Healthier WASHINGTON

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2016 COMMUNITY CHECKUP REPORT

Improving Health Care in Washington State

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CONTENTS

Dear Community Member,

Washington State is midway through a bold and ambitious initiative to transform health care in the state. The Healthier Washington initiative, funded by a grant from the federal government, has as its goal making Washington a place where the Triple Aim—better health, better care and lower cost—is an everyday part of our health care system.

A major part of that effort is knowing where there's room for improvement and where there are successes to be shared. That's why the Community Checkup plays an important role in advancing the work of Healthier Washington. Performance measurement and reporting are essential tools to help us reach our shared goal of Washington being in the top ten percent of performance nationally.

This is the tenth version of the Community Checkup, and the second time that we have reported results for the Washington State Common Measure Set for Health Care Quality and Cost. This report includes significant advances, including reporting for all primary care medical groups and clinics of four or more providers in the entire state. The report also includes new measures for the Common Measure Set, including behavioral health measures, that expand how we track important elements of health.

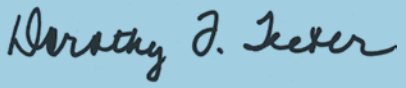
The results show us that Washington still has a ways to go to achieve the high-quality, high-value health care that we want all our citizens to receive. But just knowing our state's performance isn't sufficient. To transform the health care system, we need to move from data to action.

Recognizing the importance of laying out a path others can follow, the Health Care Authority (HCA) has decided to act as a first mover in the market. As part of the State's Healthier Washington initiative, Washington aims to drive 80 percent of state-financed health care and 50 percent of the commercial market to value-based payment by 2020. HCA has incorporated metrics related to 19 of the measures in the Common Measure Set into contracts for its Accountable Care Networks and is also including an additional 33 metrics from the common measure set in 2017 Medicaid and PEBB purchasing contracts. Of those 33, a subset will be tied to incentive payments in each contract. The decision to do so highlights how results from the Common Measure Set are being used to drive change in the market and offers an opportunity for health plans and other purchasers to follow HCA's lead in using the Common Measure Set in contracting.

The Alliance is grateful to our data suppliers for providing the data needed to produce results for the Community Checkup. We would also like to acknowledge the many organizations that also provided results for the Common Measure Set: the Washington State Hospital Association, CMS/Hospital Compare, the Washington State Department of Health, the Washington State Department of Social and Health Services, the Washington State Health Care Authority, the state's health plans and the National Committee for Quality Assurance. The release of this report is a testament to the power of collaboration that we are fortunate to have in our state.

Sincerely,

Nancy A. Giunto,
Executive Director
Washington Health Alliance



Dorothy F. Teeter,
Administrator
Washington State Health Care Authority

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Introduction

This version of the Community Checkup report is the tenth that the Washington Health Alliance has published since 2008.

With the tenth Community Checkup report, it's worth reflecting on the importance of transparency—and its limitations. We have always known that transparency *by itself* would not lead to significant improvement. We understand the role transparency plays in health care transformation: it's absolutely necessary, but it's not sufficient on its own. Making data available that is comparable, relevant and understandable and that comes from a trusted source is vitally important, but it is just the start of the cycle for transformation. *Using information* to identify opportunities and to motivate action is a critical next step.

Ongoing reporting through the Community Checkup is a valuable tool in this process of transformation and helps us, collectively, to understand over time whether efforts to improve are working. We also know that health care is far too complex for any one organization, or even any one stakeholder group (e.g., providers) to transform care on its own. Transformation requires all of us working together, across organizations and stakeholder groups, to drive change in an aligned and supportive manner. This is why convening continues to be such a critical component of the Alliance's mission.

The chart on the following page highlights the series of steps necessary to move from data to action. A database is just a collection of data points unless there is the infrastructure and trust to ensure that it is accessed and used to its fullest capacity. Moving data to information means making data comparable, relevant and understandable. It also requires that the information come from a trusted source.

The next step is moving to action. Action includes such things as benefit design and changing practice patterns among providers. This is a crucial step, the one in which information drives changes in our health care system. The Alliance adds value to this step of the process by convening various stakeholders to share ideas, learn from one another and align efforts for value-based action.

It's only when all of these steps come together that we are able to achieve the outcomes that we seek. By working to bring all of these elements of the continuum together, the Alliance is focused on helping Washington to achieve the Triple Aim: better care, better health and lower costs.

WHAT'S NEW IN THIS REPORT

- For the first time, results are now available for primary care medical groups and clinics of four or more providers for the entire state, a big step forward for Washington state transparency efforts.
- Results reflect the full expansion of Medicaid enrollment, which began in 2013.
- Results are included for new measures on behavioral health, including mental health service penetration and substance use disorder service penetration.

Health care is far too complex for any one organization, or even any one stakeholder group (e.g., providers) to transform care on its own. Transformation requires all of us working together, across organizations and stakeholder groups, to drive change in an aligned and supportive manner.

Steps Required to Achieve the Triple Aim

DATA	INFORMATION	ACTION	OUTCOMES
			
• Complete • Accurate • Valid Measures	• Trusted Source • Comparable • Relevant • Understandable	• Purchasing • Benefit Design • Changing Practice Patterns • Behavior Change	• Top 10% • Better Health • Better Care • Less Waste • Lower Cost

Yet, despite the best efforts of the Alliance and its hundreds of stakeholders, the significant quality improvements that we envisioned when the first Community Checkup report was released in 2008 remain elusive. To their credit, individual medical groups and providers have undertaken major efforts to improve their performance. Health plans have taken steps to redesign provider payment to link it to quality. Plans and purchasers have made some headway to create different benefit designs. Yet there are still plenty of opportunities for improvement.

Variation is as much a theme in this report as it was in the 2008 report. Despite the spotlight that the Community Checkup has placed on it, variation in the quality of health care is endemic. Even for tests and treatments supported by overwhelming evidence, there remains a remarkable range among the frequency with which they are likely to be provided. This variation can be among facilities (medical groups, clinics, hospitals) or geographies (counties or Accountable Communities of Health). This continuing pattern of significant variation underscores how important it is that we continue to measure, analyze and report results to target opportunities for improvement. It also underscores how challenging it is for all of us—providers, purchasers, health plans and consumers—to significantly move the needle through concerted changes in clinical decision making and in incentivizing quality.

HEALTHIER WASHINGTON IS MOVING THE MARKET TO VALUE

This report is the second time that the Alliance has reported results for the Washington State Common Measure Set for Health Care Quality and Cost. In 2016, the Common Measure Set includes 55 measures that enable a common way of tracking important elements of health and how well the health care system is performing. This year's results include four new measures: mental health services for children and adults, substance use disorder services for children and adults, medication management for people with asthma and statin therapy for patients with cardiovascular disease.

The Common Measure Set is an important element in the state's Healthier Washington initiative, an innovative and ambitious effort to improve health care in our state. Funded by a State Innovation Model (SIM) grant from the Centers for Medicare & Medicaid, Healthier Washington is employing three overarching strategies to achieve its transformational goals:

1. **Supporting multi-sector engagement.** To build a healthier Washington, the State is empowering people to come together at the local level. This includes connecting health care providers who are working to address an individual's physical and mental health needs with community-based resources that provide support-like assistance with housing, employment or the activities of daily living. Making these critical connections will help Washington address the social and economic issues that can play an important role in an individual's health.
2. **Integrating care and social support.** Strengthening the connections across the health care sector and communities is one step to transforming care. Another step is through investment in knowledge, training and tools to help providers deliver effective care where people are, when they need it. The state will promote change to improve coordination of care, connect providers to community resources and shift to paying for value rather than volume.
3. **Paying for value.** The state is testing new ways to pay for health care to lower costs, improve the care people receive and ensure that health care dollars are spent wisely. This includes rewarding providers for the quality of care people receive rather than the number of procedures or patient visits they receive. To do this effectively, the state is developing methods of collecting and sharing information so that the state, health plans, providers and citizens can see how the system is really performing—and work toward improvements based on this information. The Common Measure Set is foundational to understanding and measuring value.

Variation in the quality of health care is endemic. Even for tests and treatments supported by overwhelming evidence, there remains a remarkable range among the frequency with which they are likely to be provided.

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Achieving Excellence in Washington

The Alliance community has collectively agreed upon a goal that Washington state providers will be in the top ten percent of performance nationally. That is why we compare measure results to the national 90th percentile whenever such a benchmark is available, for example, from the National Committee for Quality Assurance (NCQA).

On all but a handful of measures in the Community Checkup report, Washington state falls short of this measure of excellence. To their credit, on many measures individual medical groups and clinics do exceed top national performance, both within the Medicaid and the commercially insured populations. These providers show us that excellence is achievable and that everyone can benefit from incorporating best practices.

Outstanding performance is just one benchmark for performance. We also need to know what the state's performance means relative to other national benchmarks. To that end, the Alliance also notes how performance compares to a series of other percentile brackets.

The results are illuminating and also disappointing. Out of 22 measures not specific to health plans that have a national benchmark, only one is above the national 90th percentile for the commercially insured population and none for the Medicaid population. Almost 40 percent of all measures for the commercially insured fall below the 50th percentile; 12 measures for Medicaid enrollees actually fall below the 25th percentile. As unfortunate as these results may be, the Alliance's hope is that they can be used to identify those areas where specific and aggressive interventions are needed to improve performance and with it the health of Washingtonians.

Everyone has a role to play in multiplying efforts to achieve more rapid change and improvement in achieving the Triple Aim. By aligning efforts to move the health care system from its current focus on volume to a focus on value, all stakeholders—health plans, purchasers, providers and consumers—can collectively assert the leverage necessary to move the market, something no single organization or stakeholder group can accomplish on its own.

Fortunately, there is momentum in our state in that direction, thanks to the Healthier Washington initiative and the Washington State Health Care Authority's Value-Based Road Map 2017–2021, both of which lay out specific plans to move the market to value.

Following are tables that show the state's performance against national benchmarks established by the NCQA, a nonprofit that has developed quality standards and performance measures that are widely recognized.

On all but a handful of measures in the Community Checkup report, Washington state falls short of excellence. To their credit, on many measures individual medical groups and clinics do exceed top national performance.

Figure 1: Washington State Performance for **Commercially Insured** as Compared to NCQA National Benchmarks

National Benchmarks	Measure	State Average	National 90th Percentile
Above National 90th Percentile	Eye exam for people with diabetes	75%	70%
Between National 75th and 90th Percentile	Avoiding antibiotics for adults with acute bronchitis	34%	38%
	Avoiding X-ray, MRI and CT scan for low-back pain	80%	83%
	Staying on antidepressant medication (6 months)	56%	60%
	Staying on antidepressant medication (12 weeks)	72%	75%
Between National 50th and 75th Percentile	Access to primary care (ages 12–19 years)	90%	95%
	Access to primary care (ages 45–64)	96%	97%
	Access to primary care (ages 65+)	98%	99%
	Blood sugar (HbA1c) testing for people with diabetes	90%	94%
	Breast cancer screening	75%	80%
	Colon cancer screening	63%	72%
	Kidney disease screening for people with diabetes	86%	90%
	Medication safety: monitoring patients on high-blood pressure medications	82%	86%
Between National 25th and 50th Percentile	Access to primary care (ages 2–6 years)	89%	96%
	Access to primary care (ages 7–11 years)	90%	97%
	Access to primary care (ages 12–24 months)	98%	99%
	Access to primary care (ages 20–44)	92%	95%
	Appropriate testing for children with sore throat	77%	92%
	Cervical cancer screening	75%	82%
	Chlamydia screening	39%	60%
	Spirometry testing to assess and diagnose COPD	40%	52%
	Well-child visits (ages 3–6 years)	73%	87%

National 90th percentile is based upon national benchmarks computed by the National Committee for Quality Assurance (NCQA). This reflects the top 10 percent of performance across the nation.

Figure 2: Washington State Performance for **Medicaid Insured** as Compared to NCQA National Benchmarks

National Benchmarks	Measure	State Average	National 90th Percentile
Between National 75th and 90th Percentile	Staying on antidepressant medication (6 months)	42%	48%
	Staying on antidepressant medication (12 weeks)	58%	63%
Between National 50th and 75th Percentile	Avoiding antibiotics for adults with acute bronchitis	30%	40%
	Avoiding X-ray, MRI and CT scan for low-back pain	77%	83%
	Eye exam for people with diabetes	63%	68%
Between National 25th and 50th Percentile	Access to primary care (ages 65+)	84%	92%
	Appropriate testing for children with sore throat	66%	85%
	Cervical cancer screening	55%	73%
	Chlamydia screening	51%	69%
Below National 25th Percentile	Access to primary care (ages 2–6 years)	75%	93%
	Access to primary care (ages 7–11 years)	86%	96%
	Access to primary care (ages 12–19 years)	86%	95%
	Access to primary care (ages 12–24 months)	89%	98%
	Access to primary care (ages 20–44)	71%	87%
	Access to primary care (ages 45–64)	75%	92%
	Blood sugar (HbA1c) testing for people with diabetes	63%	92%
	Breast cancer screening	27%	71%
	Kidney disease screening for people with diabetes	71%	88%
	Medication safety: monitoring patients on high-blood pressure medications	82%	92%
	Spirometry testing to assess and diagnose COPD	22%	41%
	Well-child visits (ages 3–6 years)	58%	84%

National 90th percentile is based upon national benchmarks computed by the National Committee for Quality Assurance (NCQA). This reflects the top 10 percent of performance across the nation.

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Areas of Focus: Well-Child Visits and Diabetes

TESTING THE THEORY OF CHANGE

The state is nearly halfway through the four-year grant supporting Healthier Washington and has decided that now is the time to test whether component parts of the system, when focused and used wisely together, can accelerate change and achieve the initiative's aims. To that end, the state has identified the focus areas of well-child visits and diabetes to test the Healthier Washington theory of change over the next year. These two focus areas align with community priorities, are being measured and tied to financial incentives in state-financed programs and have the potential to improve health and quality of life across Washington. Testing Healthier Washington's theory of change using these two areas of focus will simplify evaluating and understanding connections among different aspects of the Healthier Washington initiative.

WELL-CHILD VISITS KEY TO A HEALTHY START

Childhood is a time of rapid growth and change, including brain and body development. Patterns of nutrition and physical activity can be set that can and do have life-long effects in terms of health. During well-child visits, the primary care provider reviews the basics such as height and weight, sleep patterns, oral health, family and social relationships and age-appropriate safety precautions, making sure that both parent and child (when a little older) are attuned to things that make a big difference. The well-child visit is a key time to deliver evidence-based and age-appropriate vaccines to prevent childhood disease. In addition, the primary care provider can detect possible developmental delays or disabilities, early treatment of which can lessen future impact on both the child and family.

The well-child visit is also when primary care providers should screen children to identify those at risk for Adverse Childhood Experiences (ACEs). ACEs are traumatic events that have a negative and lasting effect on health and well-being. These experiences range from physical, emotional or sexual abuse, to parental divorce, to substance abuse, mental illness or violence within the family unit or the incarceration of a parent. As ACEs increase, so does the risk for poor outcomes later in life such as unemployment, lowered educational attainment, chronic disease (e.g., diabetes, asthma and cardiovascular disease), mental health and substance use disorders and violence victimization or perpetration.

For many in primary care, screening for and tackling the issue of ACEs is understandably a daunting task, particularly for those that do not have behavioral health resources closely linked to their practice. Even so, while not the only time or place to screen for ACEs, the well-child visit is an important opportunity to identify children who have experienced trauma or who are affected by traumatic events experienced by their parents, with the goal of getting families linked to appropriate community-based resources that can help. After all, "a huge chunk of the billions upon billions of dollars that Americans spend on health care, emergency services, social services, and criminal justice boils down to what happens—or doesn't happen—to children in families and communities."[1]

Unfortunately, Washington state has some work to do in order to achieve excellence on the well-child visit measure. For both the commercially insured and Medicaid populations, the statewide average is between the national 25th and 50th percentiles, well below the state's goal of being in the top ten percent of performance nationally.

KEY FINDINGS

- Approximately one in four children (27 percent) who are commercially insured failed to get a well-child visit in the measurement period.
- More than four out of ten children (42 percent) enrolled in Medicaid failed to have a well-child visit.
- Variation is pronounced among medical groups as well as counties.

1. Stevens, Jane E. To prevent childhood trauma, pediatricians screen children and their parents...and sometimes, just parents...for childhood trauma. ACES Too High, https://acestoohigh.com/2014/07/29/to-prevent-childhood-trauma-pediatricians-screen-children-and-their-parentsand-sometimes-just-parents/. Published July, 2014.

Figure 3: Variation among **Medical Groups** for Well-Child Visits for **Medicaid Insured**

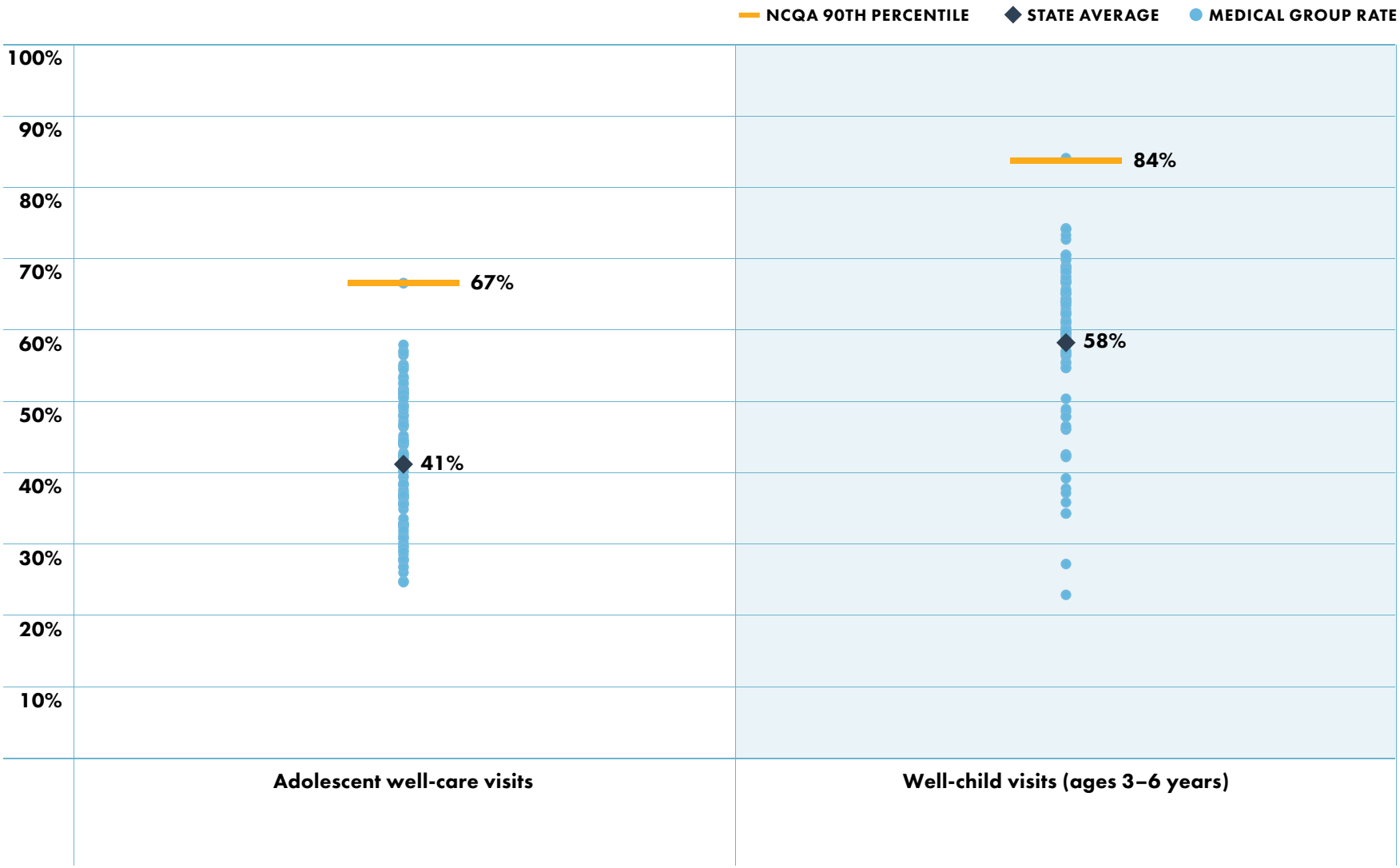


Figure 4: Variation among **Counties** for Well-Child Visits for **Medicaid Insured**

