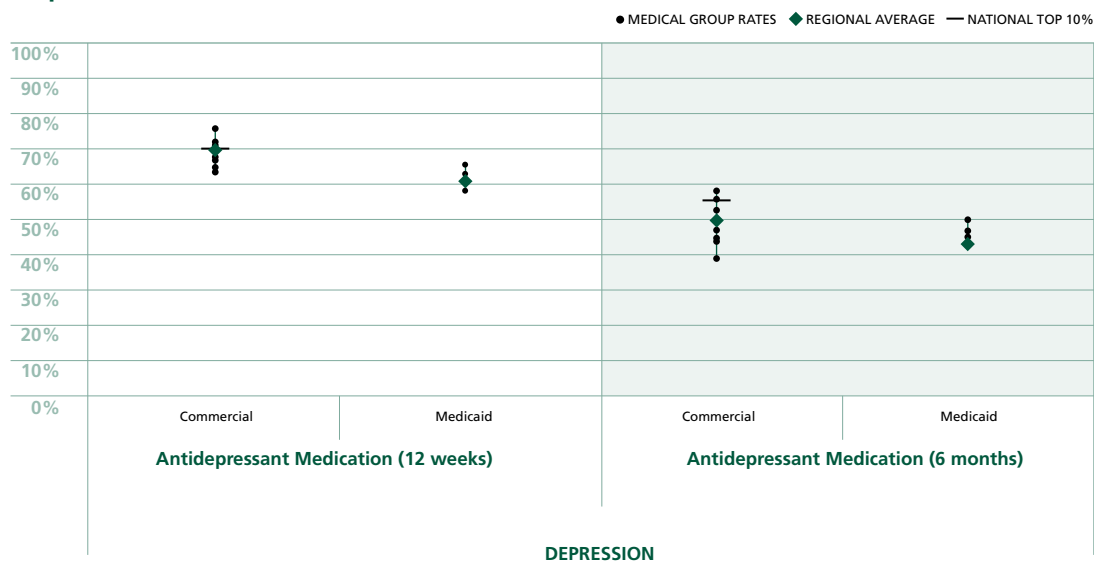
The percentage of patients ages 5 to 56 identified as having persistent asthma and who filled a prescription for long-term controller medication during the measurement year.

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

Care For Patients Who Have Depression

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

Depression Care: Commercial and Medicaid Results



What is Measured?

Depression –
Antidepressant
Medication
(12 weeks)

The percentage of patients age 18 and older who were newly diagnosed with depression and prescribed an antidepressant and remained on an antidepressant for 12 weeks after the diagnosis.

Depression –
Antidepressant
Medication
(6 months)

The percentage of patients age 18 and older who were newly diagnosed with depression and prescribed an antidepressant and continued taking an antidepressant for at least 180 days (6 months) after the diagnosis.

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

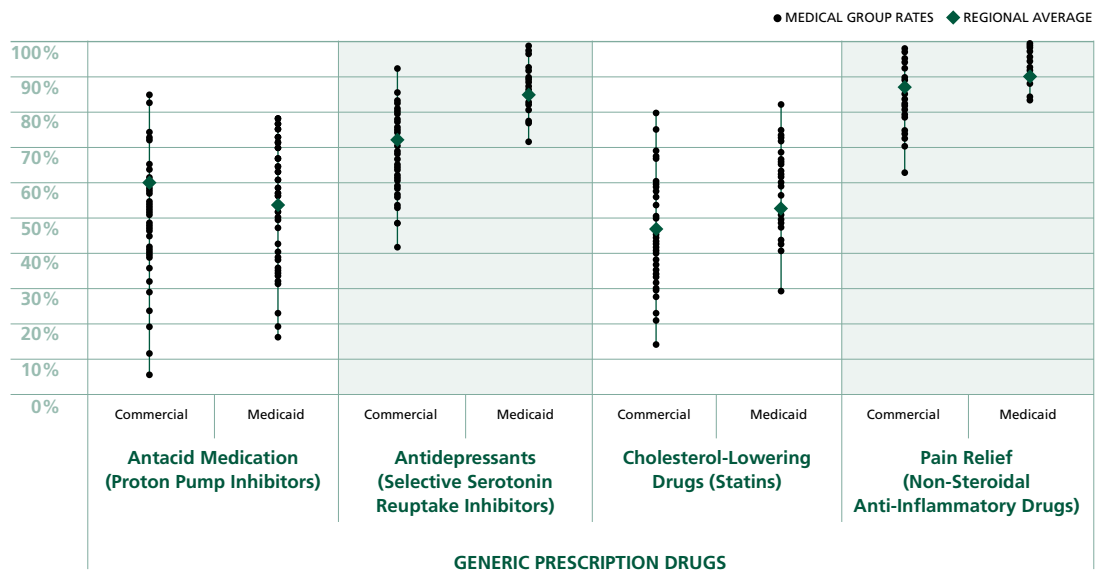
patients with depression. The Medicaid medical group results for the six month measure cluster above the regional average, indicating that a number of medical groups that did not meet thresholds for public reporting had lower rates.

