

# The exploration of use of an online knowledge base on patient experiences and health care quality: An observational cohort study in primary health care

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## Research article

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# Abstract

Background Evidence-based information available at the point of care improves patient care outcomes. Online knowledge bases can increase the application of evidence-based medicine and influence patient outcome data which may be captured in quality registries. The aim of this study was to explore the effect of use of an online knowledge base on patient experiences and health care quality. Methods The study was conducted as a retrospective, observational study of 24 primary health care centers in Sweden exploring their use of an online knowledge base. Frequency of use was compared to patient outcomes in two national quality registries. A socio-economic care need index was applied to assess whether the burden of care influenced the results from those quality registries. Non-parametric statistical methods and linear regression were used. Results Frequency of knowledge base use showed two groups: frequent and non-frequent users, with a significant use difference between the groups ( $p < 0.001$ ). Outcome data showed significant higher values for all seven National Primary Care Patient Survey dimensions in the frequent compared to the non-frequent knowledge base users ( $p < 0.001$ ), whereas 10 out of 11 parameters in the National Diabetes Register showed no differences between the groups ( $p > 0.05$ ). Adjusting for care need index had almost no effect on the outcomes for the groups. Conclusions Frequent users of a national online knowledge base received higher ratings on patient experiences, but figures on health care quality in diabetes showed near to no correlation. The findings indicate that some effects may be attributed to the use of knowledge bases and requires a controlled evaluation.

## Background

The present study explored the effect of use of an online knowledge base on patient experiences and health care quality in primary health care centers (PHCC) in Sweden.

The possible effects of knowledge base (KB) use on patient care outcomes in quality registries (QR) are scarcely reported. To the best of our knowledge, the present study is the first to examine such possible associations.

Medicine is a knowledge-intense area with a continuous need to keep up-to-date with the latest evidence and to apply it to everyday patient care. Evidence-based medicine (EBM) may be a tool for connecting the current best evidence with clinical practice (1, 2). In order to apply EBM in practice, knowledge is needed at the point of care (3). Online KBs may provide for these needs (4). By capturing EBM health care outcomes in medical QRs, real-world evidence can be used to improve the quality of health care (5, 6).

EBM is “the use of the best available evidence for decision-making related to the treatment of a specific patient by applying results of systematic, reproducible, unbiased research in clinical practice” (7, 8). EBM used at the point of care has been reported to mitigate risk, effectively improve patient care outcomes, and reduce cognitive overload which can lead to medical errors (1, 2, 7, 9). A crucial step in EBM is to translate the evidence and apply the results in clinical practice. Knowledge does not necessarily change

practice and mere dissemination of scientific evidence may be insufficient to change professional behavior (10).

Online KBs have been shown to increase the application of EBM in clinical practice (11–13).

In this study, we used Lobach's definition of a KB: "Electronic (computer-based) resources comprising distilled (synthesized) or curated information that allows clinicians to select content

germane to a specific patient to facilitate medical decision making" (14). The use of KBs is associated with a positive impact on clinician behavior and patient outcomes, and evidence suggests that use of KBs may be associated with improved knowledge and patient outcomes (12, 15, 16).

The KB explored in this study was Medibas, a web-based knowledge source for general practitioners (GPs) in Sweden providing access to evidence-based medical knowledge in everyday clinical life (17). Medibas' editorial staff of GPs and its network of over 200 specialist doctors gather and summarize new scientific studies, reviews, national guidelines and recommendations and incorporate these into the KB.

A national QR contains individual-based information on diagnoses and medical outcome measures in health care. QRs can identify factors that may impact on patient survival (18).

There are over a hundred national QRs in Sweden (19). QRs have the potential to collect

real-world data, i.e. data collected outside of randomized controlled trials showing the unbiased results of real-life daily clinical practice. Patient experience data can be collected as patient reported outcome measures – questionnaires to record their experience of health care services. This can provide an understanding of how health care interventions impact on patients' quality of life and allows for comparisons of health care providers' performances (20). Real-world data can also be collected in QRs as objective outcome data, e.g. laboratory results or findings in physical examinations.

There is a lack of knowledge on whether the use of KBs reflects the patient outcomes data in nationwide QRs and whether burden of care, measured in Sweden as a care need index (CNI),

influences the register outcomes in any way (21). The aim of this study was to explore the effect of use of an online KB on patient experiences and health care quality.

## Methods

### Study design and setting

A retrospective, observational cohort study design was used in the present study. Data on frequency of use of the KB during 2018 was collected from PHCCs in Stockholm, Sweden.