STATE AVERAGE: 58%

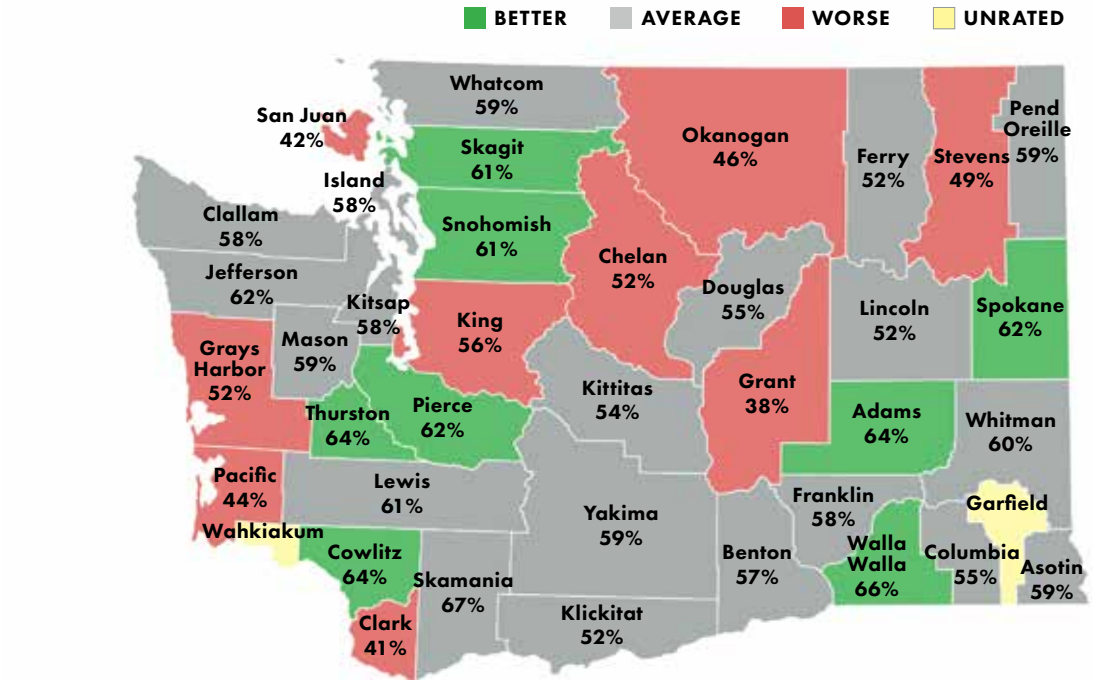
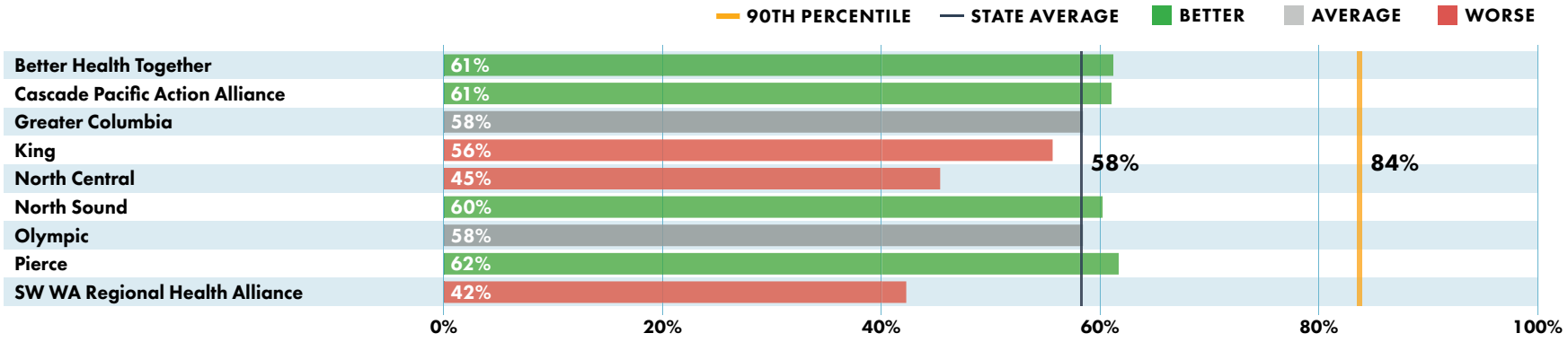


Figure 5: Variation among **Accountable Communities of Health** for Well-Child Visits for **Medicaid Insured**



AN OPPORTUNITY FOR IMPROVING DIABETES CARE

According to the most recent data from the Centers for Disease Control (2014), approximately 8.2 percent of adults in Washington were told by a doctor they had any type of diabetes. This is just slightly under the national age-adjusted rate of 8.4 percent. The prevalence of diabetes in Washington has been steadily growing, approximately doubling in the past 20 years. The risk of diabetes increases with age. Diabetes is more prevalent among males and among those with less than a high school education. There are also disparities according to race and ethnicity, with diabetes more prevalent among Hispanics, American Indians and Alaska Natives and Black adults than among White and Asian adults.

Diabetes is a chronic condition characterized by high blood glucose (sugar) resulting from the body's inability to use glucose for energy. In Type 1 diabetes (only about 5–10 percent of all diabetes) the pancreas does not make insulin. In Type 2 diabetes (90–95 percent of all diabetes) the pancreas does not make enough insulin or the body is unable to use insulin correctly. Insulin is a hormone that allows the body to use sugar (glucose) from carbohydrates in food for energy or to store glucose for future use. The right amount of insulin helps to keep blood sugar levels from getting too high or too low.

The long-term effects from having diabetes, particularly diabetes that is not well-controlled, are well known. Diabetes increases risk for many serious health problems, including high blood pressure, vision problems including blindness, kidney disease, nerve damage, amputation and stroke. These conditions are huge drivers of health care costs, and individuals with diabetes can really feel the effect of this through high-deductible health plans, co-pays and other out-of-pocket expenses. The American Diabetes Association released research in 2013 estimating the total costs of diagnosed diabetes at $245 billion, up approximately 41 percent from 2007 when the estimate was $174 billion. The largest drivers of direct costs are hospital stays and prescription medications to treat complications from diabetes. But there are also significant indirect costs associated with work absenteeism, lost productivity at work, inability to work and early mortality.

This year's results point to areas where there is room for improvement in care for diabetes and, in one case, a sign of good news.

KEY FINDINGS

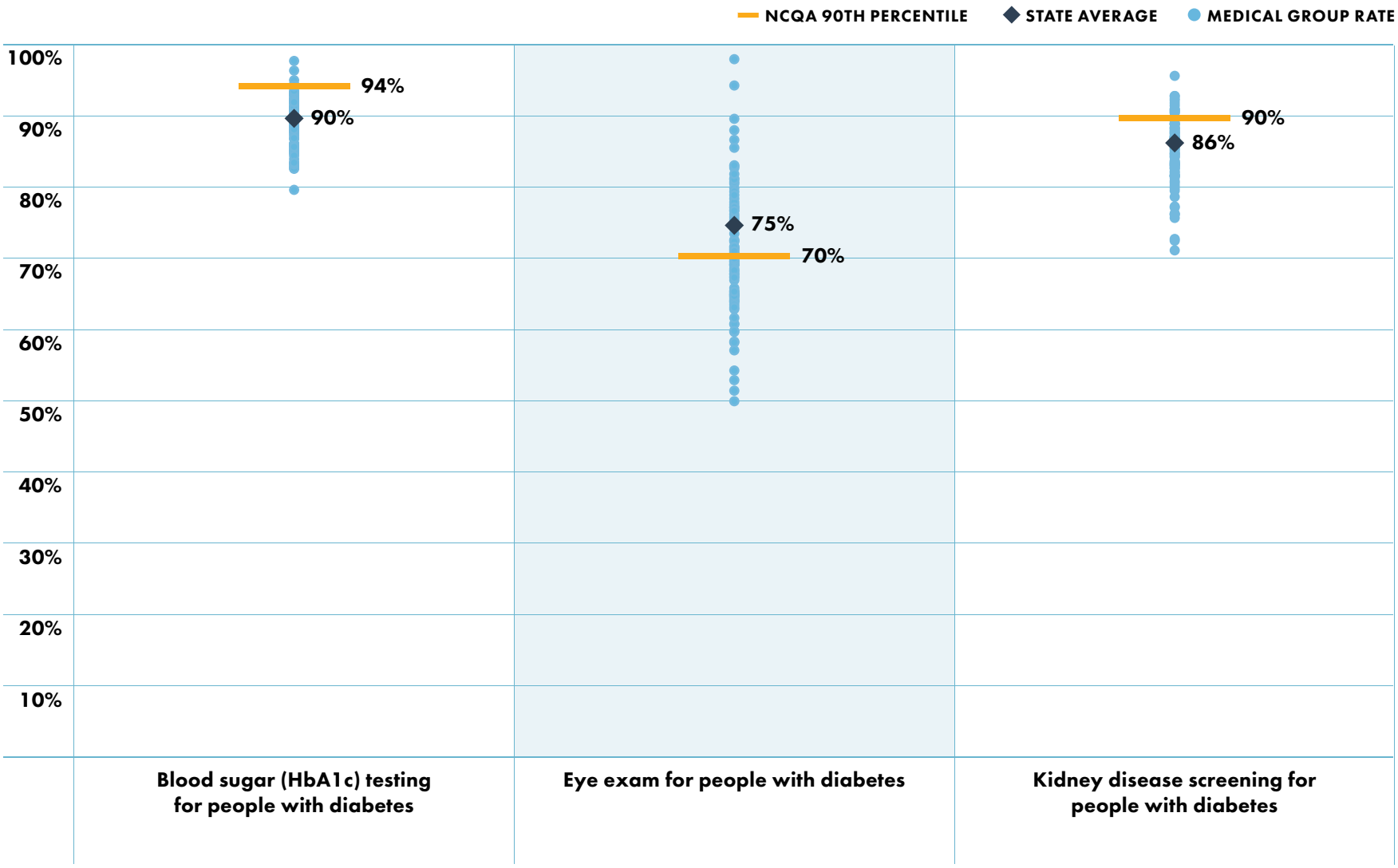
- Eye exams for people with diabetes is above the national 90th percentile for commercially insured patients. This is one of the few results this year that achieves our goal. We applaud the more than a dozen medical groups that surpassed the national benchmark for this measure.
- There is wide and significant variation for quality of care for the Medicaid population.
- More than a third of people with diabetes do not have their blood sugar under control.

As the chart on the next page with medical group results shows, there remains remarkable variation for these measures. This is particularly concerning, since these measures represent evidence-based standards of care that most, if not all, patients with diabetes should receive. For example, there is as much as an 18 percentage point difference between the highest performing and lowest performing medical groups when it comes to HbA1c (blood glucose) testing for commercially insured patients. The range difference is almost three times as wide for the Medicaid population on the same measure.

Of particular note is the number of patients whose diabetes is poorly controlled. In this year's report, we are able to provide results for this measure at the health plan level only; the measure reflects the percentage of members with diabetes enrolled in each health plan whose most recent HbA1c level was greater than 9 percent, a level considered "poor control." Controlling blood sugar is critical for avoiding both short-term and long-term health problems. Results for the commercial health plans in Washington range from a low of 23 percent to a high of 67 percent; the national 90th percentile is 21 percent (lower is better). Results for Medicaid managed care organizations in Washington range from a low of 36 percent to a high of 65 percent; the national 90th percentile is 30 percent.

Such numbers underscore the importance of Healthier Washington's focus on diabetes. Without an improvement in how well managed their blood sugar is and how regularly we test for kidney disease and vision problems, thousands of Washingtonians face a future with an increased risk of complications, accompanied by greater financial burdens that come with them and the potential for lower quality of life.

Figure 6: Variation among **Medical Groups** for Diabetes Care for **Commercially Insured**



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New Area of Focus: Behavioral Health

BEHAVIORAL HEALTH GETS A CLOSER LOOK

Another significant focus area for Healthier Washington is improving behavioral health care and more effectively integrating behavioral and physical health. In 2016, two new measures were added to the Common Measure Set to try and get a better understanding of behavioral health in our state. The Mental Health Services and Substance Use Disorder Services measures were developed by the Washington State Department of Social and Health Services' Research and Data Analysis Division (RDA). They are designed to measure access to services to treat or manage behavioral health conditions.

The measures use a two-year window to identify need for mental health or substance use disorder treatment services, and then measure the proportion of those in need who received qualifying services in the measurement year.[2] The measures have been shown in several studies (including some in peer-reviewed journals) to have a strong relationship to patient outcomes. That is, patients who receive treatment after a need has been identified have better outcomes along many domains (e.g., health service utilization, cost, disease progression, mortality, criminal justice involvement, employment, housing stability) compared to people who do not receive treatment after having a need identified.

These are important measures to include in the Common Measure Set for several reasons.

- Behavioral health risk factors are a key driver of health care utilization across physical and behavioral health settings.
- Behavioral health conditions are key risk factors affecting patient experiences and quality of life across many functional domains.
- Behavioral health services have been historically underfunded in relation to physical health care—recognition of this circumstance helped lead to behavioral health parity requirements under the Affordable Care Act.

These measures have been implemented in the Washington state Medicaid environment for some time, where they were deployed to help support the movement towards increasingly integrated delivery of physical and behavioral health care. As is the case with many measures, including NCQA HEDIS measures, we expect that the metrics will be revised over time based on input from plans, providers and other key stakeholders. In particular, there is an expectation that the metrics will continue to evolve to more comprehensively capture services provided to manage behavioral health conditions in a primary care setting.

Mental health services for children and adults

For the first time in 2016, we have results for the mental health service penetration measure (Mental Health Services for Children and Adults) for the commercially insured population in Washington. Results for both commercial and Medicaid health plans are reported in 2016, along with results by county and Accountable Community of Health.

KEY FINDINGS

- Mental health service penetration is better overall within the Medicaid insured population for both children and adults.
- Only one-third of commercially insured children and adults received mental health services following a diagnosed need for mental health services. Among the Medicaid insured, approximately two-thirds of children and one-half of adults received mental health services following a diagnosed need.
- There is significant variation among counties for both the commercially and Medicaid insured populations, which may be a reflection of different levels of access to services across different parts of the state.

2. The two-year window to identify need is motivated by the tendency for behavioral health conditions to be under-identified in insurance claims data. Given that there can be significant variation across health plans and other reporting units in the proportion of enrolled populations with behavioral health needs, using a need-based denominator provides a form of case-mix adjustment to achieve fairer comparisons of access across reporting organizations.

Figure 7: Mental Health Services for Children, Ages 6–17

RESULTS FOR HEALTH PLANS				RESULTS FOR COUNTIES			
Commercial Health Plans		Medicaid Managed Care Organizations		Washington Counties, Commercially Insured		Washington Counties, Medicaid Insured	
State Average = 35%		State Average = 63%		State Average = 35%		State Average = 63%	
Lowest performance	Highest performance	Lowest performance	Highest performance	Lowest performance	Highest performance	Lowest performance	Highest performance
15%	68%	56%	64%	11%	55%	53%	71%

Figure 8: Mental Health Services for Adults, Ages 18–64

RESULTS FOR HEALTH PLANS				RESULTS FOR COUNTIES			
Commercial Health Plans		Medicaid Managed Care Organizations		Washington Counties, Commercially Insured		Washington Counties, Medicaid Insured	
State Average = 29%		State Average = 46%		State Average = 29%		State Average = 46%	
Lowest performance	Highest performance	Lowest performance	Highest performance	Lowest performance	Highest performance	Lowest performance	Highest performance
16%	53%	42%	48%	15%	44%	35%	52%

Figure 9: Variation among **Counties** for Mental Health Services for **Commercially Insured** Adults, Ages 18–64

STATE AVERAGE: 29%

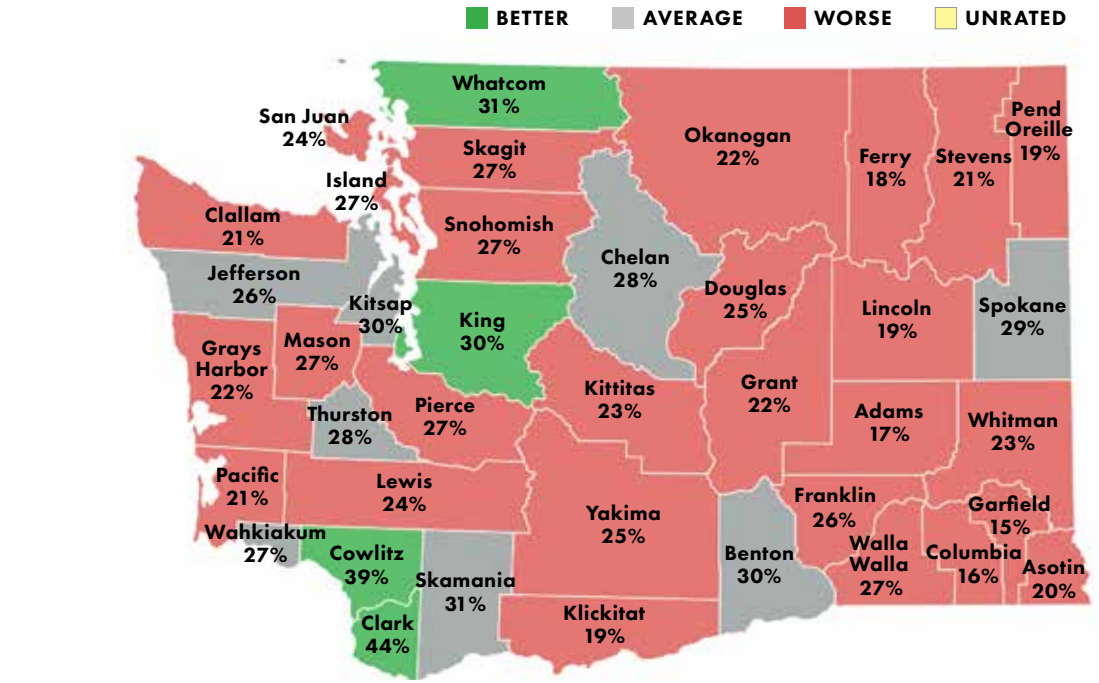


Figure 10: Variation among **Accountable Communities of Health** for Mental Health Services for **Commercially Insured** Adults, Ages 18–64

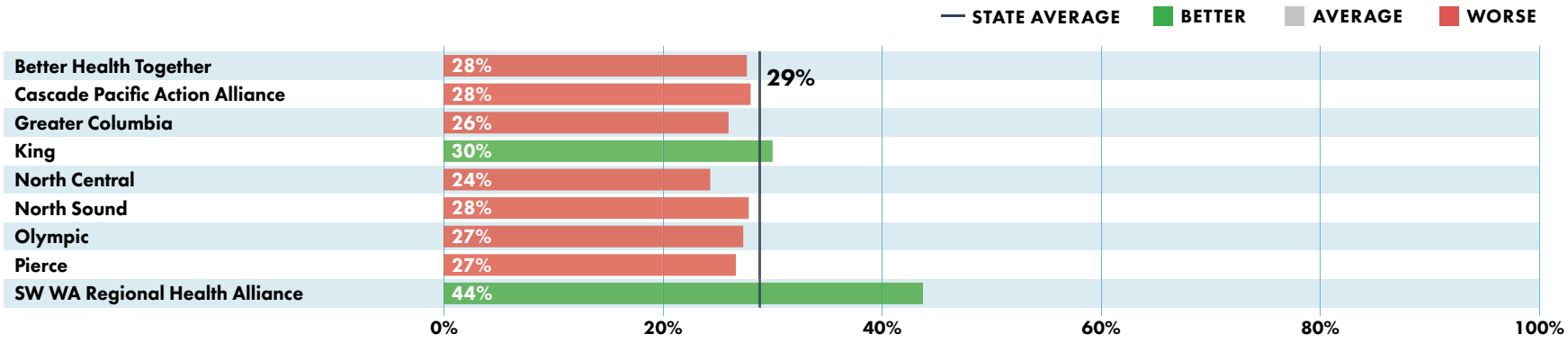


Figure 11: Variation among **Counties** for Mental Health Services for **Medicaid Insured** Adults, Ages 18–64