Use of Generic Prescription Drugs

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

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

Use of Generic Drugs: Commercial and Medicaid Results



What is Measured?

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

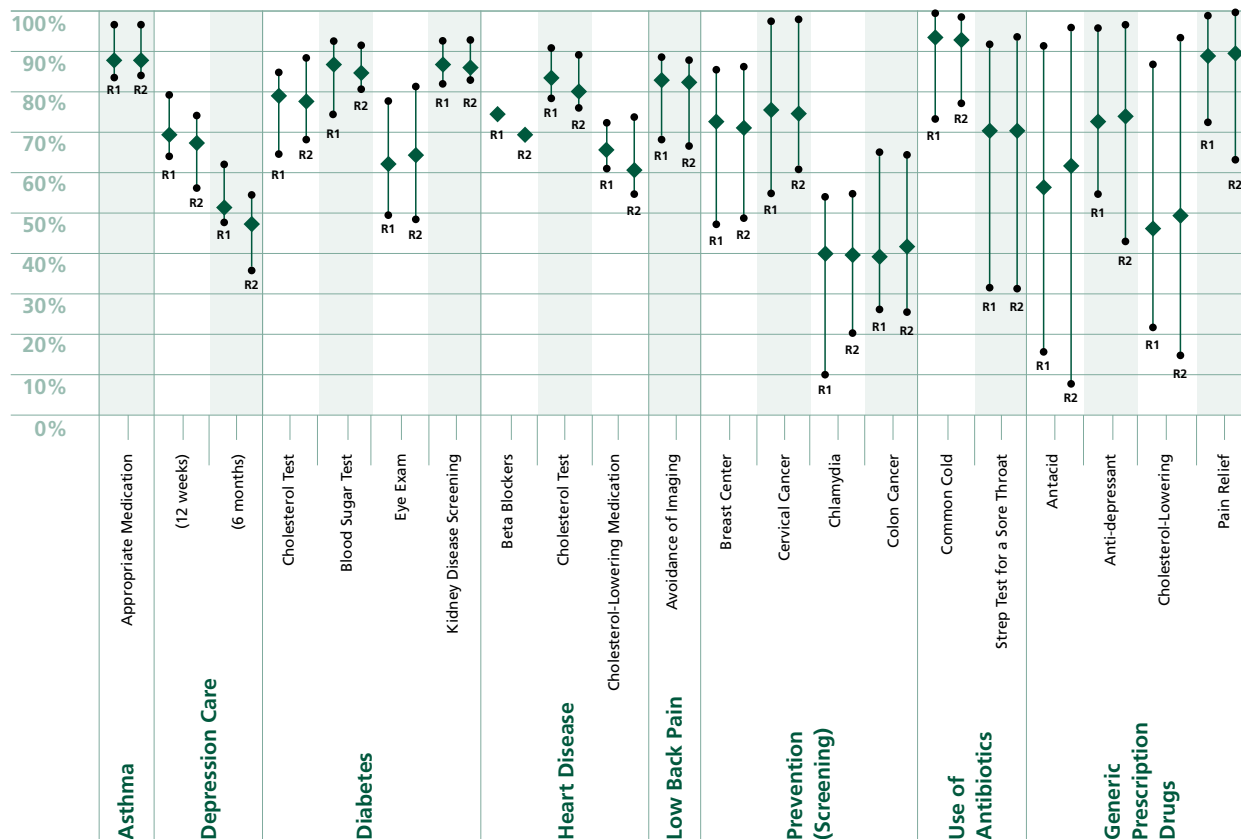
National benchmark data are not available for these measures. As shown in the graph, the region performs higher on the prescribing of generic antidepressants and pain relief than antacid medication and cholesterol-lowering drugs. More striking however, is the substantial variability across all of the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