In parallel, a cross-sectional set of standardized outcome measures were collected from two national and regional QRs: one containing subjective data of patient experiences in health care encounters and one

containing objective data of health care outcomes from diabetes care.

## **Study material**

A total of 24 privately-owned PHCCs participated in this study. No individual physicians were selected. Eligible participating sites were PHCCs in Stockholm that used Medibas during full year 2018, and all centers had online access to the Internet. PHCCs in Stockholm were chosen because they have individual IP addresses and are thereby traceable. The KB's central customer server was used to obtain data on frequency use during 2018 for each PHCC. A "session" in the KB was defined as one occasion where the user was active on the web site.

## **The knowledge base**

Medibas is a Swedish medical online KB with a focus on primary care (17). The primary target audience is GPs, but Medibas also targets other occupational groups in primary care such as nurses and physiotherapists. The aim of the KB is to provide access to evidence-based knowledge in everyday clinical practice. The KB is based on the 'Norsk Elektronisk Legehåndbok' (Norwegian Electronic Physician Handbook) which has been used by Norwegian GPs since the 1990s and was adapted to Swedish health care in 2013.

The KB used for this study contains more than 4,000 articles and covers a wide range of diagnoses in healthcare. The texts are written by specialists in general medicine and are reviewed and adapted to Swedish guidelines. In addition to facts about symptoms, diagnostics, treatment and follow-up, Medibas also features illustrations and patient information which can be easily printed out. Each text also contains references with direct links to studies in PubMed, the Cochrane library and national or regional guidelines. The content is updated on a weekly basis to include new findings from national and international evidence-based sources of knowledge. Longer texts feature a summary at the beginning to provide an overview. Medibas receives financial support through subscription fees and does not contain advertising or commercial promotion. This KB was chosen for the present study as it is the most comprehensive KB accessible to PHCCs on a nationwide scale in Sweden. It also contains patient education handouts, which may increase the willingness of patients to be compliant, according to an earlier study (22).

## **The Swedish National Primary Care Patient Survey**

The Swedish National Primary Care Patient Survey (NPCPS) is a recurrent national survey of patient experiences (23). Since 2009, all Swedish health care regions ( $n = 21$ ) have participated and the survey is coordinated by the Swedish Association of Local Authorities and Regions. The survey is carried out every two years and includes both primary and specialized care. The most recent survey in Stockholm was carried out in 2018 ( $n = 57,384$ ) and the response rate was 35.4%. Thus, 20,313 patients responded to the questionnaire. A random sample of patients who had visited PHCCs received an invitation to respond to a web or postal questionnaire. Confidentiality was ensured and it was not possible to read an individual's

responses when the results were compiled. The questionnaire consisted of seven dimensions on a five to seven graded Likert

scale: overall impression, emotional support, participation and involvement, respect and treatment, continuity and coordination, information and knowledge, and accessibility.

## **The Swedish National Diabetes Register**

The Swedish National Diabetes Register (NDR), founded in 1996, has long been a cornerstone of diabetes care in Sweden, providing clinicians with evidence-based information and supporting the improvement of health care quality (24). Both hospitals and PHCCs input diabetes patient data online, and in return benefit from opportunities to monitor risk factors, receive help in identifying needs for treatment improvements, and minimize the potential consequences of diabetes. The NDR currently contains data on 425,000 patients and has a coverage of 97% of all Swedish diabetic patients. Data is either entered manually and reported online or directly by transmission from the patient's electronic medical records (22). The Swedish Society for Diabetology is the owner of the registry and receives financial aid from the Swedish Association of Local Authorities and Regions. There are over 50 variables for each patient in the NDR, e.g. blood pressure, HbA1c and blood lipids.

## **National quality registries**

Data was extracted from the NPCPS and the NDR on a single occasion in April 2019 for the time period of a full 12 months from January to December 2018. Eligible data sets had no missing data. The number of sessions in the KB per listed patient during 2018 were dichotomized into two groups of PHCCs: frequent and non-frequent users of the KB. We did a binary split into these two groups in order to analyze how outcomes in the NPCPS and NDR were related to frequency of use of the KB.

## **Care Need Index**

CNI is a socio-economic needs index which describes the expected risk of developing ill health based on socio-economic factors on an individual level (21, 25).