STATE AVERAGE: 46%

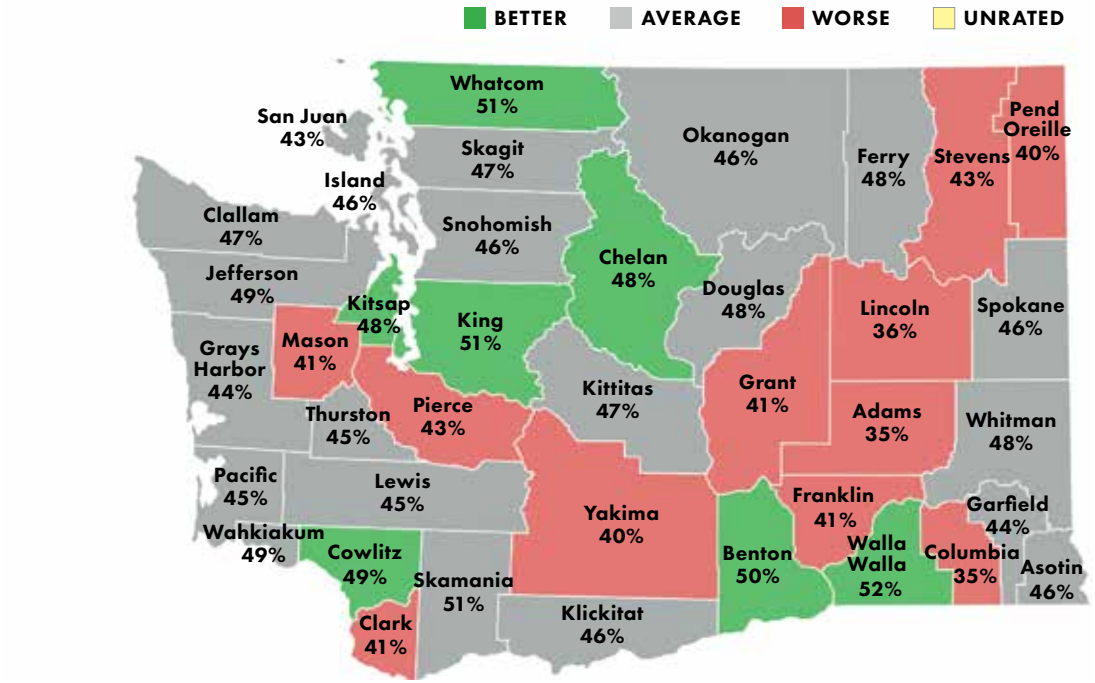
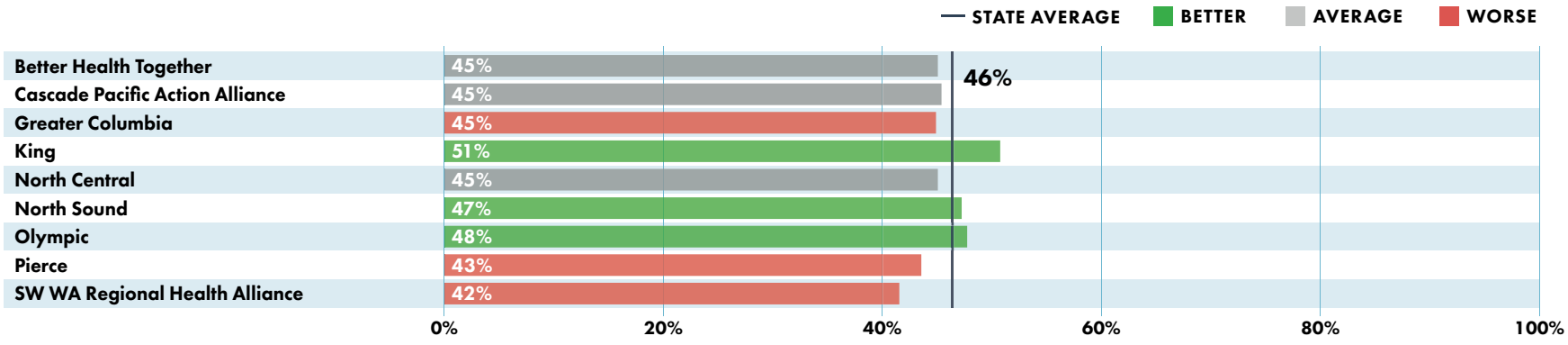


Figure 12: Variation among **Accountable Communities of Health** for Mental Health Services for **Medicaid Insured** Adults, Ages 18–64



Substance use disorder services for children and adults

The measure for Substance Use Disorder Service Penetration (Substance Use Disorder Services for Children and Adults) only includes the Medicaid population in 2016 and results are available at the county and Accountable Communities of Health levels. Results for both children and adults highlight the gap between the need for services and services delivered. On average across the state, only 28 percent of adult Medicaid enrollees received substance use disorder services following a diagnosed need for substance use disorder. For children the rate was 36 percent. Even in the best performing counties, about one of three children and six of ten adults do not get the follow-up treatment they should. Given the opioid epidemic in the state and the toll that it has taken, these numbers underscore the need for a concerted effort to improve access to substance use disorder treatment services.

Figure 13: Variation among **Counties** for Substance Use Disorder Services for **Medicaid Insured** Adults, Ages 18–64

STATE AVERAGE: 28%

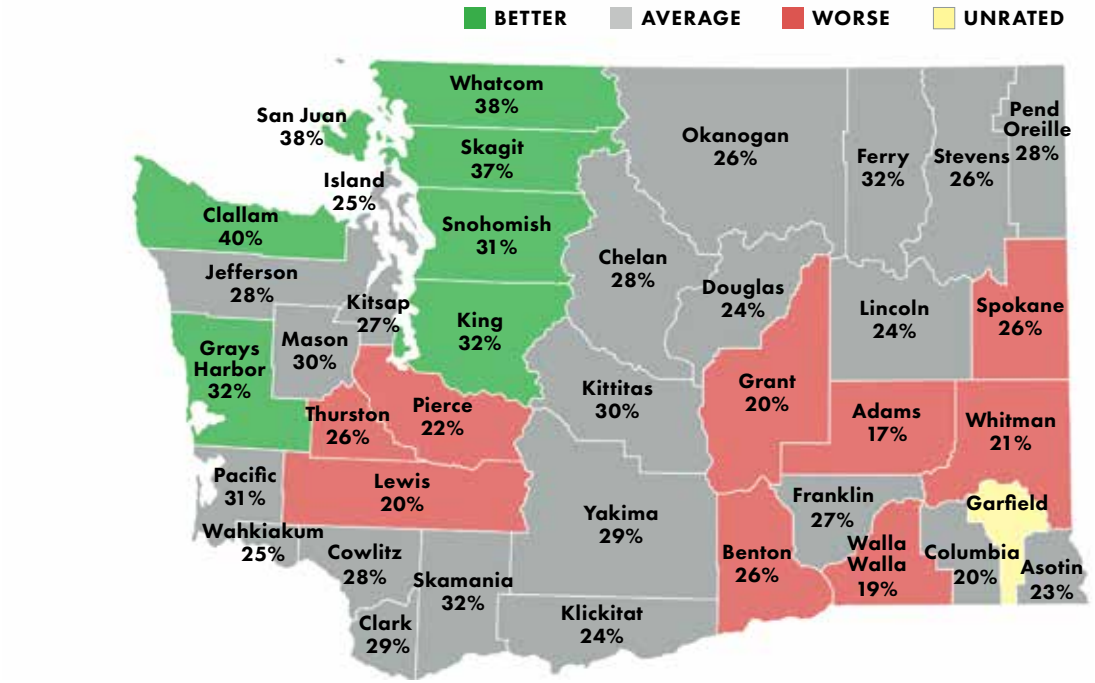


Figure 14: Variation among **Accountable Communities of Health** for Substance Use Disorder Services for **Medicaid Insured** Adults, Ages 18–64

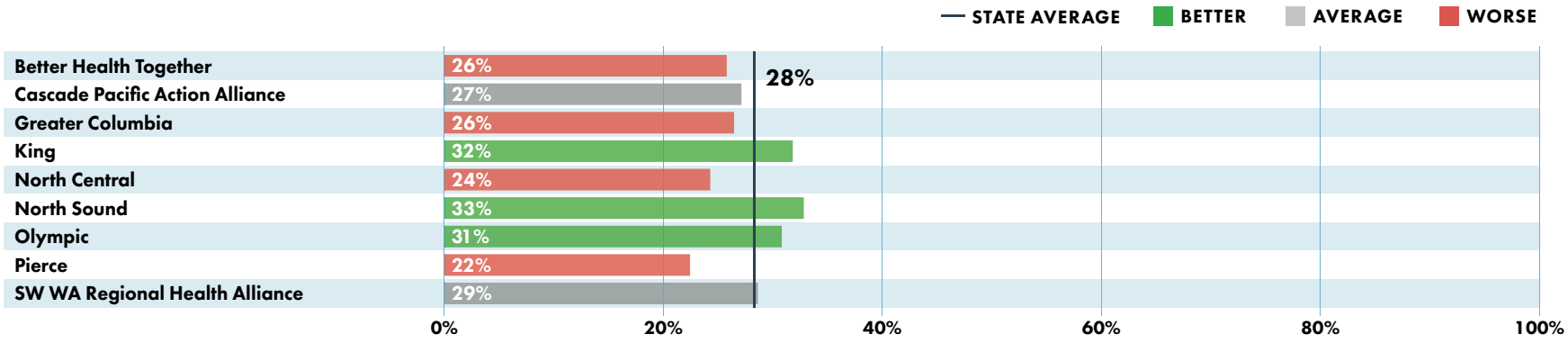


Figure 15: Variation among **Counties** for Substance Use Disorder Services for **Medicaid Insured** Children, Ages 6–17

STATE AVERAGE: 36%

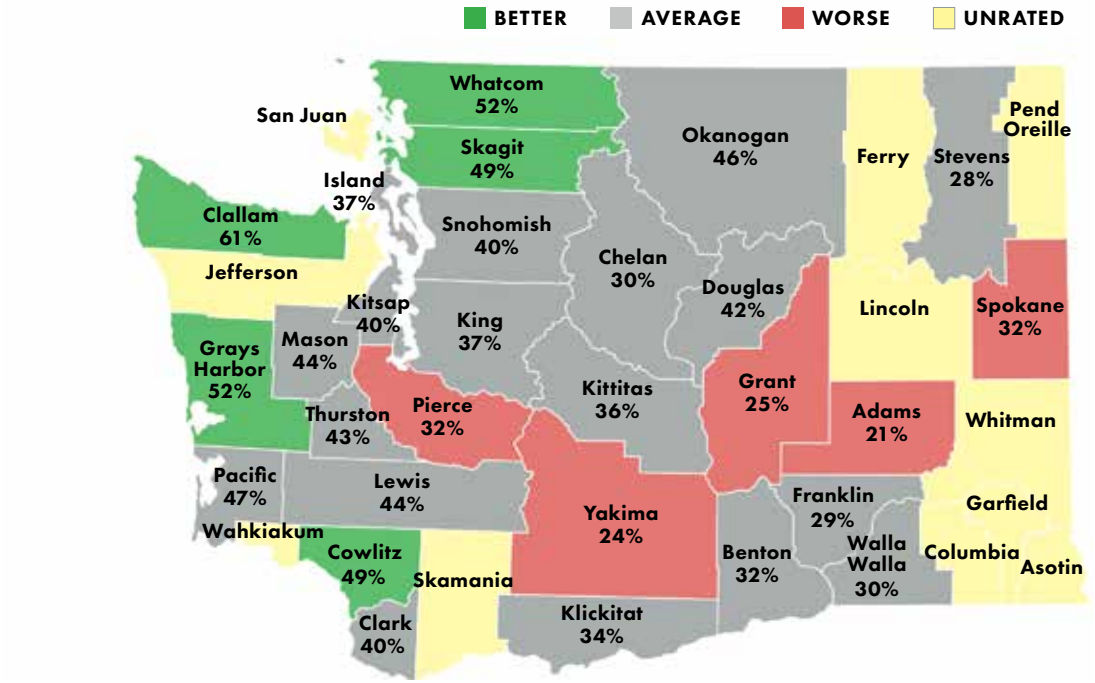
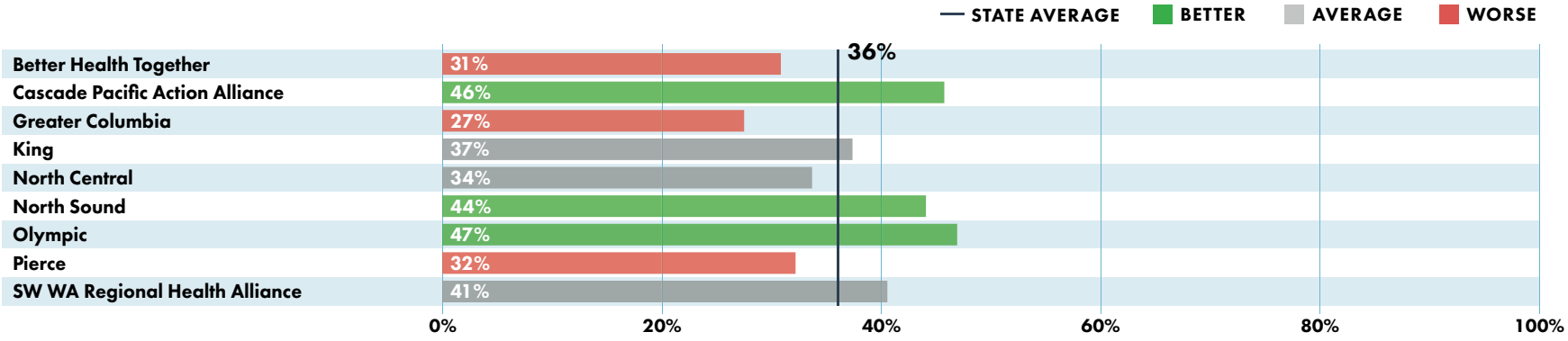


Figure 16: Variation among **Accountable Communities of Health** for Substance Use Disorder Services for **Medicaid Insured** Children, Ages 6–17



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Other Key Findings

MANAGING MEDICATIONS ARE AN IMPORTANT PART OF HEALTH CARE QUALITY

Taking medications as directed (medication adherence) is part of many treatment plans and an important step toward a healthier life. Not taking medication as directed for such conditions as asthma and depression can have a real impact on a person's health. Studies show that as many as half of people with a chronic condition don't take their medication as prescribed. Providers should be monitoring how well medication is working for their patients to ensure that they are getting the maximum benefit from the medication they prescribe.

According to the Washington State Department of Health:

- More than 600,000 people in Washington have asthma
- 120,000 of these people are children
- More than 5,000 people with asthma are hospitalized each year
- Nearly 100 die each year from asthma

When asthma is not properly controlled, it can lead to serious breathing trouble, fatigue, confusion, visits to the hospital and, as noted above, even death. Successful management of asthma is possible through regular use of medications that provide long-term control of the condition. In this report, we measure how often people (ages 5–85) with persistent asthma remained on their prescribed asthma medication at least 50 percent of the time.

Major depression is one of the most common mental disorders in the United States. In 2015, an estimated 16.1 million adults ages 18 and older in the United States had at least one major depressive episode in the past year. This number represented 6.7 percent of all U.S. adults.[3] People who are depressed can be treated with medicines called antidepressants. Making sure that patients get the right antidepressant medicine and that they continue to take it correctly is an important part of effective care for depression. In this report, we measure how often people (ages 18 and older) who were treated with antidepressant medication stayed on the medication for at least 12 weeks and then six months or more, both time periods being clinically important.

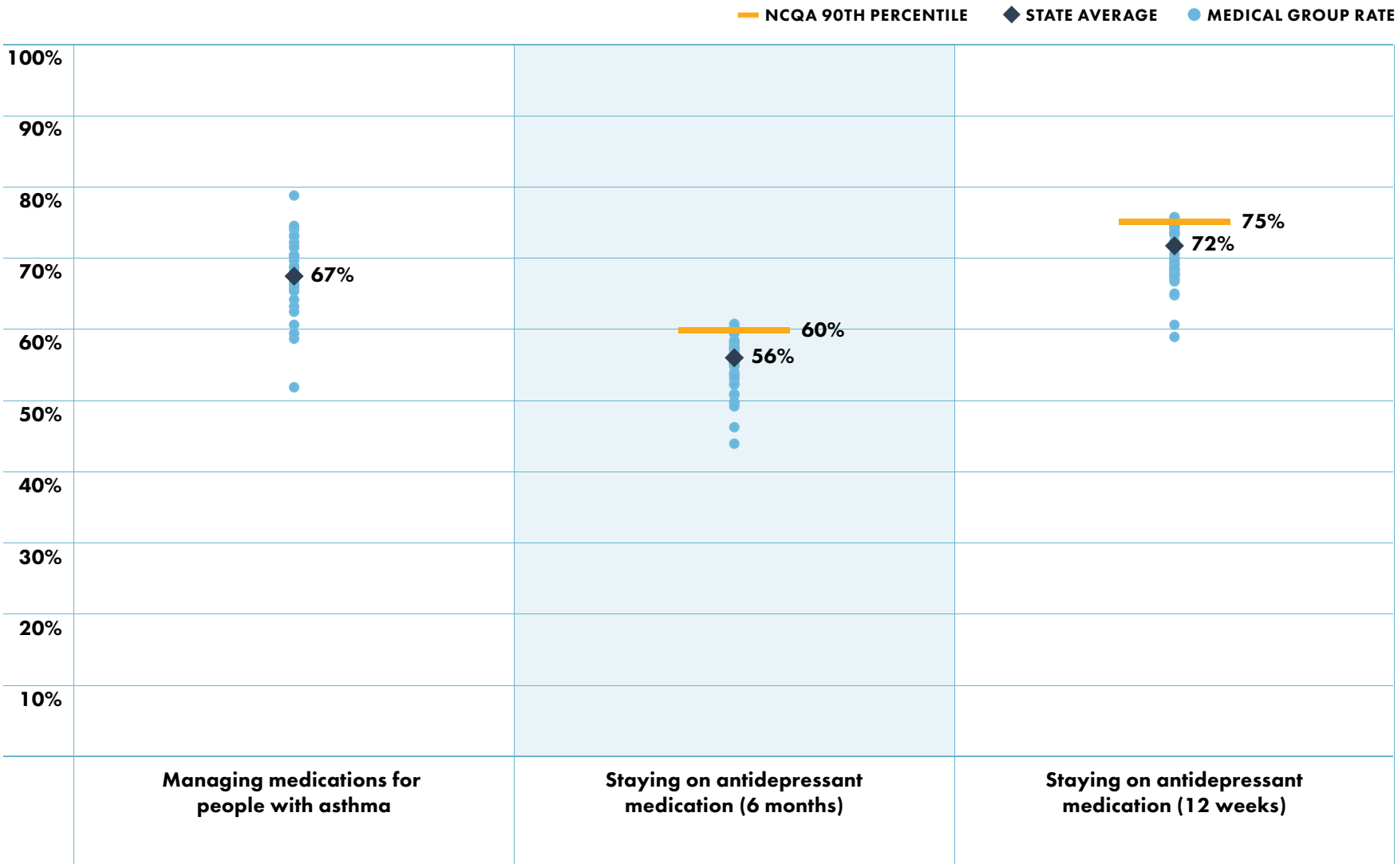
KEY FINDINGS

- There is wide variation among medical groups for both the commercially insured and those insured by Medicaid for all three measures.
- Two thirds of commercially insured patients and six out of ten Medicaid patients with asthma were dispensed appropriate medications that they remained on for at least 50 percent of the measurement year.
- The state falls short of the 90th percentile for the commercially insured and Medicaid populations on both antidepressant measures.

The results in the Community Checkup show that there is plenty of room for improvement when it comes to effectively managing medications to treat asthma and depression. Only a handful of medical groups perform at or above the national 90th percentile for the two measures that have a benchmark. Meanwhile, the range of variation is significant among medical groups, with 15 percentage points or more commonly separating high and low performers. Considering how widespread both asthma and depression are in Washington, better overall performance on these measures would mean improved health and quality of life for potentially thousands of patients.

3. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adults.shtml.

