Partners HealthCare Primary Care
Quality and Patient Experience Reports 2017
Newton-Wellesley Physician Hospital Organization
Dear Patients, Colleagues and members of the Commonwealth of Massachusetts,

Partners HealthCare works hard every day to deliver high quality care to those who trust us with their health care needs. Over the years, it has been difficult to distinguish truly exceptional care from average care due to limited data to accurately describe the care we provide. Recently, Partners installed a single electronic medical record across our entire network of hospitals and outpatient clinics. This means we are now able to capture information on the thousands of patient interactions that occur every day in our system --- whether it be for preventive care in our primary care clinics or cutting edge care for the most complicated cases delivered in our academic medical centers. Our new electronic medical record now delivers real time data that truly and accurately describes the care and value that we provide. We are now using these data to identify shared best practices and areas for improvement. This represents a significant improvement over traditional methods of measuring quality that rely on administrative claims (billing) data that are often outdated and do not completely describe the nuances of patient care.

At Partners HealthCare, we are committed to transparency as a fundamental component of providing high quality, high value care. We have decided to share our data with you and hope that you find them informative to your care choices and subsequent conversations with your Partners physicians. We have begun our journey in transparency by focusing on care delivered across our network of primary care clinics. Here you will be able to see our performance in many areas that you will find familiar, such as preventive services and care for diabetes and high blood pressure.

I invite you to share your thoughts with us and hope you find this informative and valuable. Thank you as always, for entrusting your care to Partners and our 72,000 employees here to serve you.

Warm Regards,

Tom Sequist, MD
Chief Quality and Safety Officer
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**A Note on Chart Abbreviations**

- BWPO: Brigham and Women’s Physicians Organization
- MGPO: Massachusetts General Physicians Organization
- NSHS: North Shore Health System
- NWPHO: Newton-Wellesley Physician Hospital Organization
- PHS: Partners HealthCare System
CLINICAL MEASURES
Primary care is a significant part of the care we deliver at Partners HealthCare. Our performance on measures of quality in primary care is therefore an important gauge of how we are performing as a system. In this report, we present information on both cancer screening and management of chronic illnesses including diabetes and high blood pressure. The following graphs display information on Breast Cancer Screening, Cardiovascular Disease Lipid Control, Cervical Cancer Screening, Colorectal Cancer Screening, Depression Screening, Diabetes Blood Pressure Screening, Diabetes Glycemic Control, Diabetes Lipid Control, and Hypertension Blood Pressure Control. Our electronic health record data allows for improved measurement in the following areas:

**Broader Population:** Traditional quality measurement reporting relies on administrative claims data from payers. This approach is limited to those patients with private (or “commercial”) health insurance, which might be less than one-half of all patients. Our measures are based on the entire patient population, providing a more comprehensive and representative assessment of the care we provide.

**Better Disease Identification:** We are using the full spectrum of clinical information to identify chronic diseases like diabetes and high blood pressure, or to identify the nuances of screening exams such as those for colorectal cancer screening. This includes leveraging physical examination findings such as blood pressure, medication prescription information, and laboratory and pathology results. This provides a more accurate and detailed picture of our patients’ health care.

**Physician Judgment:** Our new measurement system allows providers to document when patients should not receive the standardly recommended care plan. While we work hard to develop accurate performance metrics, we continue to rely on physician judgment to improve our measures. For example, a patient with metastatic cancer is not appropriate for colon cancer screening, even if they appear to be age-appropriate for such screening.

**Real Time Feedback for Providers:** Our measurement system allows physicians to view their quality scores in real time, which allows them to better engage and improve on their scores more rapidly. This is a vast improvement over traditional measurement approaches, which rely on administrative claims data that are often quite lagged in time.

**Measure Specific Details**

For the **wellness and screening measures** (e.g. depression, cancer screening, etc.), patients are included in the denominator because they are appropriate for screening based on age, gender, or if they have a Health Maintenance Modifier (a tool in Epic that allows clinicians to permanently modify an ongoing care-plan). A Health Maintenance Modifier can be used to add a patient who is outside of the usual screening criteria, but still needs to be screened (e.g. a 35-year-old woman who needs annual mammogram screening due to family history). For **disease-specific measures** (e.g. diabetes), patients are included in the denominator if they are indicated as having the disease on the list of patient problems in the EHR system, a billing diagnosis, or the patient encounter code in the last year indicates the condition, or the patient has a disease specific Health Maintenance Modifier.

**Permanent exclusions** allow our clinicians to identify patients for whom we are not actively managing their chronic disease or screening program. We remove these patients from the denominator. This includes patients who are deceased, no longer receiving care from one of our primary care physicians, or those incorrectly diagnosed with diabetes.

**Permanent exceptions** allow our clinicians to identify patients correctly diagnosed with a chronic disease, but for whom specific control measures may be temporarily not clinically appropriate. We count these patients as contributing positively to the numerator. This includes patients with a terminal illness, advanced dementia, or those who have a medical history making them no longer a candidate for a particular screening or condition. The exceptions are described more specifically in the measure description for each measure.

**Temporary exceptions** allow our clinicians to identify patients correctly diagnosed with a chronic disease, but for whom specific control measures may be temporarily not clinically appropriate. We count these patients as contributing positively to the numerator for 12 months following this designation. This includes patients who have a competing comorbidity, are compliant with maximum tolerated therapy, are intolerant to medical therapy or have a contraindication, are declining medication, or are not able to afford medication.
Breast Cancer Screening

What are we measuring and why?
Breast cancer is second only to lung cancer as a cause of cancer death in women. Breast cancer screening is an important method of preventing breast cancer death. This measure shows the percent of eligible patients screened for breast cancer.

How does this measure differ from traditional metrics that rely on claims (billing) data?
We use our electronic health record (EHR) to identify women at either average risk or high risk for breast cancer, such as those with a family history of breast cancer. We measure appropriate screening rates based on screening intervals determined by the patient risk status.

