Performance Measures Coordinating Committee Meeting Summary for May 7th, 2025

Present: Sharon Eloranta, Judy Zerzan-Thul, Vishal Chaudhury, Tracy Wellington (Darcy Jaffe), Herbie Duber, Ginny Weir, Karie Nicholas, Alastair Matheson, Kim Emery, David Mancuso, Becky Harless, Rick Rubin, Theresa Hattori, Frances Gough, Kelly Shaw

Guests: Meriah Gille, Kristian Rodriguez, Carey Wallace, Karen Yao, Ashley Bennett, Drew Olivera, Anna Sandige, Yogini Kulkarni-Sharma, Adrienne Lloyd, Stacey Herron

HCA Staff: Heleena Hufnagel, Heather Schultz and Laura Pennington

Welcome and Introduction

Sharon Eloranta, Executive Director of the Washington Health Alliance, welcomed attendees and thanked them for participating in the meeting. Dr. Eloranta reminded everyone of the importance of keeping this a transparent process, allowing for public input and opportunities for participation, and sharing all meeting materials and summaries on the Healthier WA website. Dr. Eloranta reviewed the objectives for the meeting which included: (1) Briefly recap the February 2025 PMCC meeting; (2) Wrap up and final recommendations from the rural health ad hoc workgroup; (3) Biennial review of the WSCMS.

1.) Brief Recap of the February 2025 PMCC meeting (Sharon Eloranta)

- Updates from the rural health ad hoc workgroup;
- Preparation for the biennial review of the WSCMS; and
- Current timelines and priorities for 2025.

2.) Rural Health Ad Hoc Workgroup final recommendations:

- Laura Pennington and Kim Emery shared the final updates from the 2025 Rural Health ad hoc workgroup, which met three times from February through April 2025.

Member	Organization
Amy Diaz	Kittitas Valley Healthcare
Becky Harless	Whidbey Health
Darcy Jaffe	Washington State Hospital Association
Heather Reathaford	Whitman Hospital & Medical Clinics
JoEllen Colson	Health Care Authority
Kari Nicholas	Foundation for Healthcare Quality
Kelly Shaw (Co-Lead)	Department of Health
Kim Emery (Co-Lead)	Columbia County Health System
Mandee Olsen	Kittitas Valley Healthcare
Melissa D Strong	Mason General
Nicole Fields	Department of Health
Theresa Hattori	Community Health Plan of Washington
Tracy Wellington	Washington State Hospital Association

- The charge of the workgroup was to Identify current alignment of measures and gaps within the WSCMS to rural health priorities; consider measures for potential addition to the WSCMS; explore opportunities to consistently apply a rural lens during the measure review process.
- The workgroup first identified what measures are currently being used in rural communities, including barriers to reporting, required and voluntary reporting of measures. Secondly, the workgroup compared

those measures to measures in the current WSCMS, and developed recommendations for the PMCC to consider.

- **Key findings and insights from the workgroup:**
    - <u>There was a general lack of alignment and standardization in measures reported across different organizations.</u>
        - The only measure reported by all participants was the Catheter-Associated Urinary Tract Infections (CAUTI) measure. (administrative)
        - It is more difficult to collect clinical measures than hospital measures due to different systems and organizational size.
        - CAHPS measures are easier for clinics to administer (compared to hospitals) due to patient size.
        - Some measures are difficult for rural communities due to lack of access to services
            - For example, breast cancer screening is difficult for some providers due to a lack of mammography services
        - Lack of OB providers in rural areas
    - <u>Numerous measures are reportable through multiple programs, with different methodologies</u>
        - Different people may report on different measures within an organization, or services may be rendered in different locations and reported separately. This leads to data fragmentation and validation issues.
        - Voluntary measures are selected by the organizations or by location and vary widely.
        - Priority measure topic areas differed by region and populations served.
            - i.e. lack of specialty service providers or small numbers influence the choice in measures for reporting.
        - Comparison is difficult because there is no standard methodology used.
    - <u>Additional General observations</u>
        - Lack of familiarity with "state produced" measures and HEDIS measures are primarily used by health plans not providers (who use CMS).
        - Several measures that were "similar" to WSCMS measures are currently being reported both required and voluntarily.
        - No mandatory reporting for pediatric measures for many health systems.
            - Low volume, no peds clinics or OB providers; patients referred out.
            - Pediatric immunizations are input into WAIIS
    - <u>Measures that should remain on WSCMS:</u>
        - All preventive screening measures
            - Breast, Cervical, Chlamydia, and Colorectal
        - Pediatric measures
            - Well care visits, immunizations, youth substance use
        - Diabetes measures
            - Blood Pressure Control, Glycemic Status Assessment, Kidney Health Evaluation
        - Other (2 or more members selected)
            - Controlling High Blood Pressure
            - Patient experience measures – provider specific
    - <u>Critical gap areas identified by this group for future consideration:</u>
        - <u>Youth behavioral health and substance use</u>
        - Impact of heat and wildfire smoke on health outcomes <u>(environmental measures)</u>
        - Overall access to care (for example, time to appointment and distance traveled)
        - Patient experience
        - Population to provider ratio
        - Screening for social needs
        - Patient reported outcomes measures (PROMS)