Figure 17: Variation among **Medical Groups** for Medication Management for **Commercially Insured**



CARDIOVASCULAR DISEASE CARE SHOWS ROOM FOR IMPROVEMENT

Cardiovascular disease, commonly called "heart disease," is the term for diseases affecting the heart and blood vessels and your heart's ability to work. The most common cause of heart disease is coronary artery disease, or the narrowing or blockage of the coronary arteries, which supply blood to the heart itself. It's the major reason people have heart attacks. Cholesterol testing and certain medications, such as statins, which lower cholesterol levels, have been proven to help in managing heart disease. In this year's Community Checkup, we include a new measure, Statin Therapy for Patients with Cardiovascular Disease. This measure looks at how often adults who were identified as having cardiovascular disease were prescribed a statin medication. For the commercially insured population, the state average is 82 percent, with some medical group results as low as 64 percent and others as high as 88 percent. Results for the population insured through Medicaid are markedly different. The state average is only 20 percent with some medical group results as low as 8 percent and others as high as 27 percent.

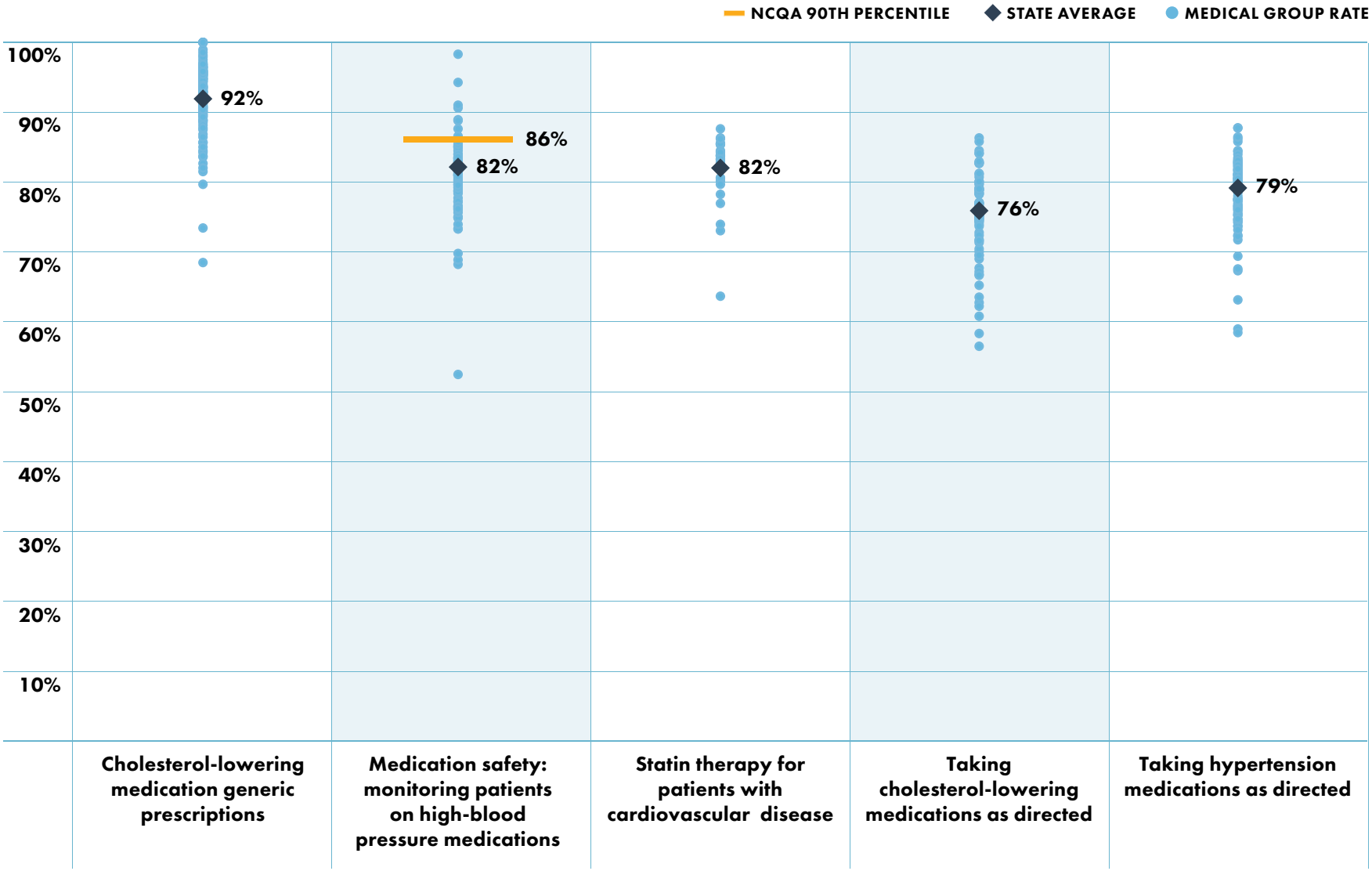
In this year's Community Checkup, we include a new measure, Statin Therapy for Patients with Cardiovascular Disease. This measure looks at how often adults who were identified as having cardiovascular disease were prescribed a statin medication.

Another important measure is Taking Cholesterol Medications as Directed. This measure looks at the percentage of patients adhering to prescribed cholesterol medications by considering the number of days the patient had access to at least one statin based on the prescription fill date and the days of supply. For the commercially insured population, the state average is 76 percent, with some medical group results as low as 56 percent and others as high as 86 percent. Again, results for the population insured through Medicaid are somewhat lower. The state average is 57 percent, with a range for medical group results from 48 to 64 percent.

Managing blood pressure is another very important part of treating cardiovascular disease. When blood pressure remains high, it puts extra strain on the heart and arteries. Over time, this strain can cause arteries to become thicker and less flexible or to become weaker, eventually causing health problems such as heart attack and stroke.

In this year's report, we include three measures related to blood pressure control. The first two measures have results for medical groups and clinics; these include (1) Taking Hypertension (High Blood Pressure) Medications as Directed, and (2) Monitoring Patients on High Blood Pressure Medications. These results are shown on the next page along with the measures related to lowering cholesterol.

Figure 18: Variation among **Medical Groups** for Cardiovascular Disease Care for **Commercially Insured**



Results for an additional measures, Controlling High Blood Pressure and Monitoring Patients on High-Blood Pressure Medications, are available at the health plan level only. The first measure looks at the percentage of adults who had a diagnosis of hypertension and whose blood pressure was adequately controlled (blood pressure lower than 140/90). The second measure looks at patients who are on high-blood pressure medications and were monitored at least once during the measurement period.

Unfortunately, many patients with high-blood pressure do not have their blood pressure well controlled, putting them at risk for potentially serious complications. The results for both commercially and Medicaid health plans fall well short of the national 90th percentile, indicating an opportunity for improvement. Performance for monitoring patients on high-blood pressure medications is better, but still lags behind the national 90th percentile for the commercially insured.

BASED ON RESULTS REPORTED BY THE HEALTH PLANS:

- More than four out of ten Medicaid patients in Washington with hypertension and nearly as many commercially insured patients do not have their blood pressure adequately under control.
- Nearly two out of ten commercially insured patients on high-blood pressure medications did not receive the proper monitoring.

Figure 19: **Medicaid** Health Plan Results for Blood Pressure Control for People with Cardiovascular Disease

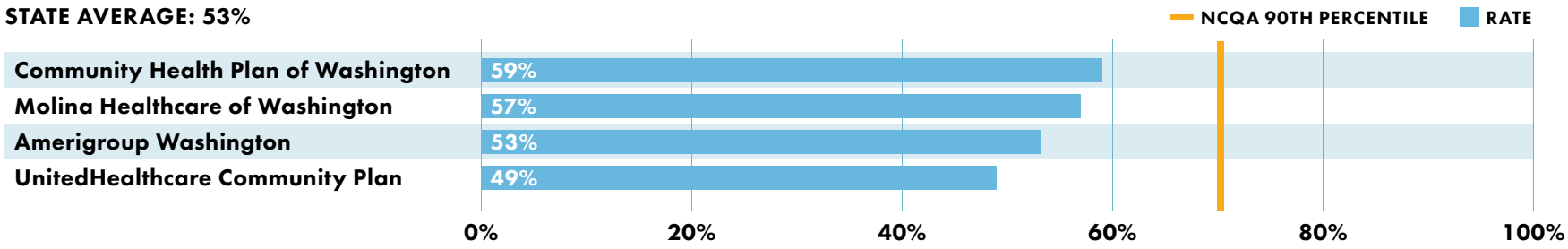


Figure 20: **Medicaid** Health Plan Results for Medication Safety: Monitoring Patients on High-Blood Pressure Medication

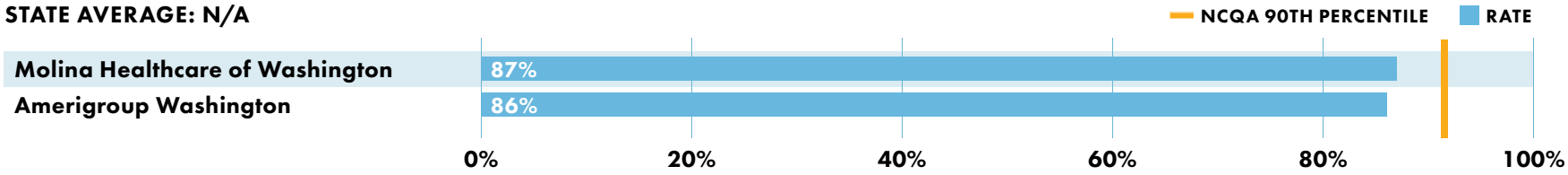


Figure 21: **Commercial** Health Plan Results for Blood Pressure Control for People with Cardiovascular Disease

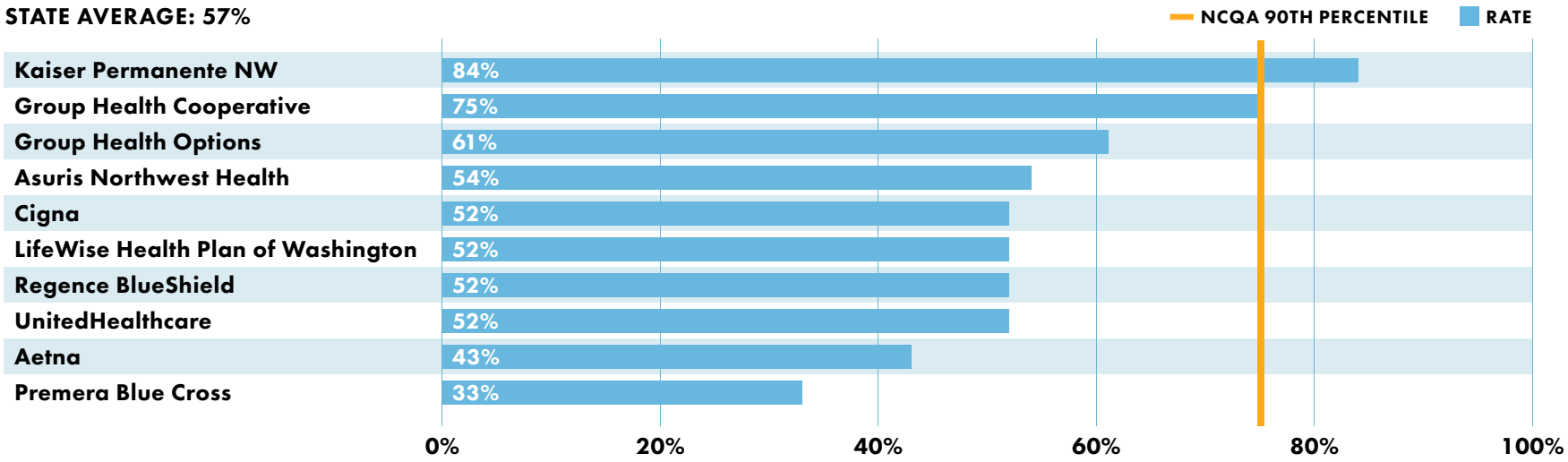
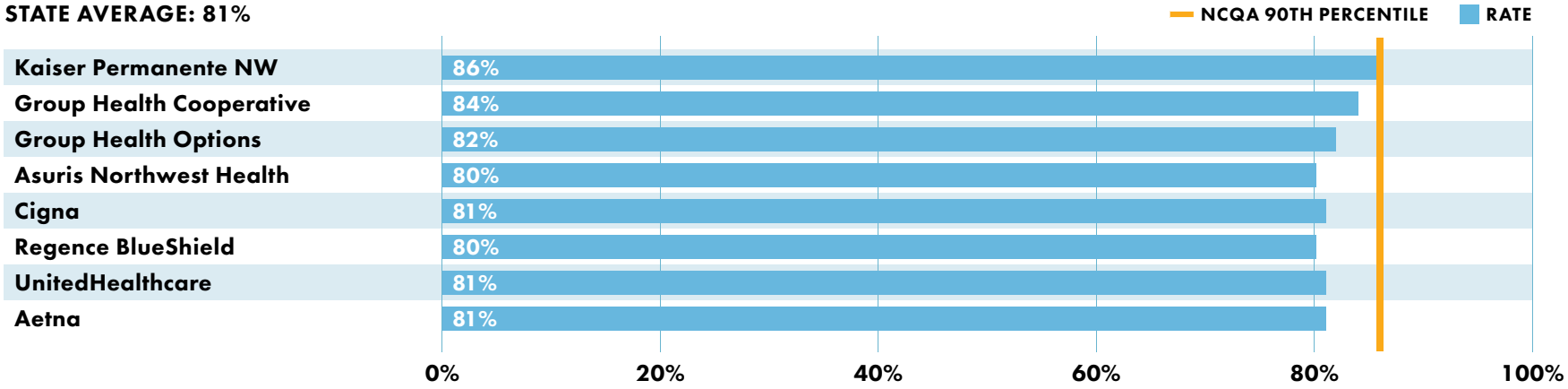


Figure 22: **Commercial** Health Plan Results for Medication Safety: Monitoring Patients on High-Blood Pressure Medication



VACCINATION RATES STILL REMAIN LOW IN PARTS OF THE STATE

In this year's report, results for the rate of immunization are available for counties and groupings of counties called Accountable Communities of Health.

Vaccines are among the most proven, effective prevention strategies in health care. They reduce the risk of infection by working with the body's natural defenses to help it safely develop immunity to disease. The diseases that vaccines prevent can be dangerous, or even deadly. But Washington is seeing the re-introduction of diseases, such as measles, formerly considered under control.

By the age of two, children should receive vaccines for diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, hepatitis A and B, chicken pox, rotavirus, pneumococcal and influenza. In this year's report, we're seeing that only 33 percent of children statewide received these recommended vaccines, with some counties as low as 6 percent and others as high as 43 percent. By the age of 13, adolescents should receive vaccines for meningococcal, human papillomavirus and a booster for tetanus, diphtheria and pertussis. Overall, 60 percent of adolescents statewide received these recommended vaccines, with some counties as low as 10 percent and others as high as 74 percent. An annual vaccine for influenza is recommended for everyone age six months and older, and adults over the age of 65 should receive a one-time vaccine for pneumococcal disease. The statewide average rate of immunization for flu and pneumonia is 21 and 73 percent, respectively.

Vaccinations are not only about preventing childhood diseases. They can also prevent cancer. Human papillomavirus (HPV) is the leading cause of cervical and anal cancers. Vaccinating adolescent girls and boys before they become sexually active can break the link and prevent diseases from occurring. Yet, in Washington, only 17 percent of boys and 22 percent of girls (age 13) received the HPV vaccine during the measurement year.

Despite the value of vaccinations in preventing disease, vaccination rates in Washington for children and adolescents are much lower than they should be.

KEY FINDINGS

- Only one-third of children have received their recommended vaccinations by age two.
- Four out of ten adolescents have not received their recommended vaccinations by age 13.
- Vaccination rates for children and adolescents show wide variation among counties.

Despite the value of vaccinations in preventing disease, vaccination rates in Washington for children and adolescents are much lower than they should be. The overwhelming majority of young children have not had all the vaccinations that they should have by their second birthday. Vaccination rates for adolescents are considerably better, but many are still at risk for diseases such as meningitis, which strikes this age group particularly hard. Moreover, depending on where they live, adolescents may be much less likely to receive the recommended vaccinations due to wide geographic variation.

Figure 23: Variation among **Counties** for Childhood Immunization Status by Age 2

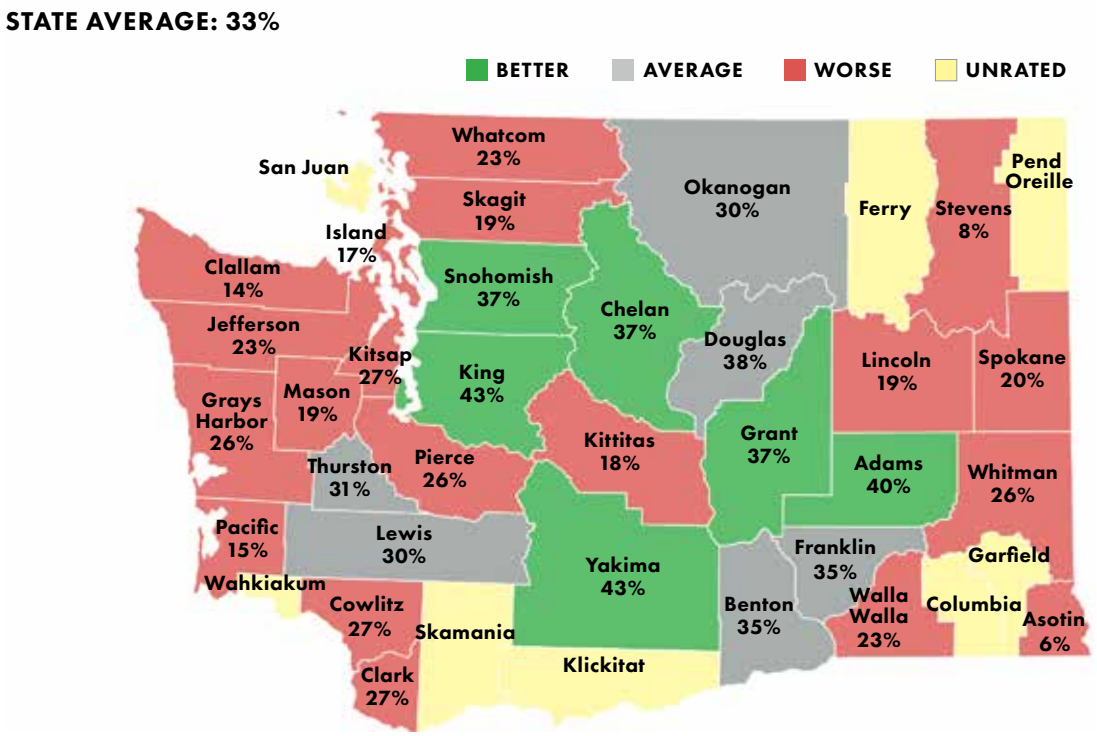


Figure 24: Variation among **Accountable Communities of Health** for Childhood Immunization Status by Age 2

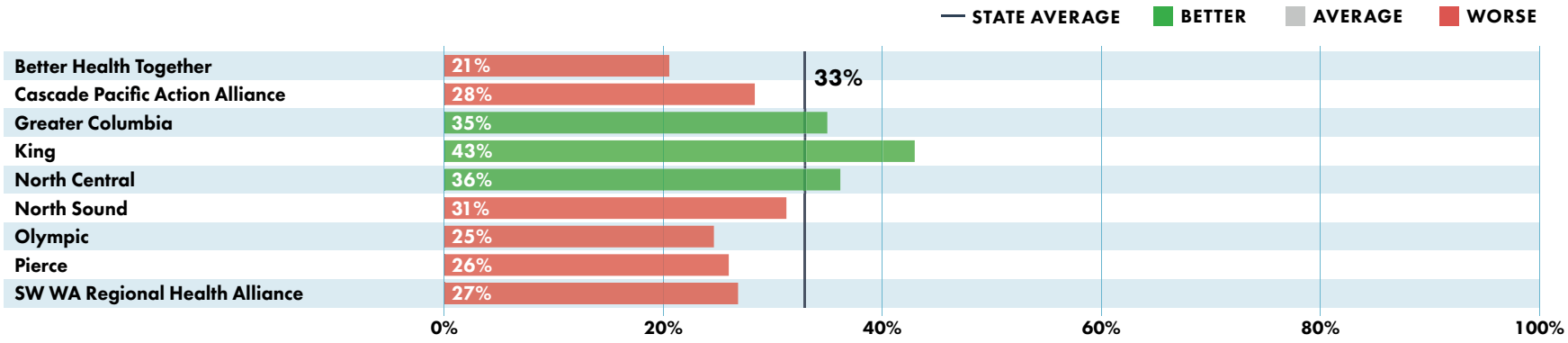


Figure 25: Variation among **Counties** for Childhood Immunization Status by Age 13