What is our approach to managing quality for such large populations of patients?
We are using our EHR to collect health information in standardized ‘registries’ (patient lists) to track prevention services for patients. These “wellness registries” group patients by age, which helps clinicians to identify and track which patients need prevention services, such as cancer or depression screenings. We also have population health coordinators that work with our clinical care teams to review the data from the registries regularly and outreach to patients to schedule appointments, conduct follow-ups for prevention services, or help the care team promote better health.

Measure Details:
We have improved our breast cancer screening metric by 1) allowing customization of more aggressive screening age and interval for patients at high risk for breast cancer, 2) allowing our physicians to identify patients as not a candidate for breast cancer screening, and 3) allowing our physicians to document mammogram results from outside of our system.

Denominator: Women who are 50-74 years of age or women of any age who have been flagged by the physician using the EHR registry tool as a candidate for breast cancer screening.

Numerator: The number of patients with either 1) a mammogram in the last 2 years or 2) a mammogram in the last 1 year if they are identified in the EHR by the physician as requiring annual mammograms.

Exceptions: Permanent standard exceptions apply (see page 5) including:

• Not a candidate for mammograms
• Not a candidate for breast cancer screening
• Anatomically not applicable (e.g. has a history of bilateral mastectomy or right and left unilateral mastectomy)

<table>
<thead>
<tr>
<th>Year</th>
<th>BWPO</th>
<th>MGPO</th>
<th>NSHS</th>
<th>NWPHO</th>
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<td>27,721</td>
<td>128,183</td>
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Footnote: *2016 data for North Shore Health System and Newton-Wellesley Physician Hospital Organization could not be collected until they upgraded to Partners’ new electronic medical record. Data period: 8/13/15 – 8/12/16 and 7/31/16-7/30/17

[Graph showing % Eligible Patients Screened for 2016 and 2017 for BWPO, MGPO, NSHS, NWPHO, and PHS Average]
What are we measuring and why?
Controlling high lipid levels will save lives by preventing the complications of cardiovascular disease. This measure shows the percentage of patients with cardiovascular disease who have their lipids under control based on LDL cholesterol level or use of appropriate lipid-lowering medication (statins).

How does this measure differ from traditional metrics that rely on claims (billing) data?
We use electronic health record (EHR) data that 1) improves our identification of patients with cardiovascular disease using information entered by clinicians into the patient problem list and individual office encounters; and 2) accounts for whether patients are treated with the appropriate dose of statin medications.

What is our approach to managing quality for such large populations of patients?
We are using our EHR to collect health information in standardized ‘registries’ (patient lists) that track blood pressure readings, lab results, and procedures all in a single location for an entire population of patients. We have population health coordinators that work with our clinical teams to review the data from the registries regularly and outreach to patients who would benefit from updated lab testing, procedures, blood pressure monitoring, or medication therapy.

Measure Details:
We have improved our cardiovascular disease lipid control measure by 1) including all adults 18 years and older with cardiovascular disease (not excluding younger women with heart disease); 2) allowing physicians to document lipid results from outside of our system; and 3) accounting for whether a patient is already being treated with maximal medication therapy.

**Denominator:** Adult patients (age≥18 years) diagnosed with cardiovascular disease defined as 1) a diagnosis present on the electronic problem list, or 2) a clinician-entered diagnosis during an office visit in the most recent 12 months, or 3) presence of a billing diagnosis (claims data) in the last 12 months.

**Numerator:** The number of patients with 1) a LDL cholesterol level less than 100 mg/dL measured in the last 12 months OR 2) a prescription for a High Dose of a Statin medication.

**Exceptions:** All standard permanent and temporary exceptions apply (see page 5).
Cervical Cancer Screening

What are we measuring and why?
Cervical cancer is an important cause of morbidity and mortality among women. Cervical cancer screening is an important method of preventing cervical cancer death. This measure shows the percent of eligible patients screened for cervical cancer.

How does this measure differ from traditional metrics that rely on claims (billing) data?
We use our electronic health record (EHR) to identify women at either average risk or high risk for cervical cancer, such as those with prior abnormal screening results. We measure appropriate screening rates based on screening intervals determined by the patient risk status.

What is our approach to managing quality for such large populations of patients?
We are using our EHR to collect health information in standardized ‘registries’ (patient lists) to track prevention services for patients. These “wellness registries” group patients by age, which helps clinicians to identify and track which patients need prevention services, such as a Pap smear or HPV test, or other screening tests. We also have population health coordinators that work with our clinical care teams to review the data from the registries regularly and outreach to patients to schedule appointments, conduct follow-ups for prevention services, or help the care team promote better health.

Measure Details:
We have improved our cervical cancer screening metric by 1) allowing customization of more aggressive screening age and interval for patients at high risk for cervical cancer, 2) allowing our physicians to identify patients as not a candidate for cervical cancer screening, and 3) allowing our physicians to document screening results from outside of our system.

Denominator: Women who are 21-64 years of age or women of any age who have been flagged by the physician using the EHR registry tool as a candidate for cervical cancer screening.

Numerator: The number of patients with either 1) a Pap smear in the last 3 years or 2) a Pap smear in the last 1, 2, or 5 years if they are identified in the EHR by the physician as requiring a modified screening interval based on risk status such as HPV screening results.

Exceptions: Permanent standard exceptions apply (see page 5) including:
- Not a candidate for cervical cancer screening
- Anatomically not applicable (e.g. history of total hysterectomy)

<table>
<thead>
<tr>
<th>Year</th>
<th>BWPO</th>
<th>MGPO</th>
<th>NSHS</th>
<th>NWPHO</th>
<th>PHS average</th>
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<tr>
<td>2016</td>
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<td>84,083</td>
<td>Not Available*</td>
<td>Not Available*</td>
<td>71%</td>
</tr>
<tr>
<td>2017</td>
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<td>78,090</td>
<td>35,609</td>
<td>47,802</td>
<td>230,441</td>
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</table>

Footnote: *2016 data for North Shore Health System and Newton-Wellesley Physician Hospital Organization could not be collected until they upgraded to Partners’ new electronic medical record. Data period: 8/13/15 – 8/12/16 and 7/31/16-7/30/17
Colorectal Cancer Screening

**What are we measuring and why?**
Colorectal cancer is the second leading cause of cancer-related death. Colorectal cancer screening is an important method of preventing colorectal cancer death. This measure shows the percent of eligible patients screened for colorectal cancer.