The seven variables and their relative weights are:

CNI variable	Relative weight (0–9)
1. Aged over 65 years and single	6.15
2. Born abroad (Eastern Europe, Asia, Africa or South America)	5.72
3. Unemployed (or in employment measure), 16–64 years	5.13
4. Single parent with children who are 17 years or younger	4.19
5. Persons, aged one year or older, who recently moved into the healthcare center's catchment area	4.19
6. Low educational status, 25–64 years	3.97
7. Aged under five years	3.23

The CNI is an estimate to measure the workload of Swedish GPs. Compensation for socio-economic weight is paid per listed patient. Based on the socio-economic weight in CNI for each listed person, an index is calculated for the entire PHCC's patient list, which then forms the basis for the compensation. CNI is not dependent on the number of visits to the PHCC. About 60% of the Swedish population (n = 10 million) do not sort into a CNI variable while 7–8% of the population are actual for two or more variables. In order to explore whether the outcomes data from the NPCPS and the NDR were influenced by socio-economic weights, we selected CNI as a measure to reveal a potential relationship.

## Statistical Analysis

Descriptive statistics (mean and standard deviation) were used to describe the KB user groups and register data (26). The Mann-Whitney test was used to calculate differences between KB user groups (27). We tested dimensions of the NPCPS against CNI using linear regression (28).

In order to test the seven dimensions from the NPCPS against CNI for the dichotomized user groups, the CNI data, originally showing an uneven distribution (non-parametric),

was transformed to a normal distribution (parametric) using the Johnson Transformation Method (29). Using linear regression, we tested the difference between the NPCPS dimensions, NDR parameters and CNI for the dichotomized user groups. A p-value of < 0.05 was considered significant for all statistical analyzes. SPSS statistical software version 26 was used to analyze the data (30).

## Results

Frequency of use, as measured by the number of sessions in the KB, and the division of the 24 PHCCs into two groups: frequent users and non-frequent users are displayed in Figure 1. The number of listed patients was on average 8,903 in the frequent user group and 11,911 in the non-frequent user group. The

listed patients were equally distributed ( $p=0.320$ ) between the two groups (Table 1). CNI was 1.95 in the frequent user group and 2.55 in the non-frequent user group ( $p=0.052$ ).

The frequency of sessions per listed patient was significantly higher in the frequent user group than in the non-frequent user group ( $p<0.001$ ), as was the response rate for the NPCPS, 39.91% vs. 33.53% ( $p=0.013$ ) (Table 1).

## Patient experiences

All seven dimensions of the NPCPS - overall impression, emotional support, participation and involvement, respect and treatment, continuity and coordination, information and knowledge, and accessibility - were rated significantly higher among patients listed at PHCCs in the frequent user group vs. those in the non-frequent user group (Table 2).

## Health care quality

The NDR parameters encompass different criteria, from medical history and physical findings such as blood pressure measurements and foot examinations to laboratory test

results of blood and urine. There was no significant difference in the NDR parameters between the user groups except for the parameter "HbA1C >70", which was significant ( $p=0.045$ ) and therefore separated the user groups (Table 3).

## Adjusting for CNI

In order to adjust for the possible effect of CNI, an additional multiple regression analysis was performed (not shown). The addition of CNI of the PHCCs in a multiple regression analysis did not affect the statistical outcomes from the NPCPS. For outcomes from the NDR, the addition of CNI of the PHCCs changed the parameter "HbA1C>70" from significant to non-significant ( $p>0.05$ ) and the parameter "Physical inactive" from non-significant to significant ( $p<0.05$ ),

i. e significantly higher percentage physical inactive patients reported to NDR among PHCCs with non-frequent use of KB. Adding mean age of PHCCs' patients reported to NDR did not affect the results from the multiple regression analysis.

## Discussion

The aim of this study was to explore the effect of an online KB on patient experiences and health care quality. We found that PHCCs using the KB grouped into two categories: frequent and non-frequent user groups. The number of sessions in the KB per listed patient, i.e. frequency of use of Medibas, showed a significant difference between these two groups.

The results showed that PHCCs using the KB frequently scored higher in the NPCPS. This may suggest that physicians who use the KB frequently are able to fulfil the needs of patients more effectively. The NPCPS contains subjective ratings by patients and reflects their views on the standard of care. The results from the NDR showed no differences between frequent and non-frequent users of the KB. This could indicate that diabetic variables such as average blood glucose level, blood lipids and blood pressure are more static and the features influencing these values are multifactorial, genotype- and phenotype-wise. Physicians' use of electronic KBs might have a diminutive influence on these physical parameters. Other researchers have found that some behavioral changes can be more easily moderated than physical parameters (31). Based on the findings of the present study, there may be a relationship between patient outcome measurements in the NPCPS and frequency of use of the KB. On the other hand, objective parameters such as those in the NDR may not be impacted by the use of an online KB. It cannot be ruled out that there is no effect, but results of this study neither confirm nor refute this.