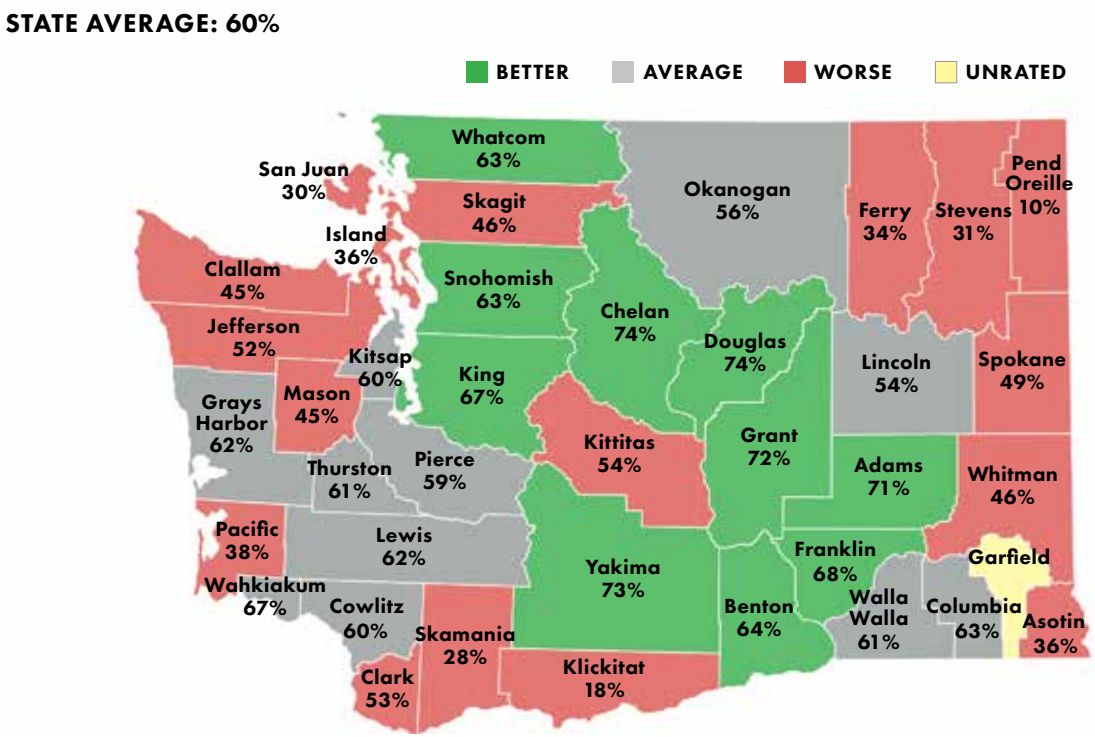


Figure 26: Variation among **Accountable Communities of Health** for Childhood Immunization Status by Age 13

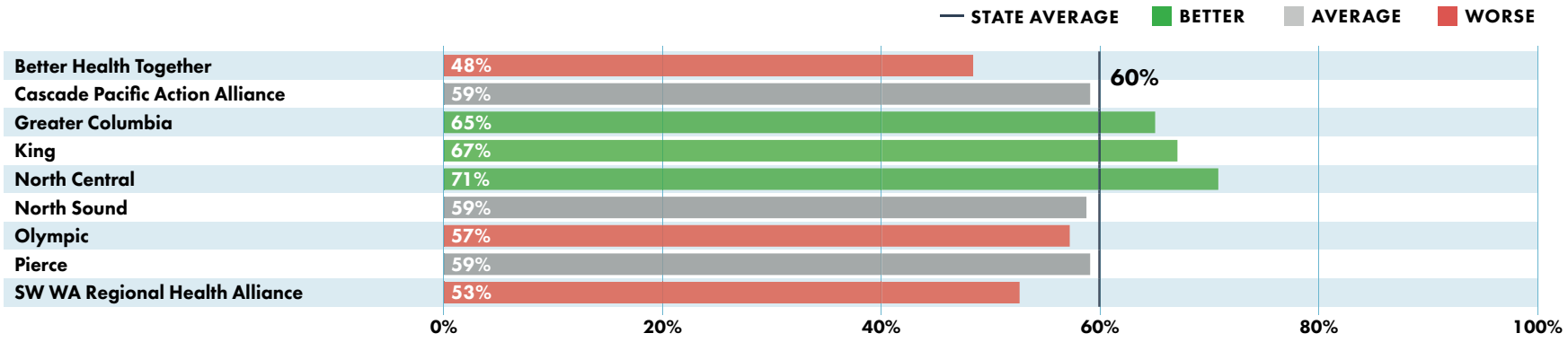


Figure 27: Variation among **Counties** for HPV Vaccination Rates for Girls

STATE AVERAGE: 22%

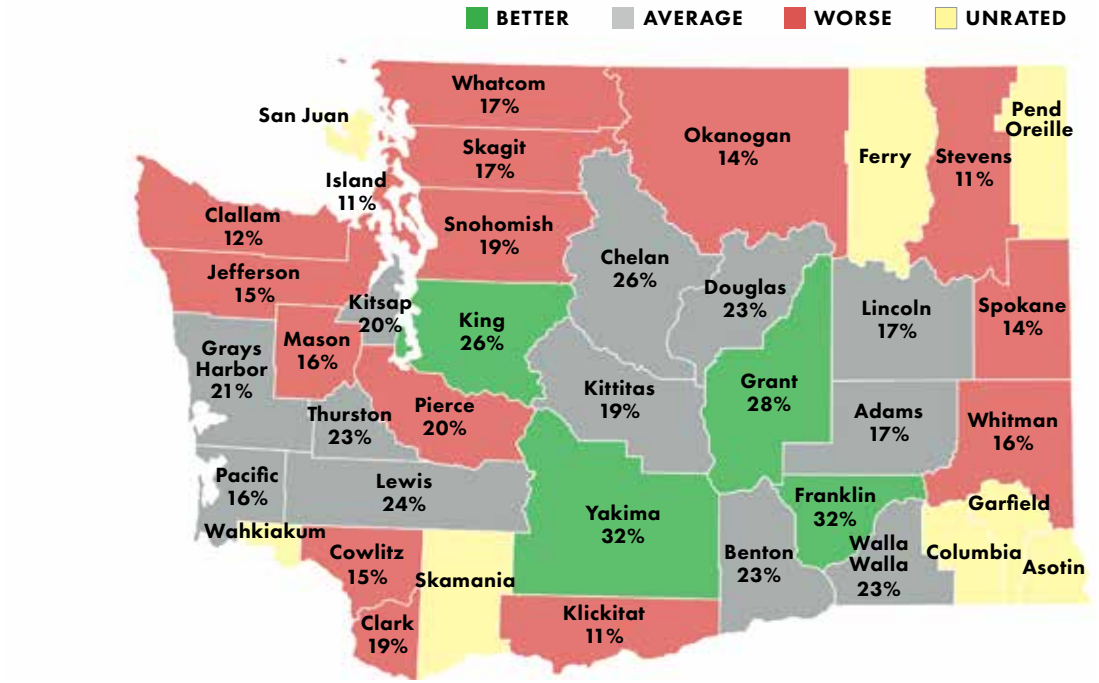


Figure 28: Variation among **Accountable Communities of Health** for HPV Vaccination Rates for Girls

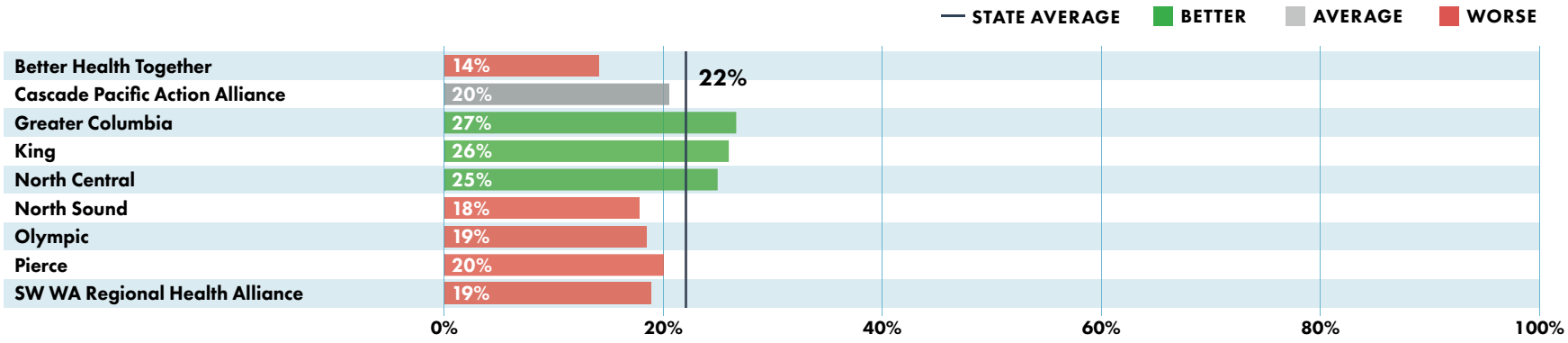


Figure 29: Variation among **Counties** for HPV Vaccination Rates for Boys

STATE AVERAGE: 17%

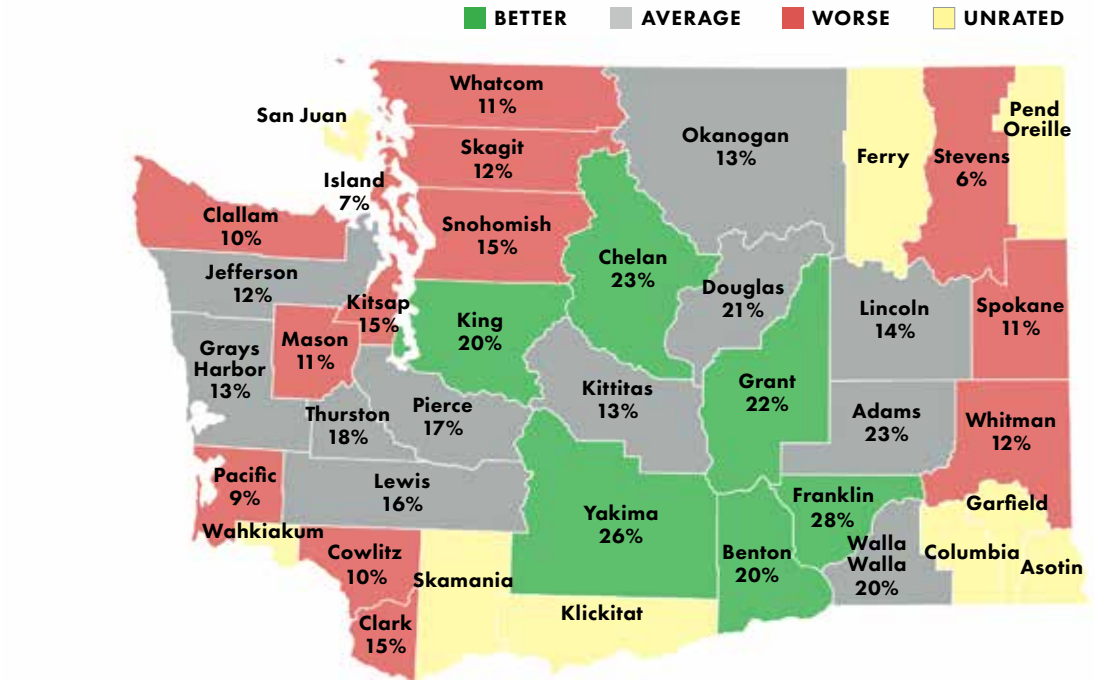
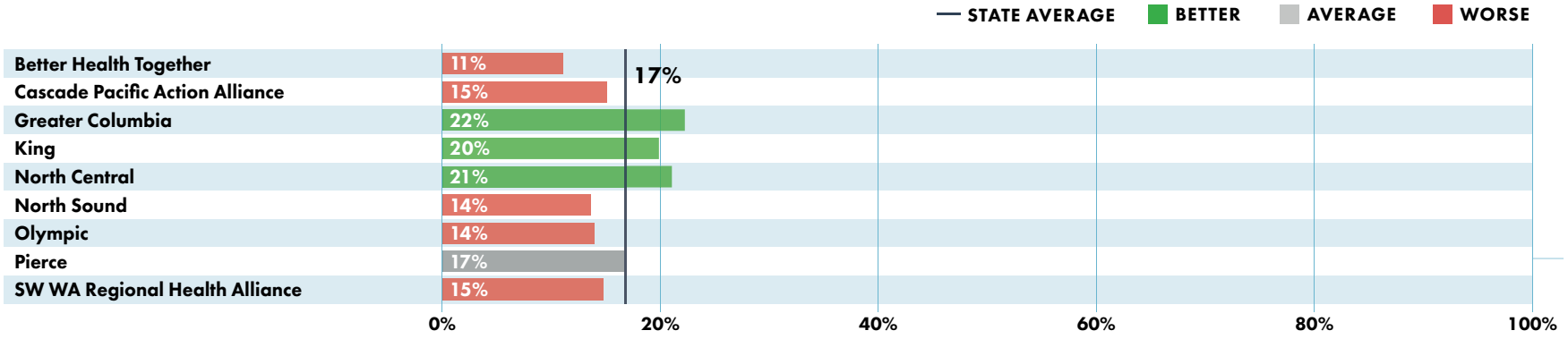


Figure 30: Variation among **Accountable Communities of Health** for HPV Vaccination Rates for Boys



CANCER SCREENING RATES SHOW ROOM FOR IMPROVEMENT

In adulthood, health screenings are an important part of a person's health regimen. Screenings for breast cancer, colon cancer, cervical cancer and chlamydia infection are recommended at appropriate intervals to detect a disease at an early stage, when it is most treatable. But as the following charts indicate, there is room for improvement to achieve national top ten percent performance and the performance of medical groups is widely divergent.

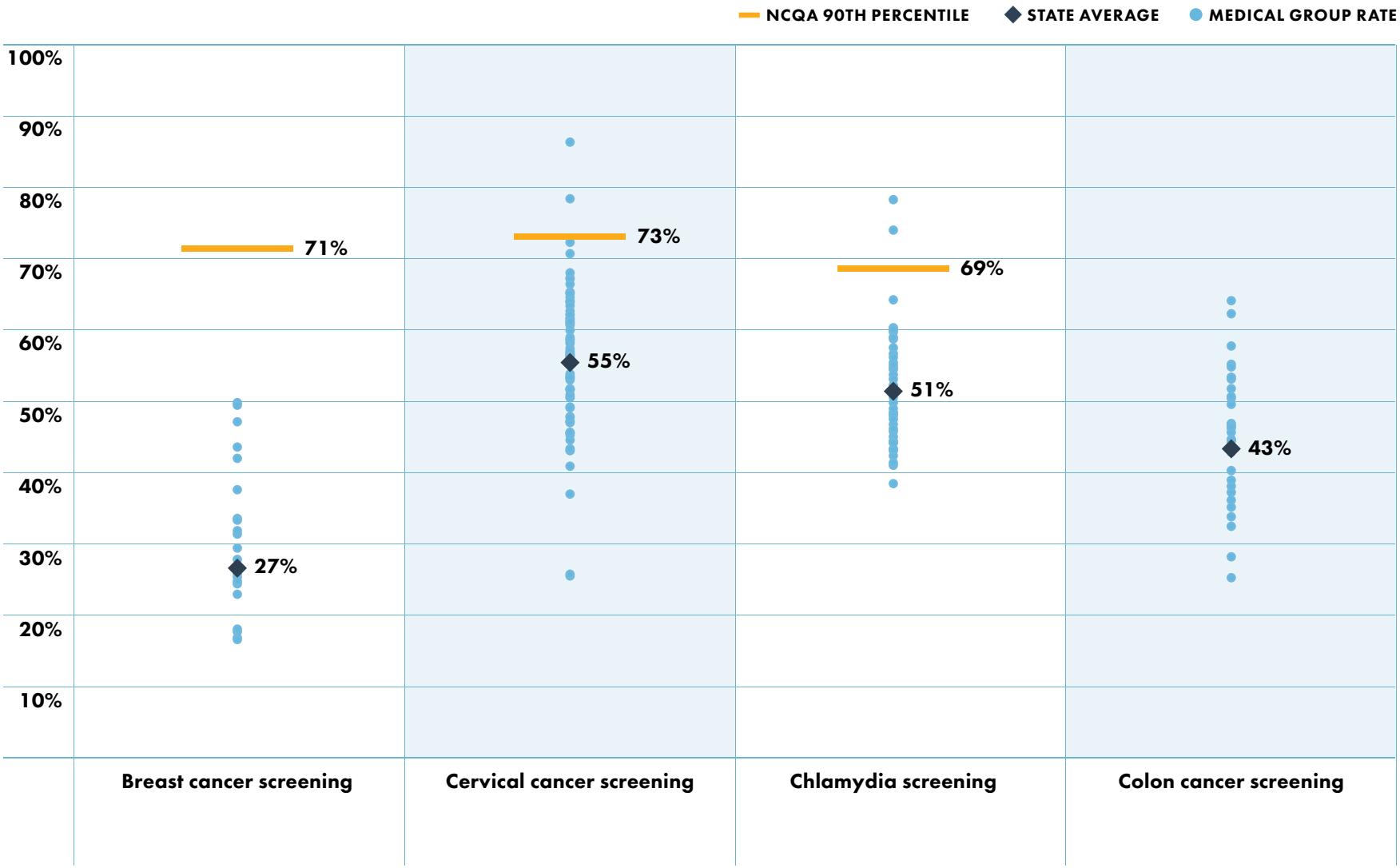
Cancer screenings represent some of the widest swings in performance among medical groups in this report. (The differences among counties are also substantial.) In a high-performing health care system, results would be tightly clustered around the state average and the state average would be at or above the national 90th percentile. The long string of medical groups arrayed on the following charts shows just how much room there is for improvement in consistently ensuring patients receive these important screenings.

Cancer screenings represent some of the widest swings in performance among medical groups in this report.

KEY FINDINGS

- Variations of 30 percentage points and more among medical groups are common for measures pertaining to cancer screenings.
- A number of medical groups perform above the national 90th percentile for commercially insured patients, particularly for breast cancer and cervical cancer screenings.
- Rates for patients insured through Medicaid are substantially lower than for the commercially insured population on all the measures except chlamydia screening, where it is significantly above the commercially insured rate.

Figure 31: Variation among **Medical Groups** for Cancer Screenings for **Medicaid Insured**



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Health Care Spending

WHY IT'S IMPORTANT TO MEASURE HEALTH CARE SPENDING

Health care represents one of the biggest expenses that individuals bear. According to the Kaiser Family Foundation, an estimated one in five Americans *with insurance* has had problems paying medical bills in the past year. Compounding the problem is the difficulty consumers can have trying to understand the cost of a treatment or procedure in advance. Even though costs can vary tremendously from facility to facility, for no apparent reason, accurate price transparency remains elusive for many consumers, making it impossible for them to make decisions about spending their health care dollars wisely.

We're only at the dawn of price transparency in Washington state. Price is one of the key elements of value (along with quality and patient experience) needed to achieve Healthier Washington's goal of achieving the Triple Aim. Over time, as stakeholders work together, we expect to see greater transparency about health care costs in our state. In the meantime, the State, as the largest purchaser of health care, is doing its part to encourage transparency by reporting what it is spending to purchase health care in Washington and continuing to look for opportunities to slow the rate of spending growth.

Annual per-capita state-purchased health care spending growth relative to state GDP

The table below contains information on the Washington State-purchased health care annual spending (Medicaid and PEB) as a percentage of Washington State Gross Domestic Product (GDP) for a six-year period (2010–2015).[4] Each year the denominator reflects that year's GDP and the numerator includes the amount spent by the state on health care (i.e. 2013 Washington state-purchased health care annual spending as a percentage of 2013 state GDP).[5] Percentages reflect year over year changes.

The chart on the following page shows the close relationship between the percentage of spending as a percentage of state GDP and the average monthly members for state purchased care. The increase in eligible members between 2013 and 2014 is a reflection of Medicaid expansion under the federal Affordable Care Act.