Changes in Results Over Time

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

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

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



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

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

Results for New Measures

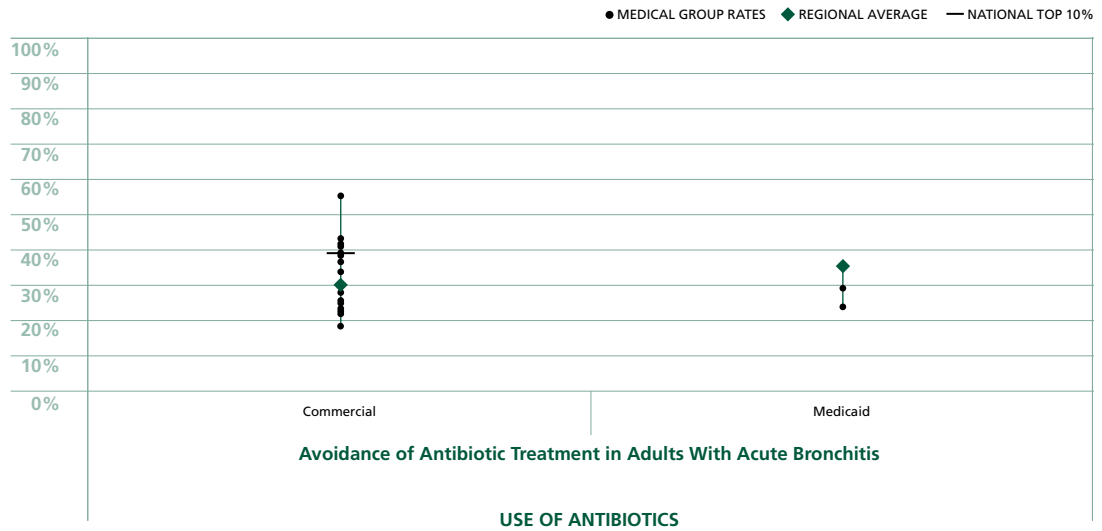
One way that the Alliance seeks to improve the Community Checkup over time is by continuing to expand the set of measures included in the report. This report introduces three new measures of care – one measure assessing appropriate antibiotic use in adults and two measures of access to preventive care.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

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis.

This measure looks at inappropriate antibiotic prescribing in adults. Antibiotics are not recommended in clinical guidelines for treating adults with acute bronchitis who do not have another condition or other infection for which antibiotics may be appropriate. Because misuse and overuse of antibiotics lead to antibiotic drug resistance, inappropriate use of antibiotics is of clinical concern to the community. Acute bronchitis consistently ranks among the ten conditions that account for the most ambulatory office visits to physicians in the United States. Despite the fact that a great majority of acute bronchitis cases have a nonbacterial cause (greater than 90%), antibiotics are prescribed 65 percent to 80 percent of the time⁹. Our collective goal is to ensure appropriate use of antibiotics and reduce or eliminate inappropriate use.

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

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



What is Measured?

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

The percentage of adults age 18 to 64 diagnosed with acute bronchitis who were not dispensed an antibiotic prescription.

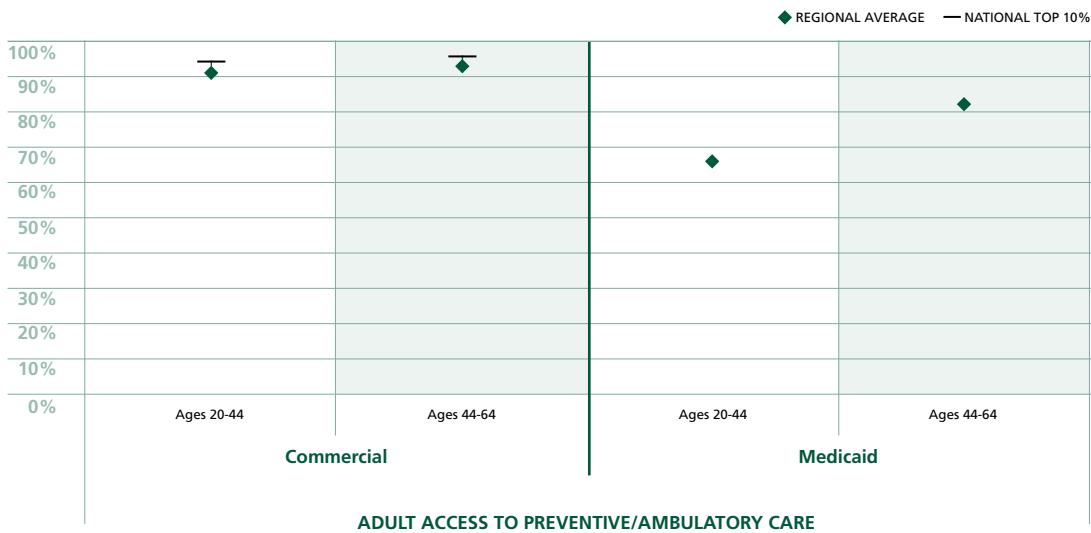
As displayed in the graph, there is substantial variability among medical groups on this measure – performance for the commercial population ranges from about 19 to 55 percent. For the Medicaid population, two groups had results below the regional average, indicating higher performance among medical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

Access to Care.