CNI describes the expected risk of developing ill health based on socio-economic factors, and could therefore possibly affect how burden of care influences patient outcomes between frequent and non-frequent users of the KB. It could be argued that patients with low expected risk of developing ill health due to socio-economic factors tend to cluster in PHCCs where physicians are highly committed to satisfying individual patients' needs and demands. We therefore added

CNI to test this hypothesis. We found no effect (apart from one minor parameter in the NDR) when adding CNI to the two groups. This may reflect that burden of care is already embodied in the NPCPS as well as in the results from the NDR. The addition of CNI, whose inherent values may already be reflected in the register data, seems to have small effect and therefore not susceptible to influence from the knowledge provided by the KB.

Previous research has focused on interventions to either increase the use of, or find new ways of using, electronic knowledge sources, whereas this study specifically examined the effect of the use of a KB on patient outcome measures in two nationwide registries. Earlier studies have found that use of register data may play a vital role in patient care (12, 15, 32). Furthermore, an excess of research has been devoted to evaluating electronic knowledge sources by employing self-reported use, which is prone to biases (33–35). We are not aware of any prior studies examining outcomes of the use of an online KB by relating frequency of use to objective data from quality registries. Recent studies have given valuable clarification on factors influencing knowledge seeking such as lack of time, resource use and accessibility (4, 36–38). The present study adds to these findings by exploring the frequency of use of an online KB and investigating its potential impact on unbiased outcome measures, e.g. objective outcome data from QRs.



The NPCPS was chosen for the study as it represents a high-quality nationwide patient reported outcomes programme. The NDR was chosen because it is the quality register for diabetes care in Sweden and contains nationwide diabetes data of high validity, reliability and granularity. The collected information is objective as it is transferred automatically from the electronic patient records.

Measuring effects of health care by studying outcomes data, e.g. in QRs, has inherent limitations and should primarily be used for hypotheses generation. This study suffers from limitations such as the small sample size of the study cohort, the low frequency of response in the NPCPS and the selection of privately-owned PHCCs. The NPCPS represents an important qualitative source of information on patient preferences, but it may be difficult to extrapolate our findings to other contexts. The generalizability of our findings into other areas, such as rural geographical areas and publicly-run PHCCs, may be limited. Further, the use of “sessions” in the KB may not adequately reflect actual use of the KB. Meanwhile, strengths of this study include the use of objective outcome measures (e.g. quality register data) and no self-reported results. Another strength is that a total geographical group of the KB’s users was investigated.

Our findings indicate that use of the KB has a positive impact on patient satisfaction with primary health care, which may contribute to the area of research on KBs. Future research in this field is needed in the form of results from an unbiased selection of patients’ and caregivers’ experiences of KB use in the form of a randomized controlled trial.

## Conclusions

Frequent users of a national online knowledge base received higher ratings on patient experiences, but figures on health care quality in diabetes showed near to no correlation. The findings indicate that some effects may be attributed to the use of knowledge bases and requires a controlled evaluation.

## List Of Abbreviations

CNI	Care Need Index
EBM	Evidence-based medicine
GP	General practitioner
KB	Knowledge base
NDR	The Swedish National Diabetes Register
NPCPS	The Swedish National Primary Care Patient Survey
PHCC	Primary health care center

## Declarations

### Ethical approval

This study was subject of an ethical application and was deemed exempt from full review by the Swedish Ethical Review Authority. The reviewing body gave an advisory statement declaring that no ethical conflicts were found in the present study (Registration number: 2019-04035).

### Consent for publication

Not applicable.

### Availability of data and materials

The data sets in the present study can be made available from the corresponding author on request.

### Competing interests

Christian Gerdesköld has received research funding support from the KB. Anna Nager is employed part-time by Medibas AB. All other authors declare no conflict of interest.

### Funding

This study was funded by Medibas AB.

### Authors' contributions

Christian Gerdesköld (C.G.) and Anna Nager (A.N.) developed the study concept. All authors contributed to the study design. Testing and data collection were performed by A.N. and C.G. The manuscript was drafted by C.G. All authors analyzed and discussed the results, contributed to the final manuscript and approved the final version of the manuscript for submission.