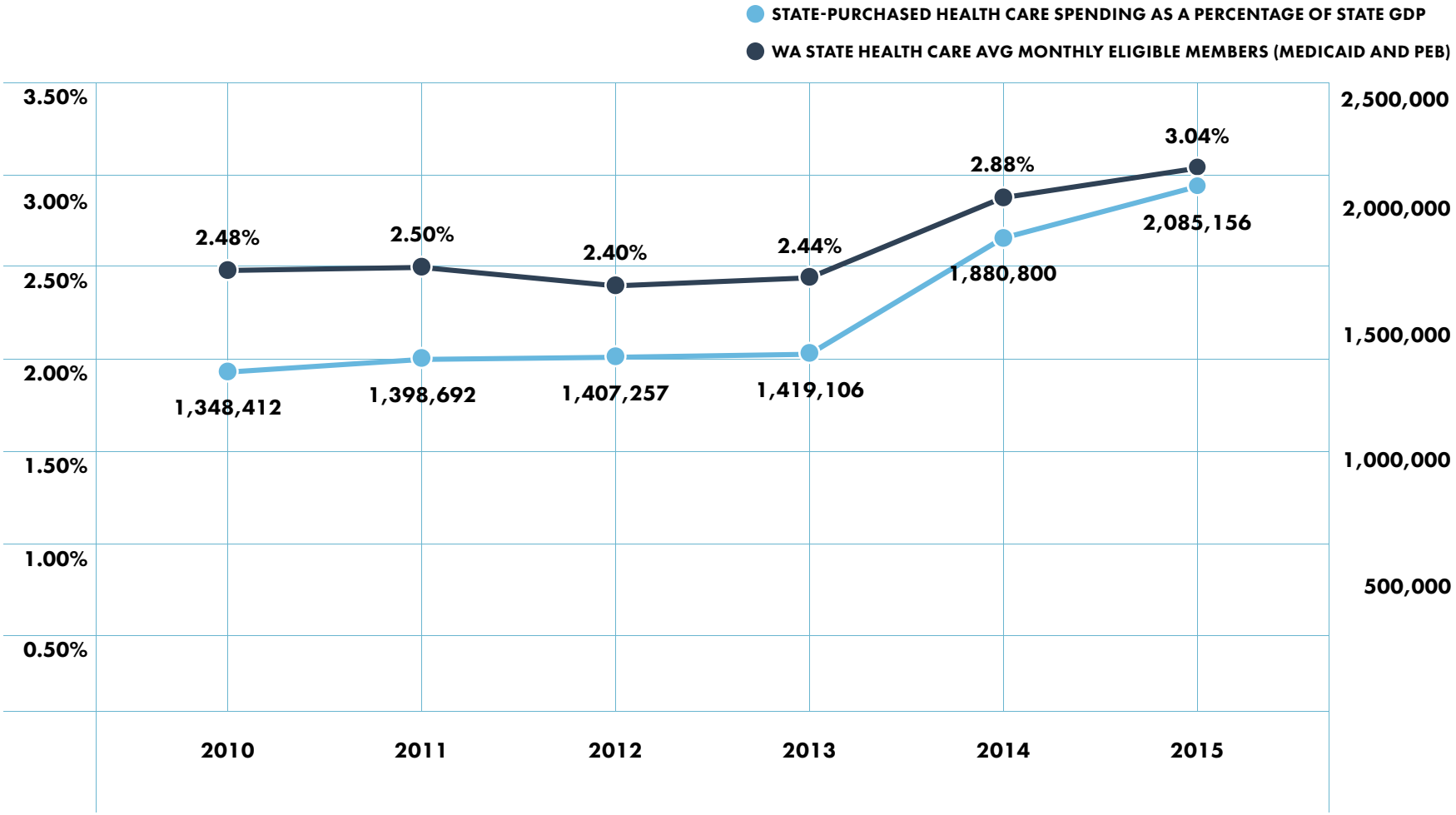
Figure 32: Heath Care Spending Growth Related to the Washington State Gross Domestic Product, 2010–2015

	WA State-Purchased Health Care Annual Spending (includes Medicaid and PEB)		WA State Health Care Avg Monthly Eligible Members (Medicaid and PEB)		WA State GDP		State-Purchased Health Care Spending as a Percentage of State GDP	
2010	$8,992,274,184		1,348,412		$362,114,000,000		2.48%	
2011	$9,306,202,545	3% Change	1,398,692	4% Change	$372,287,000,000	3% Change	2.50%	1% Change
2012	$9,363,522,897	1% Change	1,407,257	1% Change	$390,154,000,000	5% Change	2.40%	-4% Change
2013	$9,841,743,810	5% Change	1,419,106	1% Change	$402,789,000,000	3% Change	2.44%	2% Change
2014	$12,161,212,636	24% Change	1,880,800	33% Change	$422,767,000,000	5% Change	2.88%	18% Change
2015	$13,467,161,622	11% Change	2,085,156	11% Change	$443,665,000,000	5% Change	3.04%	6% Change

4. Sources: WA State GDP from the U.S. Bureau of Economic Analysis – GDP by State in current dollars; Medicaid Expenditures – February 2016 Forecast ; Medicaid Administrative Expenditures – CMS 64; LTSS, SUD and MH Expenditures based on February 2016 DSHS medical forecasts and budgets; Medicaid expenditures includes medical, dental, vision, pharmacy, long-term support services, mental health and substance use disorder expenditures. Exclude Part D Clawback and pass-through payments.

5. This is a change from data that was reported in 2015, which calculated state-purchased health care expenditures *per capita*. In order to understand what is truly being spent on state-purchased health care, it is important to track actual costs and growth in relation to the growth of the state domestic product.

Figure 33: Washington State-Purchased Health Care Spending as a Percentage of State GDP and Total Average Monthly Eligible Members for State-Purchased Health Care



Medicaid per enrollee spending

This table below contains information on annual Medicaid spending per enrollee and includes both state and federal Medicaid payments.[6] These figures represent the average (mean) level of payments across all Medicaid enrollees during a calendar year, based on month of service.[7]

The chart on the following page shows how annual spending on Medicaid per enrollee has changed over time. While Medicaid enrollment increased by more than $650,000 between 2013 and 2015, per enrollee spending dropped by nearly $600.

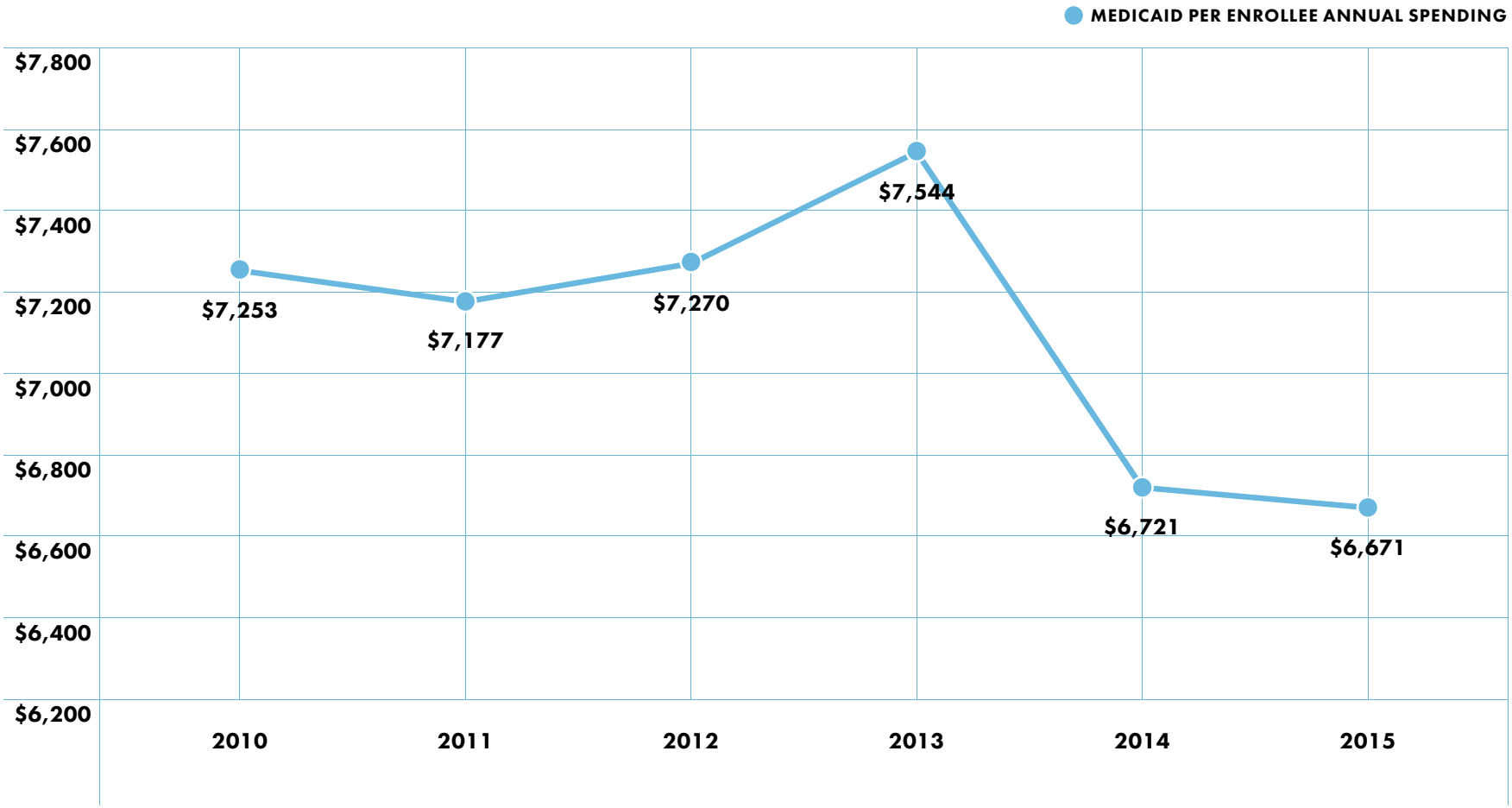
Figure 34: Medicaid per Enrollee Spending in Washington State, 2010–2015

	Medicaid Expenditures		Medicaid Average Member Enrollment		Medicaid per Enrollee Annual Spending	
2010	$7,347,364,307		1,012,990		$7,253	
2011	$7,599,043,607	3% Change	1,058,863	5% Change	$7,177	-1% Change
2012	$7,771,270,669	2% Change	1,068,886	1% Change	$7,270	1% Change
2013	$8,111,259,183	4% Change	1,075,221	1% Change	$7,544	4% Change
2014	$10,283,214,733	27% Change	1,530,091	42% Change	$6,721	-11% Change
2015	$11,538,184,702	12% Change	1,729,578	13% Change	$6,671	-1% Change

6. Source: Medicaid Expenditures – February 2016 Forecast; Medicaid Administrative Expenditures – CMS 64; LTSS, SUD and MH Expenditures based on February 2016 DSHS medical forecasts and budgets; Medicaid expenditures includes medical, dental, vision, pharmacy, long-term support services, mental health and substance use disorder expenditures. Exclude Part D Clawback and pass-through payments.

7. Changes in 2016 reporting include the addition of State Administrative costs and Mental Health data. The Part D Clawback, the monthly payment made by Washington State to the federal Medicare program, is excluded from the 2016 state-purchased health care spending.

Figure 35: Medicaid per Enrollee Annual Spending, 2010–2015



Public employee per enrollee spending

The table below contains information on annual Public Employee Benefit (PEB) spending per enrollee and calculations represent the average (mean) level of payments across all PEB enrollees, during a calendar year, based on date of payment.[8, 9]

The chart on the following page shows PEB per enrollee annual spending from 2010 to 2015.

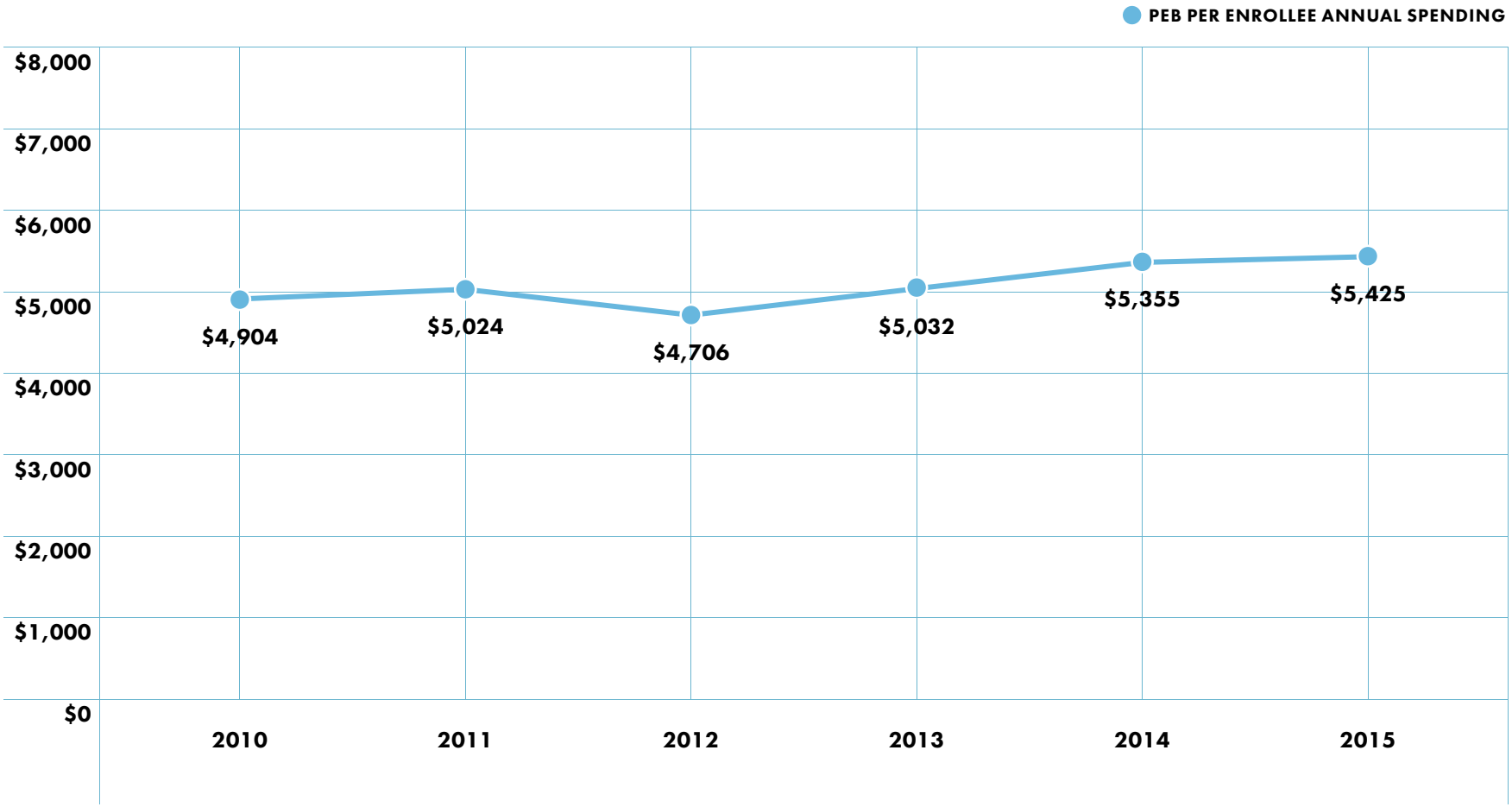
Figure 36: Public Employee per Enrollee Spending in Washington State, 2010–2015

	PEB Expenditures		PEB Average Monthly Enrollment		PEB per Enrollee Annual Spending	
2010	$1,644,909,877		335,422		$4,904	
2011	$1,707,158,938	4% Change	339,829	1% Change	$5,024	2% Change
2012	$1,592,252,228	-7% Change	338,371	0% Change	$4,706	-6% Change
2013	$1,730,484,626	9% Change	343,884	2% Change	$5,032	7% Change
2014	$1,877,997,903	9% Change	350,709	2% Change	$5,355	6% Change
2015	$1,928,976,921	3% Change	355,578	1% Change	$5,425	1% Change

8. Changes in 2016 include the addition of the Medicare risk pool in the total Public Employee spending and the addition of administrative costs.

9. Sources: Calendar Year 2010 – 2013, Milliman PFPM 8.0 (10/8/2015); Calendar Year 2014–2015, Milliman PFPM 3.0 (5/11/2016); Includes the Medicare and Non-Medicare risk pools.

Figure 37: Public Employee Benefit per Enrollee Annual Spending, 2010–2015



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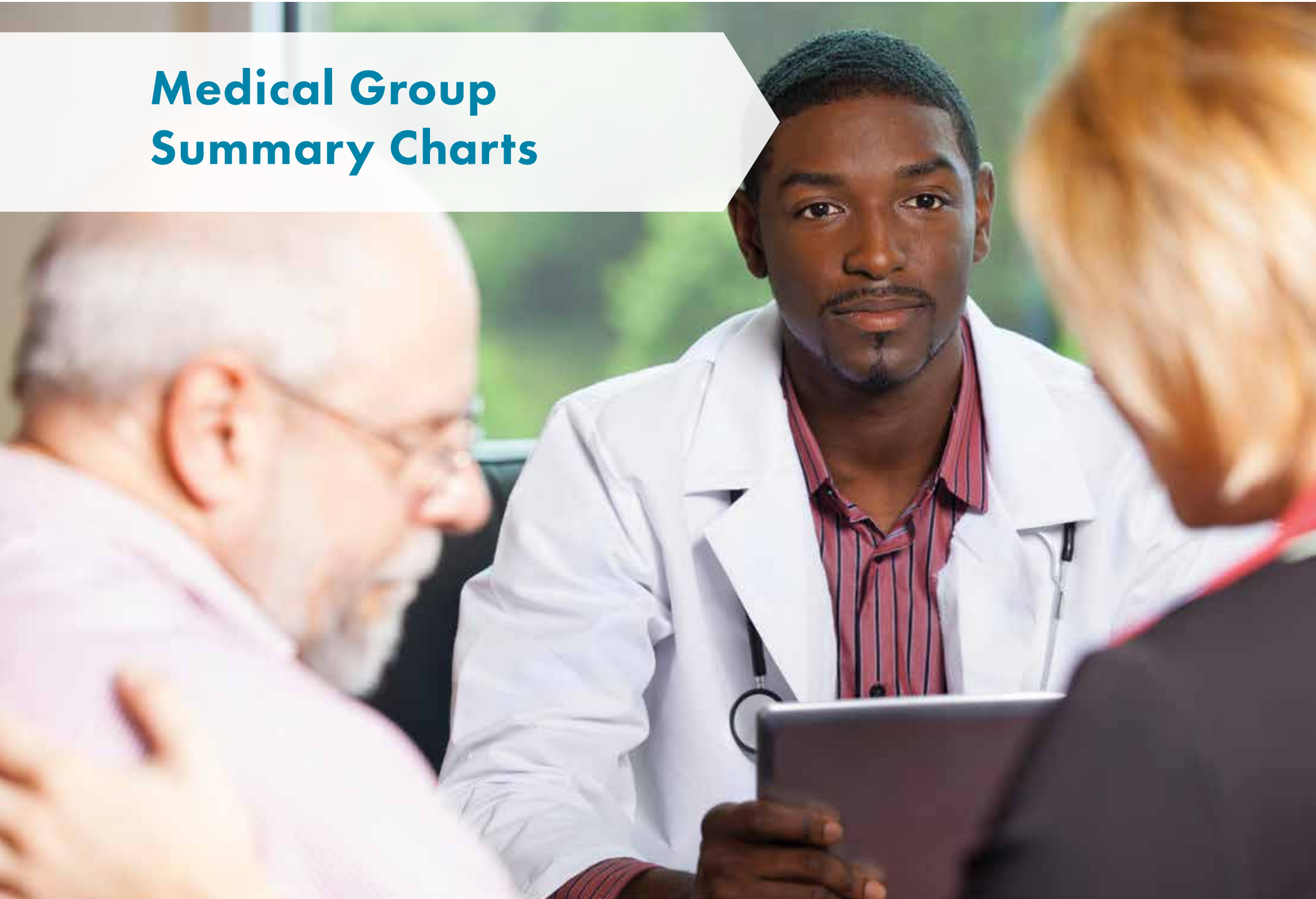
Medical Group Summary Charts