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

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

Adult Access to Care: Commercial & Medicaid Results



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

What is Measured?

Adults' Access to Preventive Health Services - Commercial

The percentage of commercially insured adults 20 years and older who had a preventive care visit within the past three years.

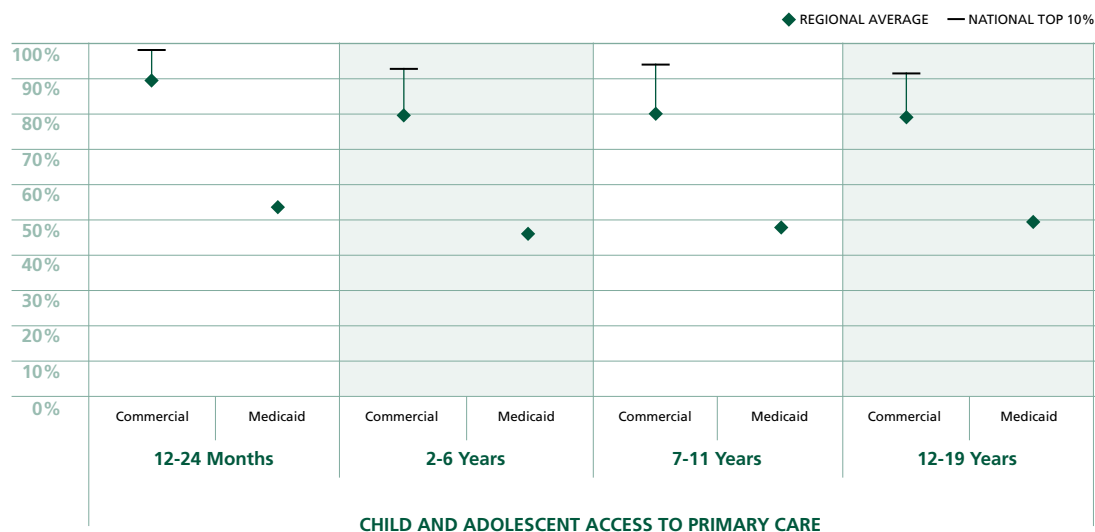
Adults' Access to Preventive/Ambulatory Health Services - Medicaid

The percentage of Medicaid insured adults 20 years and older who had a preventive care visit within the past year.

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

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

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



What is Measured?

Children’s Access to Primary Care Practitioners – 12-24 months and 25 months to 6 years

The percentage of children 12-24 months and 25 months- 6 years who had a visit with a primary care practitioner in the past year.

Children’s Access to Primary Care Practitioners – 7-11 years

The percentage of children 7–11 years who had a visit with a primary care practitioner in the past two years.

Adolescent’s Access to Primary Care Practitioners – 12-19 years

The percentage of adolescents 12-19 years who had a visit with a primary care practitioner in the past two years.

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

Data Sources and Methods

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

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

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

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

1. **Data validation** – Milliman Inc. (the Alliance’s data vendor) worked with each data supplier to validate the data submitted. There were two levels of validation – one that ensured the correct transmission of the data and another that ensured measure results were consistent between Milliman and each data supplier. Once the data were validated, they were aggregated and de-identified for measure calculation.
2. **Medical group roster update** – The Alliance worked with medical groups to update their lists of physicians and other practitioners using OneHealthPort, an organization that uses secure portal technology for the exchange of business and clinical information between health plans and providers. Because measure results were attributed first to practitioners and secondly to clinic location, it was vital to have accurate and current information about which doctors practice at which clinic locations.
3. **Measure calculation and attribution** – Milliman aggregated the data from all of the data suppliers and calculated measure results. During this process, measure results were attributed to practitioners. The Alliance then used the updated medical group rosters to attribute practitioners – and their results – to clinic locations.
4. **Medical group/clinic review** – Medical groups and their clinics received their draft measure results to review and benchmark against internal sources for a “reasonableness review.” The Alliance and Milliman worked with clinics to resolve any identified data issues.
5. **Patient verification** – To verify the project methodology, volunteer data suppliers and medical groups worked together directly to confirm that specific measure results reflected a given clinic’s patients. The data suppliers re-identified patients for medical groups who then verified that the particular patient met the measure criteria and received a particular service from a particular practitioner and clinic according to the measure specifications. Medical groups worked with the Alliance and Milliman to resolve any identified data issues.

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