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## Tables

**Table 1.**

Characteristics of the two user groups of the knowledge base, presented as mean values, standard deviations. (NPCPS: The Swedish National Primary Care Patient Survey)

Variables	Frequent users (n=8) (SD)	Non-frequent users (n=16) (SD)	P-value <sup>1</sup>
Listed patients at the primary health care centers	8,903 (2,769)	11,911 (6,067)	0.320
Care Need Index	1.95 (0.40)	2.55 (0.86)	0.052
Sessions per 1,000 listed patient	169 (95.39)	24 (21.48)	0.000*
Response rate as percent of NPCPS	39.91 (4.21)	33.53 (1.55)	0.013*
Mean age in National Diabetes Register	68.62 (0.68)	67.20 (0.66)	0.548

<sup>1</sup>Mann-Whitney test, exact significance 2-tailed

**Table 2.**

Results from the NPCPS for the frequent and non-frequent user groups, mean values and (standard deviations)

Dimensions in the NPCPS	Frequent user group (n=8) (%) (SD)	Non-frequent user group (n=16) (%) (SD)	P-value <sup>1</sup>
Overall impression	89.05 (3.67)	77.12 (8.30)	0.001*
Emotional support	84.25 (4.44)	72.11 (9.24)	0.001*
Participation and involvement	87.14 (2.77)	77.52 (5.76)	<0.001*
Respect and treatment	91.20 (2.31)	82.14 (7.29)	0.001*
Continuity and coordination	85.90 (4.49)	72.14 (9.20)	0.001*
Information and knowledge	84.25 (3.82)	72.84 (6.76)	<0.001*
Accessibility	88.45 (2.94)	80.58 (5.97)	0.001*

<sup>1</sup>Mann-Whitney test, exact significance 2-tailed

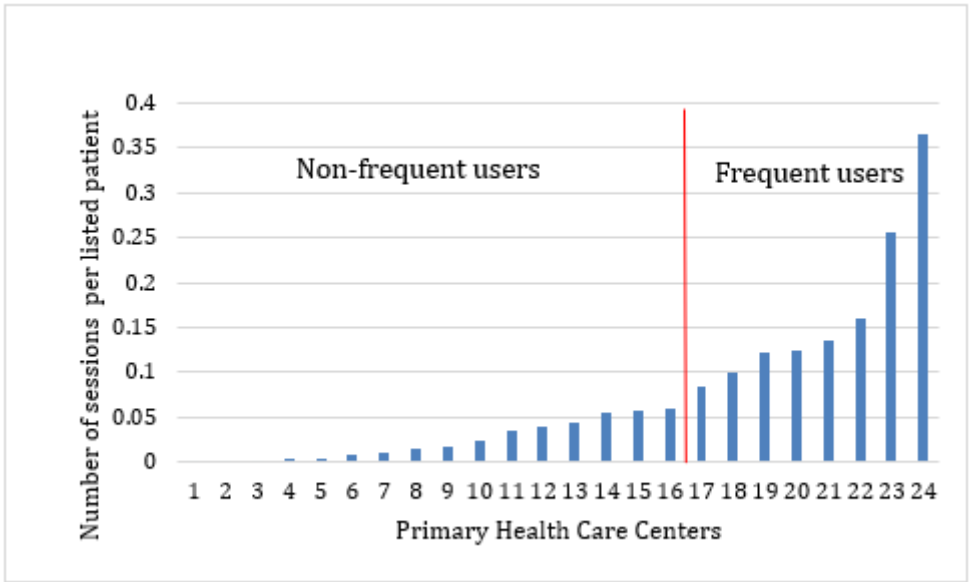
### Table 3.

Results for the NDR (The Swedish National Diabetes Register) parameters used in the study for frequent and non-frequent user groups, mean values and (standard deviations)

NDR parameters	Frequent users (n=8) (%) (SD)	Non-frequent users (n=16) (%) (SD)	P-value <sup>1</sup>
HbA1c <52 mmol/mol	61.05 (7.64)	58.44 (4.76)	0.365
HbA1c >70 mmol/mol	7.01 (1.83)	9.05 (2.27)	0.045*
Blood pressure ≤130/80 mm Hg	39.86 (6.71)	42.79 (5.17)	0.097
Blood pressure <140/85 mm Hg	57.21 (9.13)	56.07 (5.18)	0.912
LDL <2.5 mm/L	51.91 (7.03)	51.18 (8.36)	0.765
Lipid lowering drug	44.06 (12.35)	52.26 (9.38)	0.115
Albuminuria	24.44 (5.46)	23.01 (4.97)	0.717
Foot exam	76.83 (8.01)	81.55 (12.58)	0.119
Retinal examination	77.40 (13.55)	75.78 (26.06)	0.265
Smoker	12.63 (4.27)	15.30 (3.50)	0.184
Physically inactive	14.78 (8.43)	22.57 (8.90)	0.065

<sup>1</sup>Mann-Whitney test, exact significance 2-tailed

## Figures



**Figure 1**

The distribution of sessions in the knowledge base per listed patient for participating primary health care centers