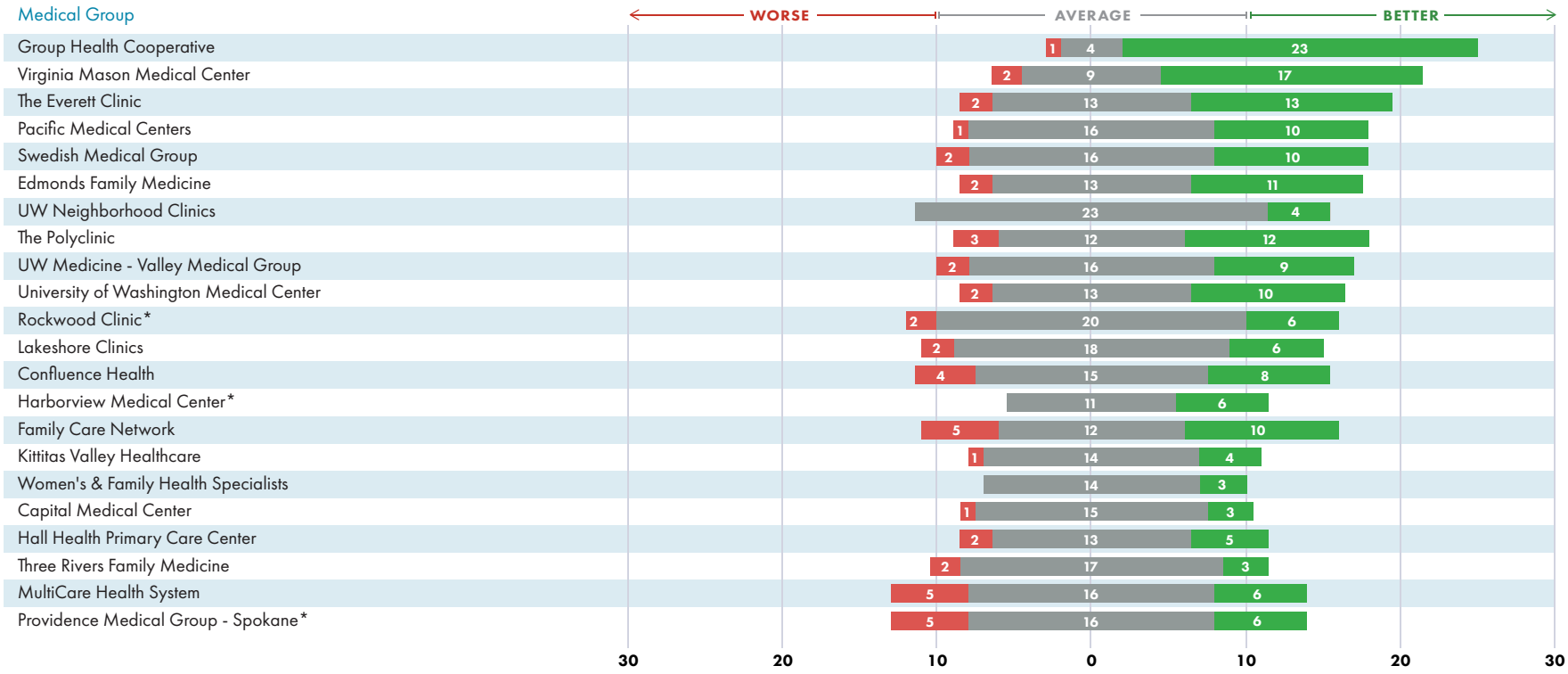


COMPARE MEDICAL GROUP OVERALL PERFORMANCE

The following charts rank medical groups in the Community Checkup based on their results. Only medical groups with five or more reportable measures are included. The ranking is based on a formula that awards two points for each measure with **above average** results, one point for each measure with **average** results and subtracts two points for each measure with **below average** results.

Medical group charts are divided into two groups. The first set is for medical groups with 15 or more reported measures. The second set of charts is for medical groups with between 5 and 14 reportable measures.

Figure 38: Ranking Medical Group Performance for **Commercially Insured**: Medical Groups That Have Results for **15 or More** Measures



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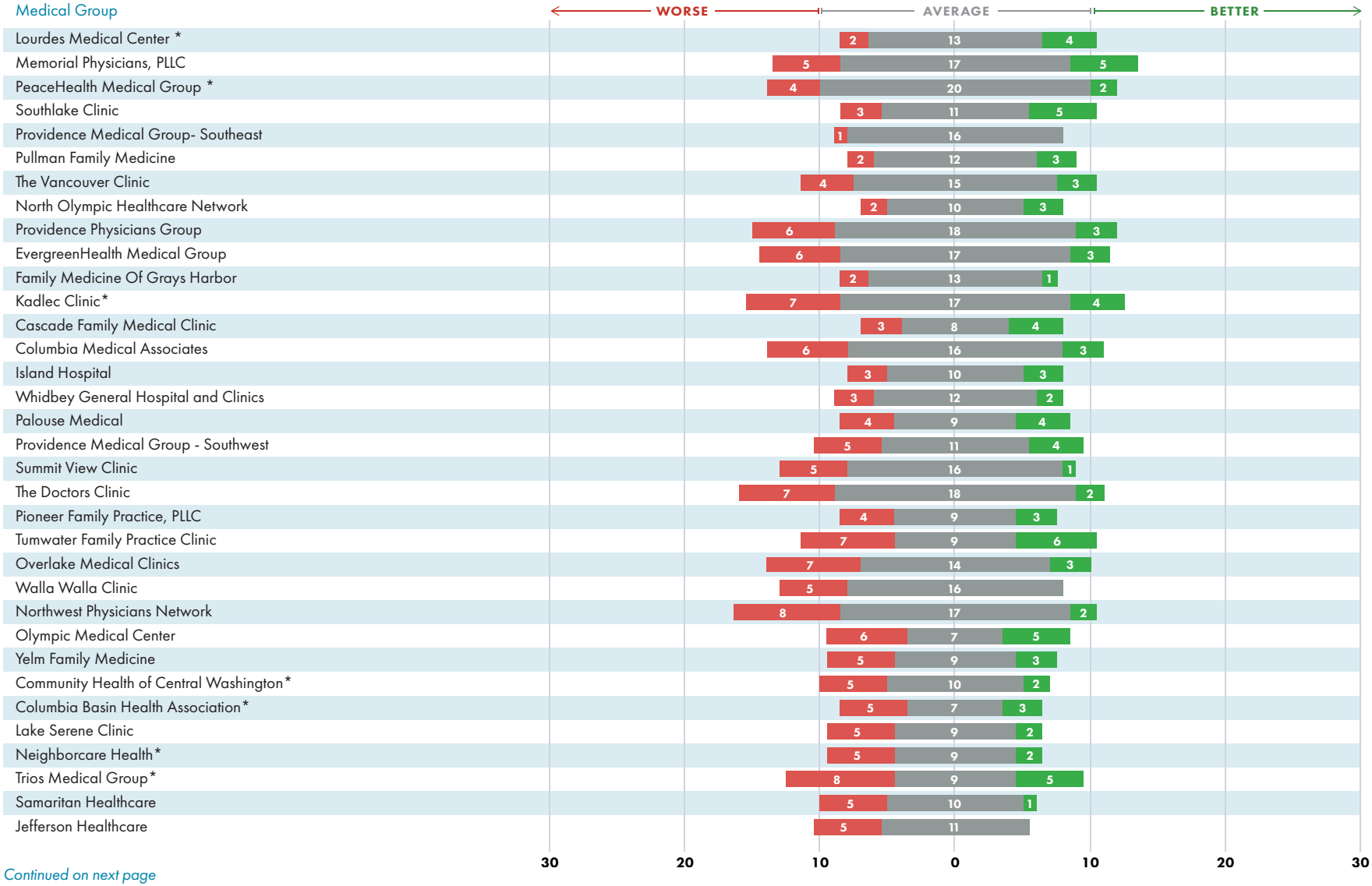
* At least 50% of patients attributed to this medical group have Medicaid coverage.
Based on claims and encounter data with dates of service between 1/1/2004 - 6/30/2015 and the measurement year of 7/1/2014 - 6/30/2015.

Figure 38: Ranking Medical Group Performance for **Commercially Insured**: Medical Groups That Have Results for **15 or More** Measures *(continued)*



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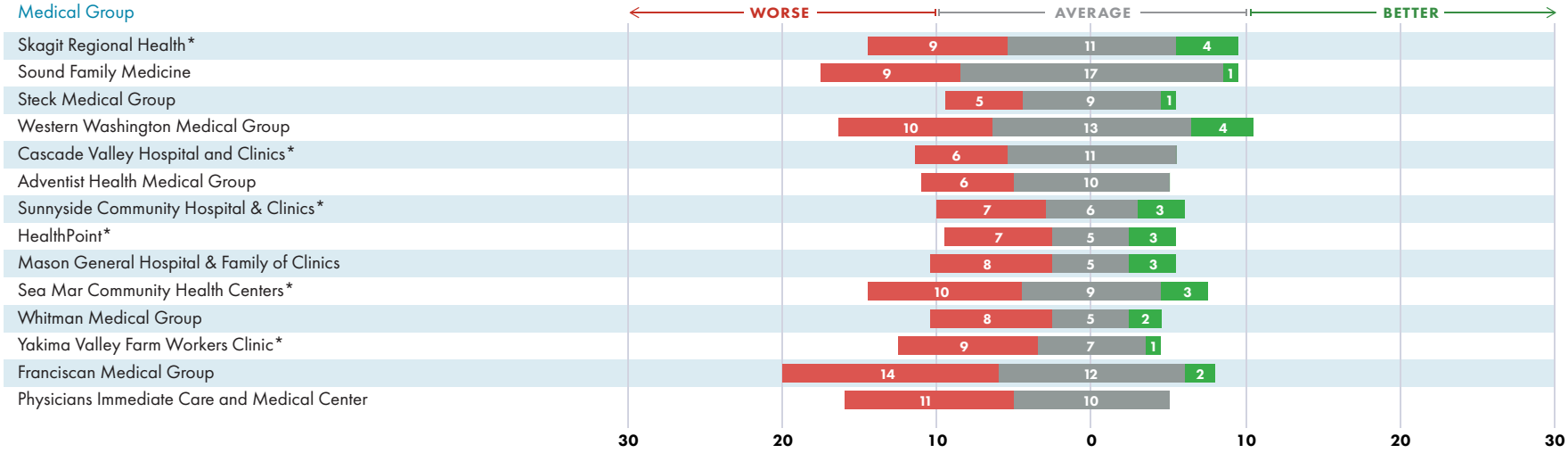
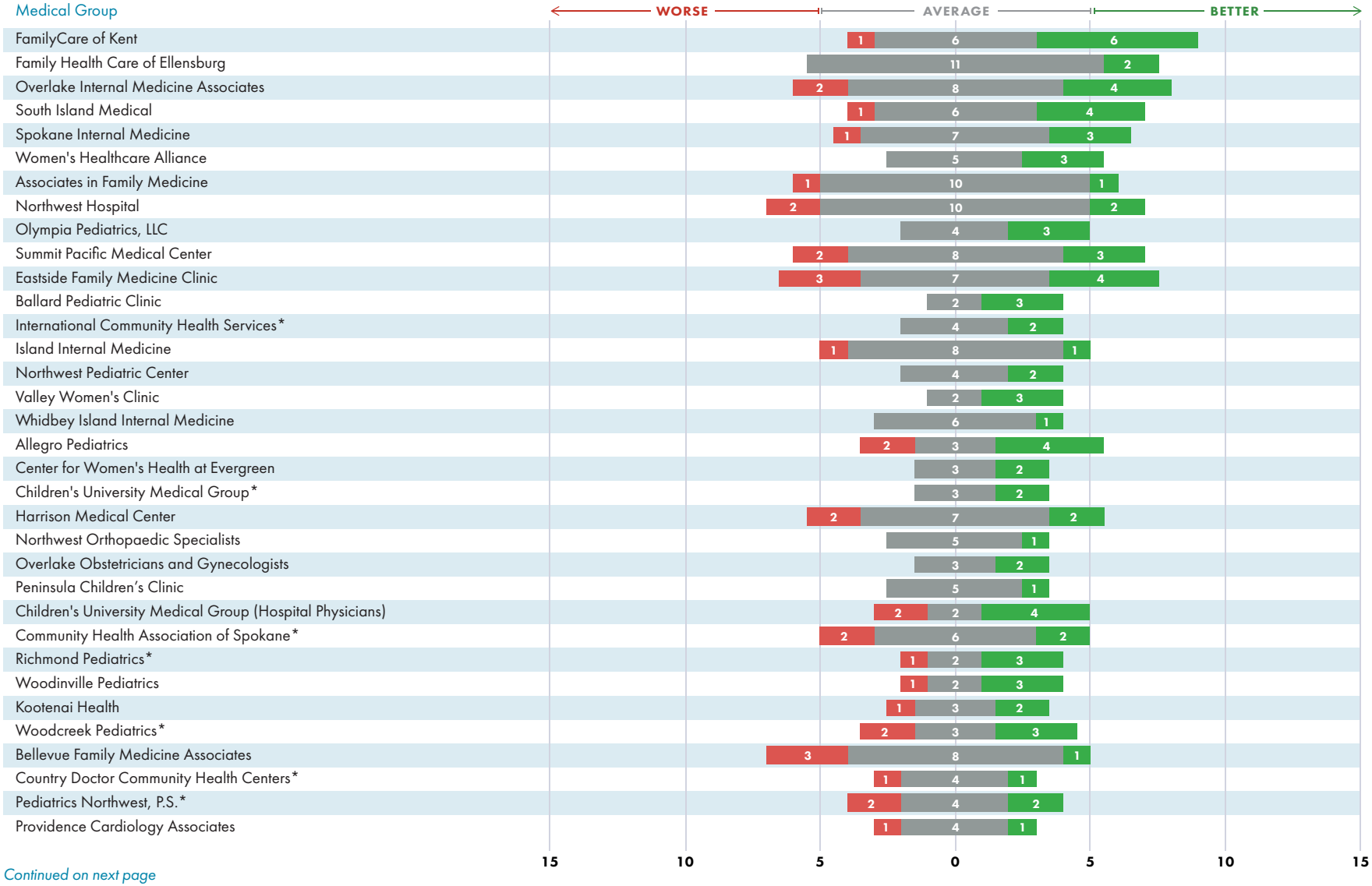
* At least 50% of patients attributed to this medical group have Medicaid coverage.
Based on claims and encounter data with dates of service between 1/1/2004 - 6/30/2015 and the measurement year of 7/1/2014 - 6/30/2015.

Figure 38: Ranking Medical Group Performance for **Commercially Insured**: Medical Groups That Have Results for **15 or More** Measures *(continued)*



* At least 50% of patients attributed to this medical group have Medicaid coverage.
Based on claims and encounter data with dates of service between 1/1/2004 - 6/30/2015 and the measurement year of 7/1/2014 - 6/30/2015.

Figure 39: Ranking Medical Group Performance for **Commercially Insured**: Medical Groups That Have Results of **Between 5 and 14** Measures



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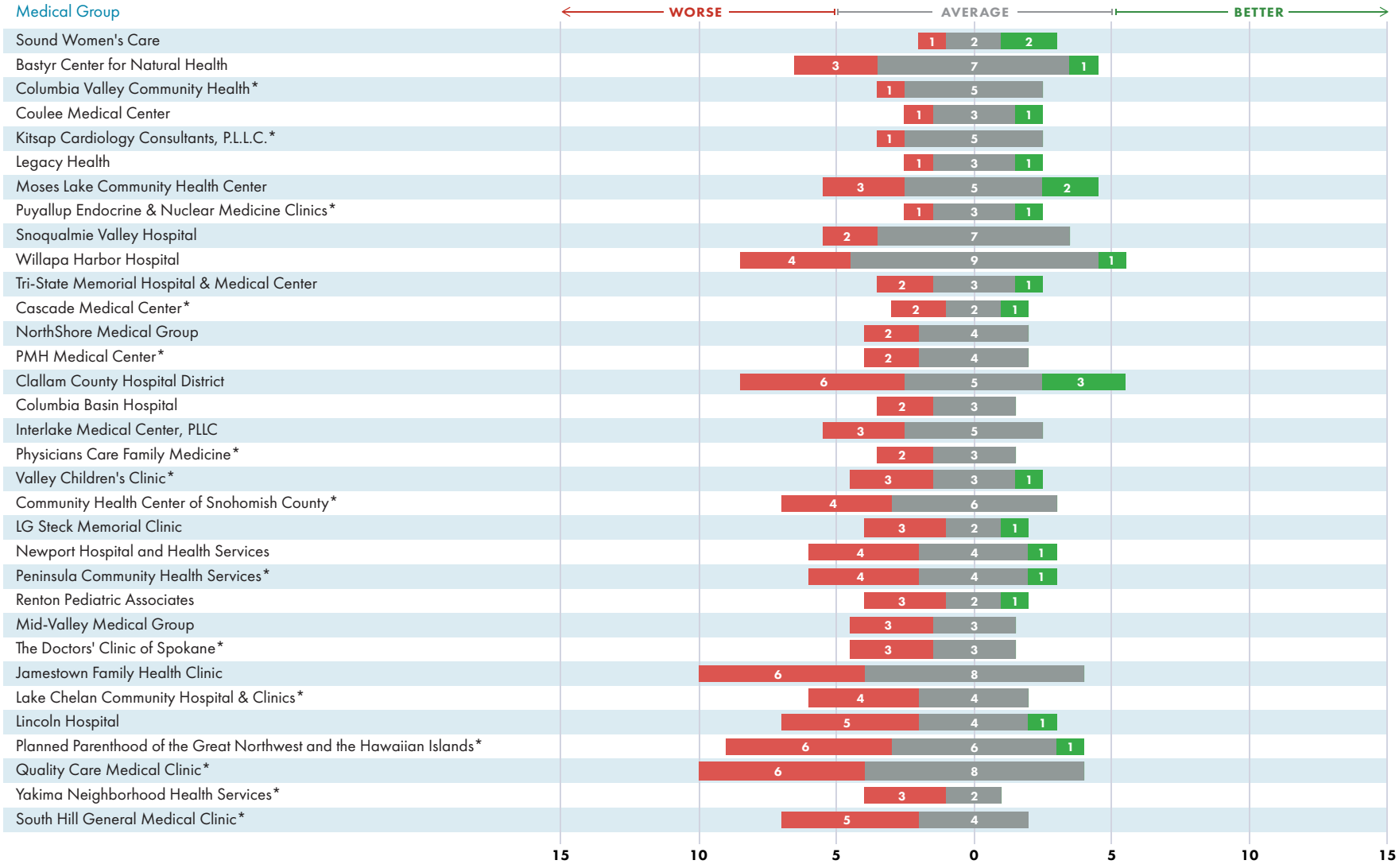
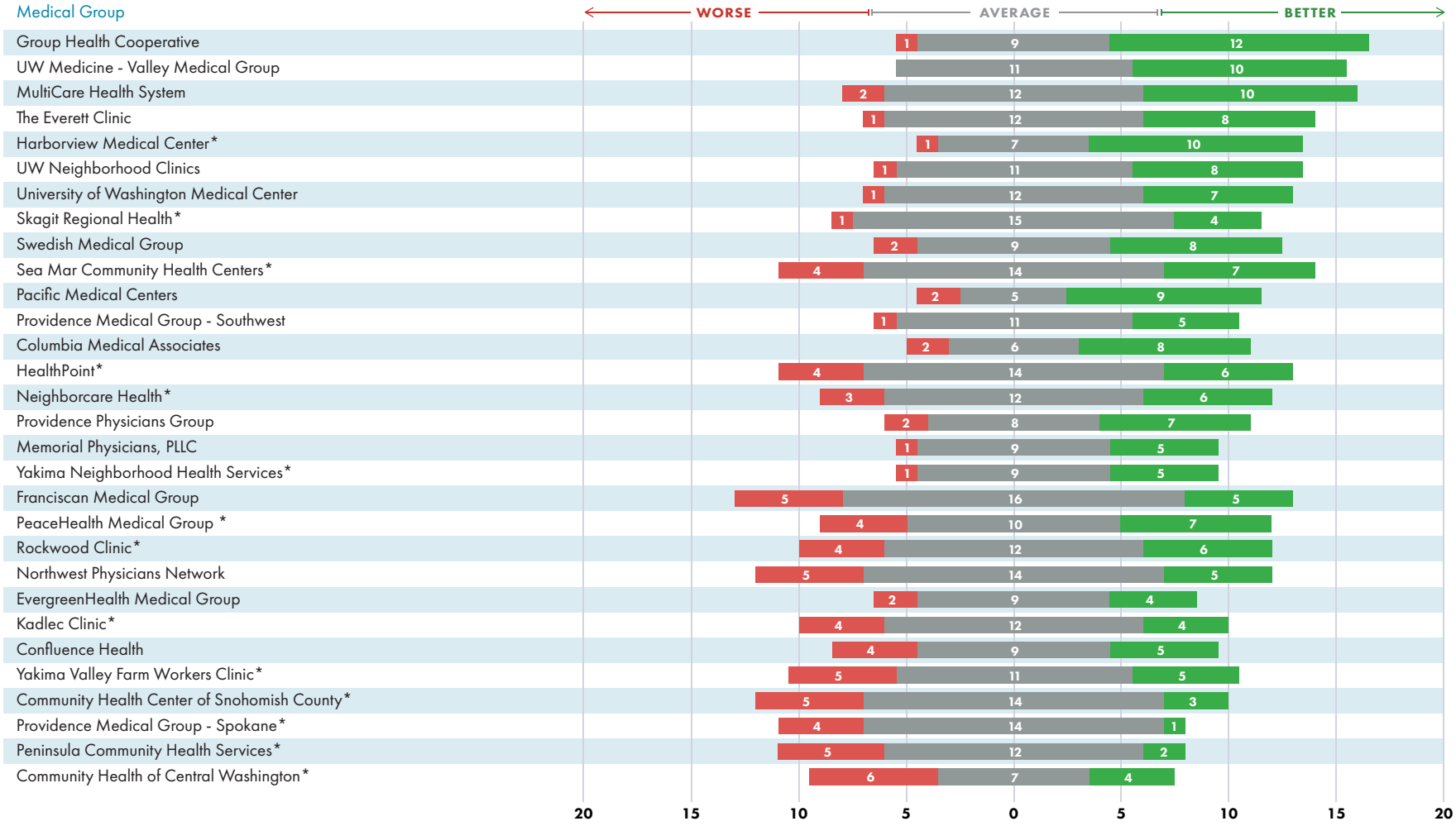
* At least 50% of patients attributed to this medical group have Medicaid coverage.
Based on claims and encounter data with dates of service between 1/1/2004 - 6/30/2015 and the measurement year of 7/1/2014 - 6/30/2015.