- Ongoing engagement of rural communities and application of rural lens to WSCMS:
  - Are there additional opportunities for collaboration with rural providers?
  - Other suggestions you may have for ensuring the WSCMS reflects the work of rural health providers.
    - Measures focused on rural health lens
    - Alternative measures that align with existing measures.
    - Subset of measures for rural health
- Overall recommendations the workgroup would like the PMCC to consider:
  - No specific measures recommended for addition, more topic-focused
  - Workgroup members would like the PMCC to consider addressing the following gap areas:
    - Youth behavioral health
      - Need to identify the best way to measure this area
    - Impact of heat and wildfire smoke on health outcomes
      - WSHA Medicaid Quality Initiative "home-grown" measure
      - Recommend the PMCC consider other ways to measure
    - Patient experience
      - CAHPS is difficult due to small numbers, although long term trending is useful
      - Is there a better way to do this?
- Committee comments:
  - We may want to revisit the full scope of the PMCC, but it is important to include the rural lens in our discussions as the WSCMS promotes quality outcomes across Washington.
  - Access - % of population not using care (no claims in a 12-month period) and by location (census block) may be valuable. More deprived neighborhoods across the state have "access" issues compared to more privileged locations.
  - The committee recognizes some areas of importance like environmental impacts to health and transportation issues. Currently there are no measures available to directly address some of these concerns. The committee will maintain awareness of rural health needs and priorities and will continue to look for opportunities to support rural partners.

3.) Biennial Review of the Washington State Common Measure Set:

- Dr. Heather Schultz from HCA facilitated the introduction to the 2025 biennial review of the Washington State Common Measure Set (WSCMS).
  - Legislation ESHB 2572 defines the PMCC, their role in reviewing the current WSCMS and the scope of measure criteria here.
  - Current 2025 WSCMS.
- Brief background:
  - In December 2024, the PMCC agreed to reduce the size of the current common measure set and identify priority measures from the existing WSCMS that may be considered for core set. Additional measures currently on the WSCMS would be removed or retained as a subset of measures.
  - Recommended core set size is 8-10 focus measures.
  - This reflects the size of other state core measure sets, as provided to the Committee.
  - Committee members were also asked to consider a max of 2-3 measures from each domain that they would like to see prioritized.
- The priority for May 2025 was to focus on core set measures and those measures identified for removal.
  - In March 2025, PMCC Committee members received a measure review template and supplemental documentation to complete prior to the May meeting.
  - No final voting occurred at the May meeting.

- Overview of responses from Committee members:
    - HCA received a total of 11 review template responses, 9 from Committee members and 2 from subject matter experts. Some templates included additional input from Committee member colleagues.
    - A total of 10 measures were recommended for addition to the core set, 9 were recommended for removal from the WSCMS, and 5 were recommended for addition to a subset of measures for monitoring purposes.
    - Some measure focus areas were identified as "high priority," but reviewers deferred to the Committee as to which measures they would prioritize for the core set (preventative screening, diabetes).