**How does this measure differ from traditional metrics that rely on claims (billing) data?**
We use our electronic health record (EHR) to identify patients at either average risk or high risk for colorectal cancer, such as those with prior abnormal screening results or a family history of colorectal cancer. We measure appropriate screening rates based on screening intervals determined by the patient risk status.

**What is our approach to managing quality for such large populations of patients?**
We are using our EHR to collect health information in standardized ‘registries’ (patient lists) to track prevention services for patients. These “wellness registries” group patients by age, which helps clinicians to identify and track which patients need prevention services such as colorectal cancer screening. We also have population health coordinators that work with our clinical care teams to review the data from the registries regularly and outreach to patients to schedule appointments, conduct follow-ups for prevention services, or help the care team promote better health.

**Measure Details:**
We have improved our colorectal cancer screening metric by 1) allowing customization of more aggressive screening age and interval for patients at high risk for colorectal cancer, 2) allowing our physicians to identify patients as not a candidate for colorectal cancer screening, and 3) allowing our physicians to document screening results from outside of our system.

**Denominator:** Men and women who are 50-74 years of age OR men and women of any age who have been flagged by the physician using the EHR registry tool as a candidate for colorectal cancer screening.

**Numerator:** The number of patients with either 1) a colonoscopy or other colorectal cancer screening per the appropriate intervals below or 2) a colonoscopy at the customized frequency identified in the EHR by the physician based on patient risk status such as prior screening results or medical history.

- Colonoscopy within 10 years, OR
- DNA FIT within 3 years, OR
- Sigmoidoscopy within 5 years with Fecal Immunochemical Testing (FIT) co-testing within 3 years
- Fecal Occult Blood Testing (FOBT) or FIT (iFOBT) within 1 year, OR
- Virtual colonography within 5 years, OR

**Exceptions:** Permanent standard exceptions apply (see page 5) including:

- Not a candidate for colon cancer screening
- Anatomically not applicable (e.g. history of total colectomy)

**Footnote:** *2016 data for North Shore Health System and Newton-Wellesley Physician Hospital Organization could not be collected until they upgraded to Partners’ new electronic medical record. Data period: 8/13/15 – 8/12/16 and 7/31/16-7/30/17

<table>
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<tr>
<th>Year</th>
<th>BWPO</th>
<th>MGPO</th>
<th>NSHS</th>
<th>NWPHO</th>
<th>PHS average</th>
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<tr>
<td>2016</td>
<td>63,007</td>
<td>80,056</td>
<td>Not Available*</td>
<td>Not Available*</td>
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<td>2017</td>
<td>63,736</td>
<td>78,135</td>
<td>41,564</td>
<td>51,367</td>
<td>234,802</td>
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**Graph:**
- Percent Eligible Patients Screened: 2017
- BWPO: 63%
- MGPO: 69%
- NSHS: 68%
- NWPHO: 76%
- PHS Average: 65%

**Data period:**
- 2016: 8/13/15 – 8/12/16
- 2017: 7/31/16-7/30/17

**Total Eligible Patients**

- BWPO
- MGPO
- NSHS
- NWPHO
- PHS average

**Denominator:** Men and women who are 50-74 years of age OR men and women of any age who have been flagged by the physician using the EHR registry tool as a candidate for colorectal cancer screening.

**Numerator:** The number of patients with either 1) a colonoscopy or other colorectal cancer screening per the appropriate intervals below or 2) a colonoscopy at the customized frequency identified in the EHR by the physician based on patient risk status such as prior screening results or medical history.

- Colonoscopy within 10 years, OR
- DNA FIT within 3 years, OR
- Sigmoidoscopy within 5 years with Fecal Immunochemical Testing (FIT) co-testing within 3 years
- Fecal Occult Blood Testing (FOBT) or FIT (iFOBT) within 1 year, OR
- Virtual colonography within 5 years, OR

**Exceptions:** Permanent standard exceptions apply (see page 5) including:

- Not a candidate for colon cancer screening
- Anatomically not applicable (e.g. history of total colectomy)

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**PHS Average 2017:** 70%

**Graph:**
- Percent Eligible Patients Screened: 2017
- BWPO: 63%
- MGPO: 69%
- NSHS: 68%
- NWPHO: 76%
- PHS Average: 65%
Depression Screening

What are we measuring and why?
Major depression is one of the most common mental disorders in the United States and is associated with significant morbidity. This measure shows the percentage of eligible patients screened for depression.

How does this measure differ from traditional metrics that rely on claims (billing) data?
We use electronic health record (EHR) data to administer an annual depression screening tool for our entire patient population. This differs from the traditional metrics that rely on identifying patients prescribed an anti-depressant medication rather than our focus on patient reported symptoms.

What is our approach to managing quality for such large populations of patients?
We are using our EHR to collect health information in standardized ‘registries’ (patient lists) to track prevention services for patients. These “wellness registries” group patients by age, which helps clinicians to identify and track which patients need prevention services. We also have population health coordinators that work with our clinical care teams to review the data from the registries regularly and outreach to patients to schedule appointments, conduct follow-ups for prevention services, or help the care team promote better health.

Measure Details:
We have improved our depression screening metric by implementing a standardized survey to identify the presence of depression among our entire adult patient population, regardless of the presence of treatment with an anti-depressant medication.

Denominator: All patients 18 years and older with a Partners primary care physician.

Numerator: The number of patients with a recorded PHQ2 or PHQ9 survey completed within the past 12 months.

Exceptions: None.