Figure 39: Ranking Medical Group Performance for **Commercially Insured**: Medical Groups That Have Results of **Between 5 and 14** Measures *(continued)*



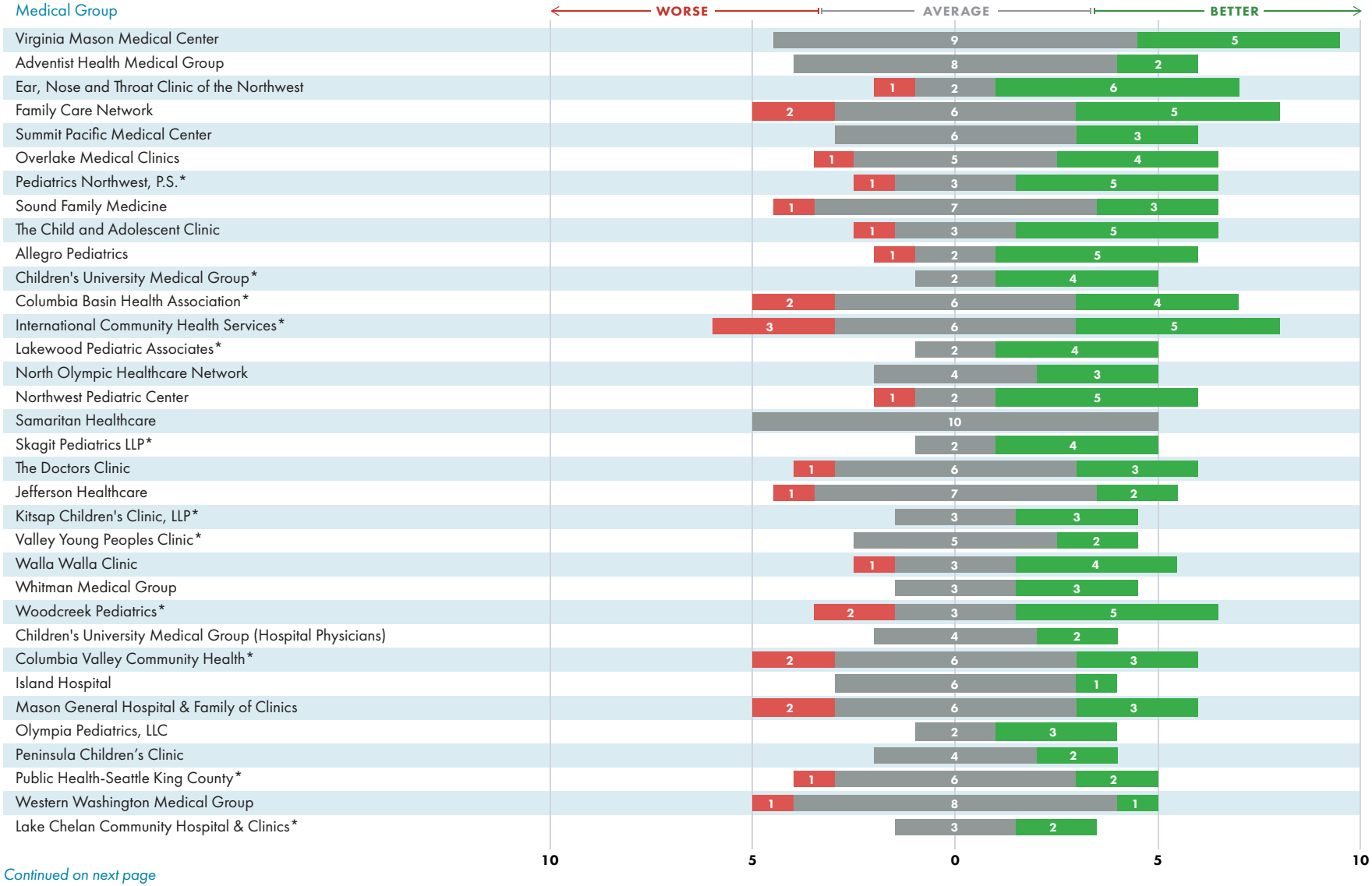
* At least 50% of patients attributed to this medical group have Medicaid coverage.
Based on claims and encounter data with dates of service between 1/1/2004 - 6/30/2015 and the measurement year of 7/1/2014 - 6/30/2015.

Figure 40: Ranking Medical Group Performance for **Medicaid Insured**: Medical Groups That Have Results for **15 or More** Measures



* At least 50% of patients attributed to this medical group have Medicaid coverage.
Based on claims and encounter data with dates of service between 1/1/2004 - 6/30/2015 and the measurement year of 7/1/2014 - 6/30/2015.

Figure 41: Ranking Medical Group Performance for **Medicaid Insured**: Medical Groups That Have Results of **Between 5 and 14** Measures



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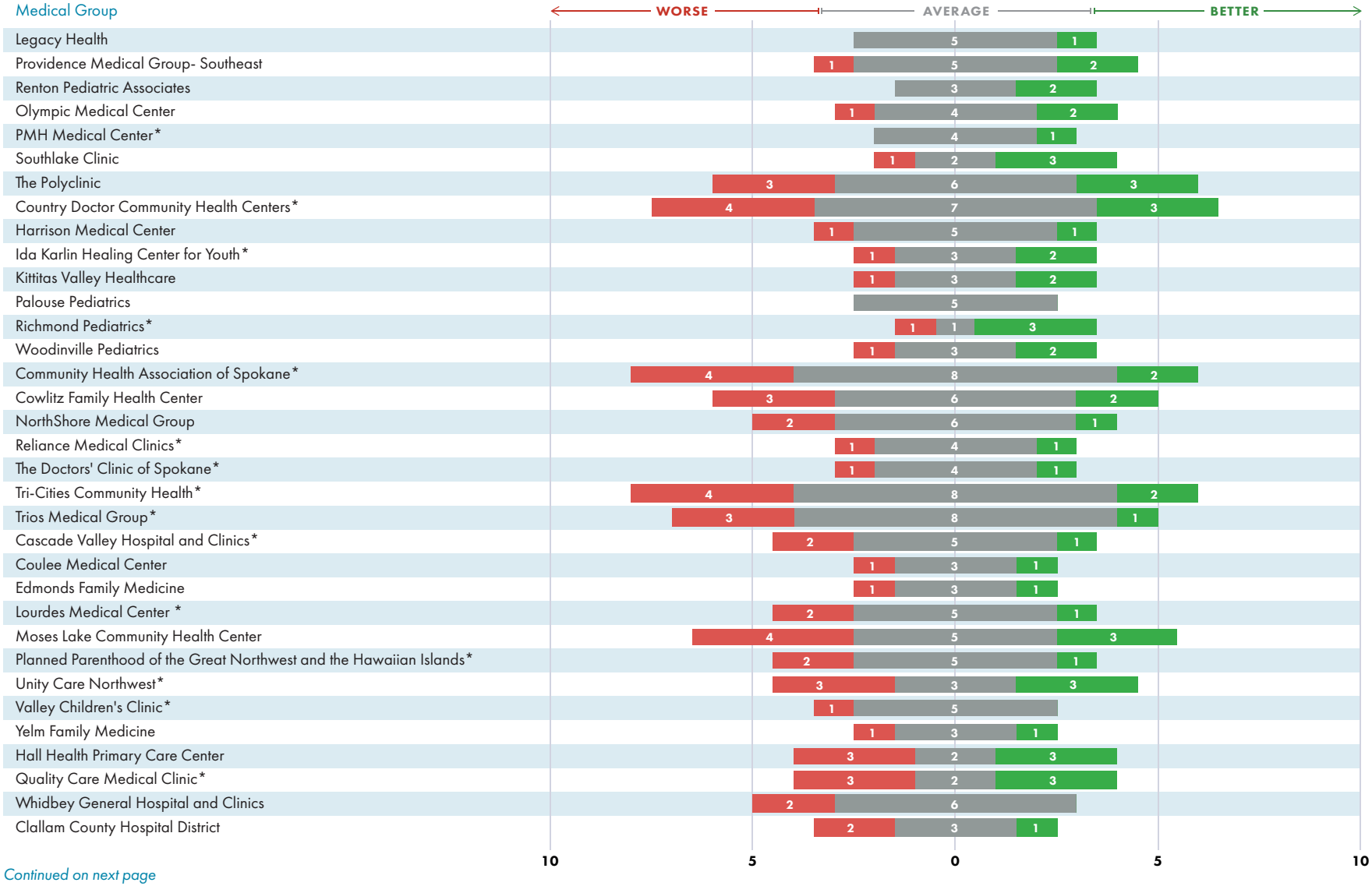
* At least 50% of patients attributed to this medical group have Medicaid coverage.
Based on claims and encounter data with dates of service between 1/1/2004 - 6/30/2015 and the measurement year of 7/1/2014 - 6/30/2015.

Figure 41: Ranking Medical Group Performance for **Medicaid Insured**: Medical Groups That Have Results of **Between 5 and 14** Measures *(continued)*



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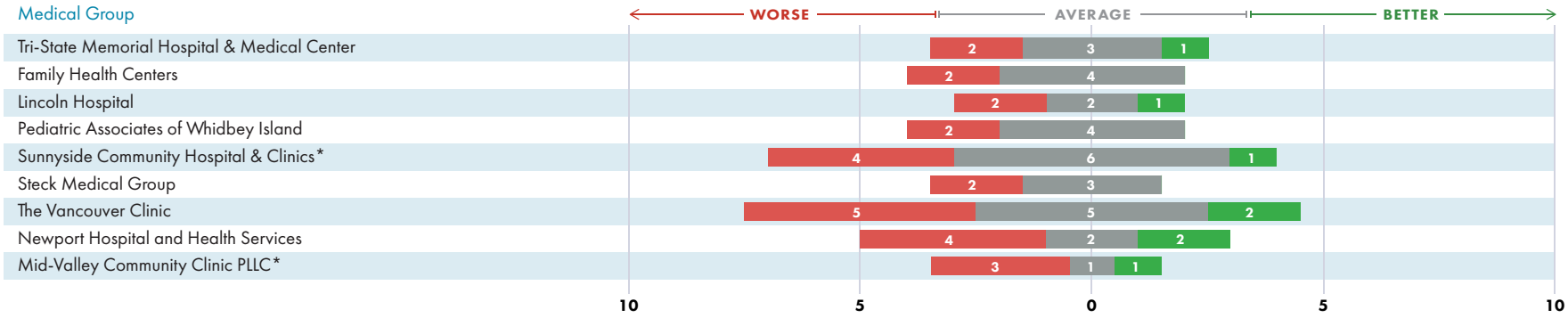
* At least 50% of patients attributed to this medical group have Medicaid coverage.
Based on claims and encounter data with dates of service between 1/1/2004 - 6/30/2015 and the measurement year of 7/1/2014 - 6/30/2015.

Figure 41: Ranking Medical Group Performance for **Medicaid Insured**: Medical Groups That Have Results of **Between 5 and 14** Measures *(continued)*



* At least 50% of patients attributed to this medical group have Medicaid coverage.
Based on claims and encounter data with dates of service between 1/1/2004 - 6/30/2015 and the measurement year of 7/1/2014 - 6/30/2015.

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About the Community Checkup

HOW IS THE COMMUNITY CHECKUP CREATED?

Technical Specifications

Every measure has detailed specifications about what will be measured and how. These specifications are used by health plans and health care providers to guide their own measurement activities. The Community Checkup primarily uses technical specifications from government agencies such as the Centers for Medicare & Medicaid Services and the Agency for Health Care Research and Quality as well as nationally-recognized private nonprofits such as the National Committee for Quality Assurance and the Pharmacy Quality Alliance. The Alliance has also developed our own measures specifications on a much more limited basis.

Provider Attribution Methodology

To report performance results at the clinic level, Milliman assigns patient-level measure results to those providers deemed most appropriate for each type of measure. This varies based upon the type of care each measure reflects.

The Alliance worked with expert committees and medical groups within the region to develop and test several different attribution methods. PCP attribution is applied to prevention-related measures based on the concept that the PCP is the clinician who is primarily responsible for a patient's preventive care management. The Team method is applied to measures related to specific health conditions, based on the belief that patients benefit most when their entire medical team works together to ensure that they receive appropriate care.

After results have been attributed to providers, the Alliance leverages its clinic roster (that is regularly reviewed and updated by medical groups) to assign and summarize these results at clinic and medical group levels.

How we calculate our scores

Summary rates are calculated and scores are then assigned to the results based upon how each rate compares to the state rate. If a clinic's rate is significantly lower than the state rate—if the computed confidence interval around that clinic's rate is entirely below the state rate—the score is worse. If a clinic's rate is significantly higher than the state rate—if the computed confidence interval around that clinic's rate is entirely above the state rate—than the score is better. If the confidence interval of the clinic's rate overlaps the state's confidence interval, then the score is average.

Working with stakeholders

The Alliance works closely with the Washington State Health Care Authority (HCA) and the governor-appointed Performance Measures Coordinating Committee (PMCC) to publish results for the Washington State Common Measure Set for Health Care Quality and Cost.

ABOUT MEDICAID RESULTS

This Community Checkup report reflects the full enrollment due to Medicaid expansion under the Affordable Care Act. (The previous Community Checkup report only captured six months of expanded enrollment.) This report, also for the first time, fully captures Medicaid enrollees in Medicaid managed care organizations (MCOs).

Besides dramatically increasing the number of people in Washington covered under Medicaid, the expansion may have an impact on the results in this report. For example, some measures in this report require continuous enrollment over a period of time in order for a patient to be included in results. Moreover, as the health care system works to absorb this large number of new patients, some results may be affected as patients seek access to providers.

Because of these transitional issues, results for Medicaid enrollees in the current Community Checkup may not necessarily reflect future results.

USE CAUTION WHEN COMPARING DATA OVER TIME

Each Community Checkup report provides a snapshot of performance during a particular time period. However, comparing results between years may carry the risk of inaccurate conclusions. Keep in mind the following caveats when comparing results between years or over time. Any of these factors, or any combination of them, can influence how results may change from report to report.

- **The database changes over time.** The addition of new data suppliers or new enrollees (such as those from Medicaid expansion) means that the population being measured may change from one report to another.
- **Measure specifications change.** Many of the results in the Common Measure Set (or in the Community Checkup) are based on nationally vetted measures, such as measures from the National Committee for Quality Assurance (NCQA). Over time, national measure stewards such as NCQA modify measure specifications to reflect updated knowledge, modified coding and stakeholder input. While these changes result in improved measurement, they do make trending results more challenging.
- **Statewide results can change overall results.** With statewide reporting, the number of medical groups and clinics has dramatically expanded. The addition of provider organizations for the entire state is an important improvement for the Community Checkup, but it may have an impact on results.
- **Attribution methods change.** The Alliance is continuously improving how it attributes patients in the Community Checkup. This results in improved accuracy of the overall results.

COMMUNITY CHECKUP DATA SUPPLIERS

The Alliance is grateful to the following data suppliers, who voluntarily shared their data to be used in this report.

HEALTH INSURERS AND NETWORK ADMINISTRATORS

Aetna Health and Life Insurance Company
Asuris Northwest Health
Cigna Health and Life Insurance Company
Group Health Cooperative
Premera Blue Cross
Regence BlueShield
UnitedHealthcare Insurance Company (including Pacificare and Optum)
Washington State Health Insurance Pool

MANAGED MEDICAID PLANS

Amerigroup
Community Health Plan of Washington
Coordinated Care Health
Molina Healthcare of Washington
UnitedHealthCare Community Plan

MEDICAID

Washington State Health Care Authority

PURCHASERS AND LABOR UNION TRUSTS

The Boeing Company
Carpenters' Trust
City of Seattle
King County
Recreational Equipment Inc. (REI)
Sound Health and Wellness Trust
Washington State Health Care Authority Uniform Medical Plan
Washington Teamsters

INDEPENDENT PRACTICE ASSOCIATION – PROVIDER NETWORK

First Choice Health

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ABOUT HEALTHIER WASHINGTON

Healthier Washington is the state's vision for transforming the health care system to achieve better health, better care and lower costs for the people of Washington State.

We are using the state's health care dollars more wisely to drive change that improves the quality of care people receive.

Healthier Washington brings a diverse set of stakeholders together with a focus on achieving this vision. While the state plays a leading role, everyone has a stake in the health of our state and we can have a greater impact by working on projects together and focusing on common goals.

Healthier Washington is a project that uses federal funds and state resources to improve health for people and communities in a sustainable way. Through Healthier Washington, multiple state agencies are coordinating their efforts and working with diverse stakeholders across the state to drive and reward positive change at all levels of the health care system.

The goals of Healthier Washington are simple. A Healthier Washington is one where:

- People and communities are healthier (better health)
- Washington's health care system delivers whole-person care; addressing the needs of the head and the body in a coordinated way (better care)
- Care is affordable (lower costs)

ABOUT THE WASHINGTON HEALTH ALLIANCE

The Washington Health Alliance is a place where stakeholders work collaboratively to transform Washington state's health care system for the better. The Alliance brings together organizations that share a commitment to drive change in our health care system by offering a forum for critical conversation and aligned efforts by stakeholders: purchasers, providers, health plans, consumers and other health care partners. The Alliance believes strongly in transparency and offers trusted and credible reporting of progress on measures of health care quality and value. The Alliance is a nonpartisan 501(c)(3) nonprofit with more than 185 member organizations. A cornerstone of the Alliance's work is the Community Checkup, a report to the public comparing the performance of medical groups, hospitals and health plans and offering a community-level view on important measures of health care quality (www.wacommunitycheckup.org).

For more information on how the Alliance produces the Community Checkup, please visit www.wacommunitycheckup.org/about/.

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Community Checkup report:
www.WACommunityCheckup.org

More about the Alliance:
www.WAHealthAlliance.org

More about Healthier Washington:
www.hca.wa.gov/hw/