Footnote: *2016 data for North Shore Health System and Newton-Wellesley Physician Hospital Organization could not be collected until they upgraded to Partners’ new electronic medical record. *Data period: 11/1/15 – 10/31/16 and 5/1/16-4/30/17 with the exception of NSHS which was measured 1/1/16-12/31/16 (* differs from other clinical measures)

### Total Eligible Patients

<table>
<thead>
<tr>
<th>Year</th>
<th>BWPO</th>
<th>MGPO</th>
<th>NSHS</th>
<th>NWPHO</th>
<th>PHS average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
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<td>68,491</td>
<td>Not Available*</td>
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<td>Not Available*</td>
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<tr>
<td>2017</td>
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<td>178,424</td>
<td>27,060</td>
<td>118,706</td>
<td>464,314</td>
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What are we measuring and why?
Controlling high blood pressure ("hypertension") will save lives by preventing the complications of heart disease. This measure shows the percentage of eligible patients diagnosed with diabetes whose most recent blood pressure reading occurred within the past 6 months and is well controlled.

How does this measure differ from traditional metrics that rely on claims (billing) data?
We use electronic health record (EHR) data that 1) improves our identification of patients with diabetes using information entered by clinicians into the patient problem list and individual office encounters; and 2) captures additional details regarding the results of blood pressure readings over time and across different settings (including home blood pressure readings).

What is our approach to managing quality for such large populations of patients?
We are using our EHR to collect health information in standardized ‘registries’ (patient lists) that track blood pressure readings, lab results, and procedures all in a single location for an entire population of patients. We have population health coordinators that work with our clinical teams to review the data from the registries regularly and outreach to patients who would benefit from updated lab testing, procedures, blood pressure monitoring, or medication therapy.

Measure Details:
We have improved our diabetes blood pressure control metric by accounting for patient age (where risk/benefit assessments of aggressive blood pressure control are needed), including all adults over 18 years old (not excluding the elderly over 75 years old), and accounting for whether the patient is already on maximum medication therapy.

Denominator: Adult patients (age ≥18 years) with diabetes defined as 1) a diagnosis present on the electronic problem list, or 2) a clinician-entered diagnosis during an office visit in the most recent 12 months, or 3) presence of a billing diagnosis (claims data) in the last 12 months, or 4) the patient has been flagged by the physician as having a diagnosis of diabetes using the EHR registry tool.

Numerator: The number of adult patients with diabetes and a recorded blood pressure reading in the most recent six months AND either 1) the most recent blood pressure reading meets the blood pressure goal, OR 2) the average of the most recent 3 blood pressure readings within the last 18 months meets the blood pressure goals as defined below:
- Age < 60 years, blood pressure ≤140/90 mmHg
- Age ≥ 60 years, diastolic blood pressure < 70 mmHg
- Prescribed three or more anti-hypertensive medications from three different drug classes (regardless of blood pressure readings)

Exceptions: All standard permanent and temporary exceptions apply (see page 5).
Diabetes Glycemic Control

What are we measuring and why?
Diabetes can lead to harmful effects on blood vessels and nerves if the blood sugar is not well controlled, causing kidney disease and contributing to vision loss. These complications can be prevented by controlling the blood sugar. This measure shows the percentage of patients with diabetes whose blood sugar is under control based on Hemoglobin A1c (HbA1c) level.

How does this measure differ from traditional metrics that rely on claims (billing) data?
We use electronic health record (EHR) data that 1) improves our identification of patients with diabetes using information entered by clinicians into the patient problem list and individual office encounters; and 2) requires a more recent (prior 6 months) measurement of HbA1c level.

What is our approach to managing quality for such large populations of patients?
We are using our EHR to collect health information in standardized ‘registries’ (patient lists) that track blood pressure readings, lab results, and procedures all in a single location for an entire population of patients. We have population health coordinators that work with our clinical teams to review the data from the registries regularly and outreach to patients who would benefit from updated lab testing, procedures, blood pressure monitoring, or medication therapy.

Measure Details:
We have improved our diabetes glycemic control measure by 1) requiring the HbA1c to be measured in the last 6 months as opposed to the 12 month timeframe seen in traditional measures, 2) including all adults over 18 years old (not excluding the elderly over 75 years old), and 3) allowing physicians to document HbA1c results from outside of our system.

Denominator: Adult patients (age≥18 years) with diabetes defined as 1) a diagnosis present on the electronic problem list, or 2) a clinician-entered diagnosis during an office visit in the most recent 12 months, or 3) presence of a billing diagnosis (claims data) in the last 12 months, or 4) the patient has been flagged by the physician as having a diagnosis of diabetes using the EHR registry tool.

Numerator: The number of adult patients with diabetes with a HbA1c level less than or equal to 9% measured in the last 6 months.

Exceptions: All standard permanent and temporary exceptions apply (see page 5).
What are we measuring and why?
Controlling high lipid levels will save lives by preventing the complications of cardiovascular disease. This measure shows the percentage of patients with diabetes who have their lipids under control based on LDL cholesterol level or use of appropriate lipid-lowering medication (statins).

How does this measure differ from traditional metrics that rely on claims (billing) data?
We use electronic health record (EHR) data that 1) improves our identification of patients with diabetes using information entered by clinicians into the patient problem list and individual office encounters; and 2) accounts for whether patients are treated with the appropriate dose of statin medications.

What is our approach to managing quality for such large populations of patients?
We are using our EHR to collect health information in standardized ‘registries’ (patient lists) that track blood pressure readings, lab results, and procedures all in a single location for an entire population of patients. We have population health coordinators that work with our clinical teams to review the data from the registries regularly and outreach to patients who would benefit from updated lab testing, procedures, blood pressure monitoring, or medication therapy.

Measure Details:
We have improved our diabetes lipid control measure by 1) including all adults 18 years and older with diabetes (not excluding the elderly over 75 years old); 2) allowing physicians to document lipid results from outside of our system, and 3) accounting for whether a patient is already being treated with maximal medication therapy.

### Denominator:
Adult patients (age≥18 years) with diabetes defined as 1) a diagnosis present on the electronic problem list, or 2) a clinician-entered diagnosis during an office visit in the most recent 12 months, or 3) presence of a billing diagnosis (claims data) in the last 12 months, or 4) the patient has been flagged by the physician as having a diagnosis of diabetes using the EHR registry tool.

### Numerator:
The number of patients with 1) a LDL cholesterol level less than 100 mg/dL measured in the last 12 months OR 2) a prescription for a Moderate or High Dose of a Statin medication.

### Exceptions:
All standard permanent and temporary exceptions apply (see page 5).

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### Total Eligible Patients

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<thead>
<tr>
<th>Year</th>
<th>BWPO</th>
<th>MGPO</th>
<th>NSHS</th>
<th>NWPHO</th>
<th>PHS average</th>
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Footnote: *2016 data for North Shore Health System and Newton-Wellesley Physician Hospital Organization could not be collected until they upgraded to Partners’ new electronic medical record. Data period: 8/13/15 - 8/12/16 and 7/31/16-7/30/17

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### Diabetes Lipid Control

<table>
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<tr>
<th>Year</th>
<th>BWPO</th>
<th>MGPO</th>
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<th>NWPHO</th>
<th>PHS Average 2017</th>
<th>% Eligible Patients Achieving Control</th>
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<td>2016</td>
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<td>78%</td>
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<td>76%</td>
<td>75%</td>
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<tr>
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<td>71%</td>
<td>72%</td>
<td>71%</td>
<td>67%</td>
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</table>

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Footnote: *2016 data for North Shore Health System and Newton-Wellesley Physician Hospital Organization could not be collected until they upgraded to Partners’ new electronic medical record. Data period: 8/13/15 – 8/12/16 and 7/31/16-7/30/17
High Blood Pressure Control

What are we measuring and why?
Controlling high blood pressure ("hypertension") will save lives by preventing the complications of heart disease. This measure shows the percentage of eligible patients diagnosed with high blood pressure whose most recent blood pressure reading occurred within the past 6 months and is well controlled.

How does this measure differ from traditional metrics that rely on claims (billing) data?
We use electronic health record (EHR) data that 1) improves our identification of patients with high blood pressure using information entered by clinicians into the patient problem list and individual office encounters; and 2) captures additional details regarding the results of blood pressure readings over time and across different settings (including home blood pressure readings).

What is our approach to managing quality for such large populations of patients?
We are using our EHR to collect health information in standardized ‘registries’ (patient lists) that track blood pressure readings, lab results, and procedures all in a single location for an entire population of patients. We have population health coordinators that work with our clinical teams to review the data from the registries regularly and outreach to patients who would benefit from updated lab testing, procedures, blood pressure monitoring, or medication therapy.

Measures Details
We have improved our high blood pressure metric by accounting for patient age (where risk/benefit assessments of aggressive blood pressure control are needed), presence of diabetes (where more aggressive blood control may be needed), and whether the patient is already on maximum medication therapy.

Footnote: *2016 data for North Shore Health System and Newton-Wellesley Physician Hospital Organization could not be collected until they upgraded to Partners' new electronic medical record. Data period: 8/13/15 – 8/12/16 and 7/31/16-7/30/17.

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Measures Details
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Denominator:
Adult patients (age ≥ 18 years) with high blood pressure defined as 1) a diagnosis present on the electronic problem list, or 2) a clinician-entered diagnosis during an office visit in the most recent 12 months, or 3) presence of a billing diagnosis (claims data) in the last 12 months.

Numerator:
The number of patients with a recorded blood pressure reading in the most recent six months AND either 1) the most recent blood pressure reading meets the blood pressure goal, OR 2) the average of the most recent 3 blood pressure readings within the last 18 months meets the blood pressure goals as defined below:

<table>
<thead>
<tr>
<th>Blood Pressure Readings</th>
<th>Diagnosis of Diabetes</th>
<th>No Diagnosis of Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 60 years</td>
<td>&lt; 140/90 mmHg</td>
<td>&lt; 140/90 mmHg</td>
</tr>
<tr>
<td>≥ 60 years</td>
<td>&lt; 150/90 mmHg or diastolic ≤ 70 mmHg</td>
<td>&lt; 140/90 mmHg or diastolic ≤ 70 mmHg</td>
</tr>
<tr>
<td>Any age, with or without diabetes</td>
<td>Prescribed 3 or more anti-hypertensive medications from 3 different drug classes (regardless of blood pressure readings)</td>
<td></td>
</tr>
</tbody>
</table>

Exceptions: All standard permanent and temporary exceptions apply (see page 5).
PATIENT EXPERIENCE MEASURES
The data presented in this section are taken from Massachusetts Health Quality Partner's (MHQP) 2016 Patient Experience Survey (PES). These data include patients with private (commercial) health insurance sampled from adult practice sites from Newton-Wellesley’s primary care centers with at least three primary care providers (PCPs). The survey asked patients to report about their experiences with a specifically named primary care provider and his or her practice.

The MHQP 2016 PES Instrument for adults is a 61 question tool based on the CAHPS® Patient Centered Medical Home (PCMH) Survey.

The measures included in this section are:

- How well do doctors communicate with patients;
- How well do doctors coordinate care;
- How well do doctors know their patients;
- How well do doctors flag mental/behavioral health issues;
- How timely are patients’ appointments, care, and information;
- How well do doctors support self-care management;
- What is the quality of the office staff;
- Patients’ willingness to recommend their provider to friends and family.
- Patients’ willingness to recommend their provider to friends and family.

To be eligible for surveying, patients had to meet the following criteria:

- Current enrollment in one of the five major commercial health plans in Massachusetts;
- Commercial member in an HMO, POS, or PPO health plan product;
- Age 18 and older;
- Patient of a Massachusetts primary care provider.

MHQP uses both visit data and health plan membership data to link patients to their primary care providers. Targeted sample sizes were designed to achieve results with very high site-level reliability. All survey responses are coded to a 0 to 100 scale so that questions with different response options may be easily combined. Higher values indicate more positive responses where “Always” equals 100%, “Usually” is 66.67%, “Sometimes” is 33.33%, and “Never” is 0%. Composites are calculated as a simple average of the response values for each of the component questions.
How Well Doctors Communicate with Patients

Why measuring how well doctors communicate with their patients is important
When doctors communicate well, patients are more likely to feel that they are well informed. Patients can also better understand the diagnosis, treatment, and how to care for themselves at home. When doctors are clear and honest in their communication, it can help patients stay healthy, or if sick, get better faster.

MHQP asks 6 questions to measure how well doctors communicate with patients:
- In the last 12 months, how often did your provider explain things in a way that was easy to understand?
- In the last 12 months, how often did your provider listen carefully to you?
- In the last 12 months, how often did your provider give easy to understand answers to your health questions?
- In the last 12 months, how often did your provider give you easy to understand information about what to do if your health problems got worse or came back?
- In the last 12 months, how often did your provider show respect for what you said?
- In the last 12 months, how often did your provider spend enough time with you?

What are we doing to improve?
Primary care practices are working to transform their environment to be more patient centered and gain recognition as a Patient Centered Medical Home. Key to this recognition is quality improvement projects focused on understanding patient feedback and innovating to improve those areas.
How Well Doctors Coordinate Care

Why measuring how well doctors coordinate care is important
Doctors play an important role in coordinating care for patients. This means knowing about the treatments or tests from specialists and any care received at other hospitals and doctors’ offices. Coordination of care helps make sure that patients are getting the right care, at the right time, without errors.

MHQP asks 2 questions to measure how well doctors and other healthcare providers coordinate care:
• In the last 12 months, how often did your provider seem informed and up-to-date about the care you received from specialists?
• In the last 12 months when your provider ordered a blood test, x-ray, or other test for you, how often did someone from his or her office follow-up to give you the test results?

What are we doing to improve?
We work with primary care practices to improve coordination of care across the entire spectrum of care. Patient Centered Medical Homes work to coordinate lab tests, imaging studies and referrals to specialists, ensuring that each is completed, reviewed and shared with the patient. Robust workflows are also in place to ensure ED visits and hospital admissions are known by and followed up on by care team members. We also implemented an eConsults program where primary care physicians can quickly reach out to specialists to get input on how to best manage the patient and determine if a referral is necessary and developed collaborative care agreements between primary care physicians and specialists to define clear roles and responsibilities regarding care coordination.
How Well Doctors Know Their Patients

Why measuring how well doctors know their patients is important
Doctors can give better quality care when they know as much as possible about their patients. This not only includes knowing about a patient’s medical history but also values and beliefs about treatment and care.

MHQP asks 2 questions to measure how well doctors know their patients:
- In the last 12 months, how often did your provider seem to know the important information about your medical history?
- How would you rate this provider’s knowledge about you as a person – special abilities, concerns, fears?

What are we doing to improve?
We work with primary care practices to develop individualized care plans for complex patients. Key to these care plans, in addition to the clinician’s goals for the patients, are the patient’s goals for themselves.
How Well do Doctors Pay Attention to Mental (Behavioral) Health Issues

### Why Measuring How Well Doctors Pay Attention to Mental (Behavioral) Health is Important
Mental health problems can happen when patients feel sad or anxious, are stressed by family or work concerns, or have problems with alcohol or drug use. Primary care doctors may be the only doctor a patient sees so it is important for primary care doctors to pay attention to a patient’s mental health and refer them to get help as needed.

### MHQP asks 3 questions to measure how well doctors pay attention to the mental health of their patients.
- In the last 12 months, did anyone in this provider’s office ask you if there was a period of time when you felt sad, empty, or depressed?
- In the last 12 months, did you and anyone in this provider’s office talk about things in your life that worry you or cause you stress?
- In the last 12 months, did you and anyone in this provider’s office talk about a personal problem, family problem, alcohol use, drug use, or a mental or emotional illness?

### What are we doing to improve?
Our primary care practices integrate behavioral health assessments and practitioners into the everyday care of the patient. We employ a team-based collaborative care model, which includes input from psychiatrists, social workers, and non-clinical behavioral health coordinators. Behavioral health support specialists collaborate with patients to ensure resources are identified that meet their needs.

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Why measuring access to care is important
Getting timely access to care is important for patients and includes making appointments, giving care, and answering patients’ questions in a timely way - when and how they need it.

MHQP asks 5 questions to measure how well doctor’s offices gave patients access to care in a timely way:
- When you called your provider’s office to make an appointment for care you needed right away, how often did you get this appointment as soon as you needed?
- When you made an appointment for a check-up or routine health care for you, how often did you get an appointment as soon as you needed?
- When you called your provider’s office with a medical question about yourself during office hours, how often did you get an answer on the same day?
- When you called your provider’s office with a medical question about yourself after office hours, how often did you get an answer as soon as you needed?
- How often did you see your doctor within 15 minutes of your appointment time?

What are we doing to improve?
In our work with primary care practices we help practices learn to monitor their own patient population and the kinds of access to care they need. We have several initiatives to ensure same-day access to urgent care and to make sure that both primary and specialty physicians have room to see new patients without long wait times. We also have made large investments in a patient portal that allows patients to email their provider and get a response usually the same day.
Why measuring how well doctors provide self-management support is important
Self-management support is when healthcare providers talk with patients (and maybe also the family) about goals for good health and ways to meet these goals. This includes choices patients have and actions they can take to get and stay healthy.

MHQP measures self-management support by asking patients two questions:
- In the last 12 months, did you and anyone in this provider’s office talk about specific goals for your health?
- In the last 12 months, did anyone in this provider’s office ask you if there are things that make it hard for you to take care of your health?

What are we doing to improve?
We work with primary care practices to provide tools and resources for staff and patients to help patients better care for themselves. This includes a range of resources such as care planning, assessment and tracking tools, and shared decision making materials. For example, we offer patients a range of multi-media tools and programs designed to engage patients in self-care that include short single-topic educational videos about various health care topics customized to their specific populations and online health coaching and texting programs for patients with chronic conditions such as diabetes, as well as comprehensive shared decision making materials.

Data Period: 1/1/14-12/31/14 and 1/1/15-12/31/15
Getting Quality Care from Staff in the Doctor's Office

Why measuring care and service from office staff is important
The doctors’ office staff can make a big difference in a patient's experience of care. Office staff includes those who answer the phone, greet patients as they arrive, make appointments, call with test results, and discuss insurance or billing questions. Office staff may also be the ones who weigh and measure patients or take their temperature, pulse, blood pressure, and other vital signs.

MHQP asks 2 questions to measure how well a doctor's office staff gave quality care and service:
• How often were office staff at your provider's office as helpful as you thought they should be?
• How often did office staff at your provider's office treat you with courtesy and respect?

What are we doing to improve?
We work with primary care practices to improve patient-centered activities and to streamline administrative and operational processes to be more efficient, patient-focused, and error free. The care team (clinicians and non-clinicians) is provided with relevant training to ensure patients have a positive and meaningful interaction both in the office and on the phone. Many practices include the entire care team in discussions related to improving the patient experience of care.
Why measuring patients’ willingness to recommend their doctor is important.
People often ask others for a recommendation when choosing a new doctor.

MHQP asks one question to measure patients’ willingness to recommend their doctor:
• Would you recommend this provider to your family and friends?

What are we doing to improve?
Patient Centered Medical Home is an approach focused on improving patient experience, access to care, and patient health outcomes. A major component also includes creating more efficient and streamlined processes to better coordinate care and ensure that our clinicians have the support they need to deliver high quality care. We take a well-rounded approach to meet the needs of our patients and our practices are in a constant cycle of evaluation and quality improvement initiatives to make sure we are always improving the care we deliver.
PRACTICE SNAPSHOTS
Measuring quality of primary care is not easy, but some measures like chronic disease management, preventive services, access to care, and communication, among others, are critical to providing important insights into the quality of care we deliver and how patients experience that care. In addition to the physician organization level comparison graphs, we believe it’s also important to provide feedback and be transparent at the practice level so that our practices can work towards improving their performance on these metrics. The following reports display “practice snapshots” for Newton-Wellesley Physician Hospital Organization, sharing quality and patient experience scores for our largest primary care practices.

These data are not representative of all primary care practices across the system – they are limited to practices that have implemented our new electronic health record (EHR) platform. In the long term we plan to include all hospitals and primary care practices across the Partners system, including our community affiliate practices.

A note on the designation “No Available Data (NAD)”

There are not enough data to report on this measure for this doctor's office. This can happen when:

- Not enough patients answered the questions about a doctor's office
- Not enough patients at a doctor’s office received care that could be included in measure results
- Not enough doctors in a doctor’s office gave care that could be included in measure results
Primary Care Quality Measures

Footnotes: All patient experience data from the period of 1/1/15 - 12/31/15

Patient Experience Scores are based on MHQP scoring system where yes or no questions are scored a 100 for yes or 0 for no. Multiple choice questions are scored according to favorability: 100 for always, 66.66 for usually, 33.33 for sometimes, 0 for never. © 2016 Massachusetts Health Quality Partners, Inc. (MHQP). MHQP data are proprietary and provided under license. All rights reserved. Some of MHQP’s data may have been regrouped by Partners Healthcare for reporting purposes.
Practice: Medical Associates of Greater Boston, P.C.

Patient Count: 6298

Primary Care Quality Measures

- Breast Cancer Screening: 74%
- CV Disease Lipid Control: 68%
- Cervical Cancer Screening: 58%
- Colorectal Cancer Screening: 62%
- Diabetes Glycemic Control: 79%
- Diabetes BP Control: 66%
- Depression Screening: 74%
- Hypertension BP Control: 77%
- Depression Screening: 22%

Footnotes:
- All patient experience data from the period of 1/1/15 - 12/31/15
- Patient Experience Scores are based on MHQP scoring system where yes or no questions are scored a 100 for yes or 0 for no. Multiple choice questions are scored a 100 for yes or 0 for no. Multiple choice questions are scored according to favorability: 100 for always, 66.66 for usually, 33.33 for sometimes, 0 for never.
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Patient Experience Survey Performance Chart

- Communication: 85
- Integration of Care: 77
- Knowledge of Patient: 75
- Adult Behavioral Health: 55
- Organizational Access: 69
- Self-Management Support: NAD
- Office Staff: 80
- Willingness to Recommend: 80

Footnotes:
- All measures except depression screening use data from the period 7/31/16 - 7/30/17
- Depression uses data from the period 5/1/16-4/30/17.
Practice: Needham Wellesley Family Medicine, P.C.

Patient Count: 5344

Primary Care Quality Measures

- Breast Cancer Screening: 71%
- CV Disease Lipid Control: 72%
- Colorectal Cancer Screening: 48%
- Diabetes Glycemic Control: 63%
- Diabetes BP Control: 81%
- Hypertension BP Control: 66%
- Depression Screening: 68%
- PHS Average: 77%
- % Eligible Patients Screened or Achieving Control: 45%

Footnotes: All patient experience data from the period of 1/1/15 - 12/31/15. Patient Experience Scores are based on MHQP scoring system where yes or no questions are scored a 100 for yes or 0 for no. Multiple choice questions are scored according to favorability: 100 for always, 66.66 for usually, 33.33 for sometimes, 0 for never. © 2016 Massachusetts Health Quality Partners, Inc. (MHQP). MHQP data are proprietary and provided under license. All rights reserved. Some of MHQP’s data may have been regrouped by Partners Healthcare for reporting purposes.

Patient Experience Survey Performance Chart

Footnotes: All measures except depression screening use data from the period 7/31/16 - 7/30/17. Depression uses data from the period 5/1/16-4/30/17.
Primary Care Quality Measures

Practice: Newton Wellesley Internists, P.C.

Patient Count: 11345

Primary Care Quality Measures

Footnotes: All patient experience data from the period of 1/1/15 - 12/31/15
Patient Experience Scores are based on MHQP scoring system where yes or no questions are scored a 100 for yes or 0 for no. Multiple choice questions are ranked according to favorability: 100 for always, 66.66 for usually, 33.33 for sometimes, 0 for never. © 2016 Massachusetts Health Quality Partners, Inc. (MHQP). MHQP data are proprietary and provided under license. All rights reserved. Some of MHQP’s data may have been regrouped by Partners Healthcare for reporting purposes.
Practice: Newton Wellesley Physicians - Primary Care

Patient Count: 11473

Primary Care Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>% Eligible Patients Screened or Achieving Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>79%</td>
</tr>
<tr>
<td>CV Disease</td>
<td>70%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>74%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>69%</td>
</tr>
<tr>
<td>Diabetes Glycemic Control</td>
<td>80%</td>
</tr>
<tr>
<td>Diabetes Lipid Control</td>
<td>65%</td>
</tr>
<tr>
<td>Hypertension BP Control</td>
<td>74%</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>78%</td>
</tr>
<tr>
<td>PHS Average</td>
<td>49%</td>
</tr>
</tbody>
</table>

Footnotes: All patient experience data from the period of 1/1/15 - 12/31/15
Depression uses data from the period 5/1/16-4/30/17.

Patient Experience Survey Performance Chart

Footnotes: All patient experience data from the period of 1/1/15 - 12/31/15
Patient Experience Scores are based on MHQP scoring system where yes or no questions are scored a 100 for yes or 0 for no. Multiple choice questions are scored according to favorability: 100 for always, 66.66 for usually, 33.33 for sometimes, 0 for never. © 2016 Massachusetts Health Quality Partners, Inc. (MHQP). MHQP data are proprietary and provided under license. All rights reserved. Some of MHQP’s data may have been regrouped by Partners Healthcare for reporting purposes.
Practice: Newton Wellesley Primary Care, P.C.

Patient Count: 3326

Primary Care Quality Measures

Footnotes: All patient experience data from the period of 1/1/15 - 12/31/15

Patient Experience Survey Performance Chart

Footnotes: All measures except depression screening use data from the period 7/31/16 - 7/30/17

Depression uses data from the period 5/1/16-4/30/17.

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Primary Care Quality Measures

Patient Experience Survey Performance Chart

Footnotes:
All measures except depression screening use data from the period 7/31/16 - 7/30/17
Depression uses data from the period 5/1/16-4/30/17.

Footnotes:
All patient experience data from the period of 1/1/15 - 12/31/15
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Practice: Newton-Wellesley Physicians - Family Medicine, Waltham

Patient Count: 3581

Primary Care Quality Measures

Footnotes: All patient experience data from the period of 1/1/15 - 12/31/15

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Footnotes: All measures except depression screening use data from the period 7/31/16 - 7/30/17
Depression uses data from the period 5/1/16-4/30/17.
Practice: Newton Wellesley Physicians - Primary Care, Wellesley Hills

Patient Count: 10369

Primary Care Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>% of Eligible Patients Screened or Achieving Control</th>
<th>PHS Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>68%</td>
<td></td>
</tr>
<tr>
<td>CV Disease Lipid Control</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>Diabetes Glycemic Control</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Diabetes BP Control</td>
<td>58%</td>
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<tr>
<td>Hypertension BP Control</td>
<td>66%</td>
<td></td>
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<tr>
<td>Depression Screening</td>
<td>74%</td>
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</tr>
<tr>
<td></td>
<td>43%</td>
<td></td>
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</tbody>
</table>

Footnotes: All measures except depression screening use data from the period 7/31/16 - 7/30/17. Depression uses data from the period 5/1/16-4/30/17.

Patient Experience Survey Performance Chart

<table>
<thead>
<tr>
<th>Category</th>
<th>Adjusted Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>90</td>
</tr>
<tr>
<td>Integration of Care</td>
<td>82</td>
</tr>
<tr>
<td>Knowledge of Patient</td>
<td>84</td>
</tr>
<tr>
<td>Adult Behavioral Health</td>
<td>57</td>
</tr>
<tr>
<td>Organizational Access</td>
<td>71</td>
</tr>
<tr>
<td>Self-Management Support</td>
<td>47</td>
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<tr>
<td>Office Staff</td>
<td>81</td>
</tr>
<tr>
<td>Willingness to Recommend</td>
<td>84</td>
</tr>
</tbody>
</table>

Footnotes: All patient experience data from the period of 1/1/15 - 12/31/15. Patient Experience Scores are based on MHQP scoring system where yes or no questions are scored 100 for yes or 0 for no. Multiple choice questions are scored according to favorability: 100 for always, 66.66 for usually, 33.33 for sometimes, 0 for never. © 2016 Massachusetts Health Quality Partners, Inc. (MHQP). MHQP data are proprietary and provided under license. All rights reserved. Some of MHQP’s data may have been regrouped by Partners Healthcare for reporting purposes.
Practice: Primary Care of Wellesley

Patient Count: 6174

Primary Care Quality Measures

Footnotes: All patient experience data from the period of 1/1/15 - 12/31/15
Depression uses data from the period 5/1/16-4/30/17.

Patient Experience Survey Performance Chart

Footnotes: All patient experience scores from the period of 1/1/15 - 12/31/15
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Practice: Wellesley Family Care Associates, PC

Patient Count: 7183

Primary Care Quality Measures

Footnotes: All patient experience data from the period of 1/1/15 - 12/31/15
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Patient Experience Survey Performance Chart

Footnotes: All measures except depression screening use data from the period 7/31/16 - 7/30/17
Depression uses data from the period 5/1/16-4/30/17.
Practice: Weston Primary Care, P.C.

Patient Count: 753

Primary Care Quality Measures

Footnotes: All patient experience data from the period of 1/1/15 - 12/31/15

Patient Experience Survey Performance Chart

Footnotes: All measures except depression screening use data from the period 7/31/16 - 7/30/17
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