- **Initial review of measures:**

    - Measures recommended for addition to the core set:
        - Child and Adolescent Well-Care Visits (WCV)
        - Childhood Immunization Status (CIS-E) Combination 10
        - Immunizations for Adolescents (IMA)
        - Breast Cancer Screening (BCS-E)
        - Colorectal Cancer Screening (COL-E)
        - Prenatal/Postpartum Care (PPC)
        - Depression Remission or Response for Adolescents and Adults (DRR-E)
        - Follow-Up After ED Visit for Substance Use (FUA)
        - Follow-Up After Hospitalization for Mental Illness (FUH)
        - Substance Use Disorder Treatment Rate

    - Initial review of measures recommended for removal:
        - Audiological Evaluation No Later Than 3 months of age
        - Primary Caries Prevention Offered by a Medical Provider
        - Youth Obesity (Self-reported BMI)
        - Youth Substance Use
        - Adult Obesity (Self-reported BMI)
        - Adult Tobacco Use
        - Contraceptive Care – Most & Moderately Effective Methods
        - Unintended Pregnancies

    - Measures recommended for additional discussion:
        - Well Child Visits in the First Thirty Months of Life (W30)
        - Adult Immunization Status (AIS-E)
        - Cervical Cancer Screening (CCS)
        - Chlamydia Screening (CHL)
        - Depression Screening and Follow Up for Adolescents and Adults (DSF-E)

- PMCC member comments:

    - For this meeting, the committee agreed to focus on the measures where there was no consensus to add to the core set or remove from the WSCMS altogether.

    - Youth SUD rate:
        - There may be other measures that may be more useful for capturing the information.
        - The Bree released Behavioral Health: Early Interventions for youth last year.
        - Attendees supported David's comment regarding all the survey measures (that they are not as actionable or consistent as other types of measures).

    - Childhood Immunization Status (Combo 10) (CIS):
        - NCQA requires ECDS reporting for the CIS measure. That reporting allows vaccine registries to be used.
        - Early visits also connect the family with a source of care (as well as immunizations)

        - From the DOH side, the two measures-(well child and vaccination)-don't correlate as closely as we would like. And it is likely to be an increasing problem in the current environment. Additional context is that we are likely to lose our measles elimination status.
        - Given the increase in vaccine preventable diseases, I think it's important to keep.
        - Consideration for federal changes that impact data dashboards. Well child visits will correlate even less with fully vaccinated status with the current rise in anti-vaccine sentiment.
    - Adult Immunization Status (AIS-E):
        - Similar comments to child immunization.
        - Consider keeping on subset and set realistic goals for providers when reporting.
    - Well Child Visits in the First Thirty Months of Life (W30):
        - Should your measure set have those with the greatest gap in care? In that case WCV under age 3 is a significant gap in WA
        - Okay with this being in a subset of peds metrics
        - Early visits also connect the family with a source of care (as well as immunizations)
    - Cancer Screening measures (All):
        - Priority can depend on the population represented in the region.
        - Some members recommended selecting between Breast Cancer Screening (BCS-E) or Colorectal Cancer Screening (COL-E) for core set.
            - I would prioritize colorectal cancer screening given the equity issues and the recent surge in colorectal cancer diagnoses in younger people.
            - This seems like an important measure for rural health in particular.
            - Cervical screening given equity issues and also the recent surge in cervical cancer diagnoses in younger people.
            - There is also some overlap in exposure between viral causes of cervical cancer and STI's.
    - Chlamydia Screening (CHL)
        - The rates of sexually transmitted diseases have been going up, especially among older adults.
        - Only 36% of Medicaid and 44% of commercial members are screened for chlamydia ... BIG gap in care.
        - Focus measure for state (assignment measure).
        - Few STD measures available, important to have something.
        - Federal changes may impact data dashboards, need to keep eye on this.
    - Behavioral health measures (broad):
        - Depression Remission or Response in Adolescents and Adults (DRR-E)
            - Mixed feelings on adding to core.
            - Production challenges with measure and equity issues for those individuals not represented in the EHR data.
            - Depression Screening and Follow Up in Adolescents and Adults (DSF-E) is more familiar to providers.
            - Primary Care measure set has both DRR-E and DSF-E. Both measures incorporate PHQ-2/PHQ-9, which are the most commonly used tools.
            - Judy: Acknowledgement that it is a challenging measure, but it is also an outcomes-based measure.
                - Current VBP measure for state contracts
                - We are starting with the first of 3 reporting rates, PHQ9 assessment

        - There was a suggestion that we include ECDS measures, as NCQA and CMS are moving in that direction. DRR-E was selected, as it has been one we've advocated for because it addresses health outcomes.
        - What is unique (and problematic!) about the DRR-E measure is that unlike many of the ECDS measures that can use claims data, DRR-E requires pulling data from EHRs using LOINC. Many of the ECDS measures aren't as challenging to report. But, the upside of DRR-E, if anyone can figure out how to get the data is that it is one of the few measures looking at outcomes.
            - There is at least one large system using LOINC for this purpose.
        - We don't want to lose progress on the implementation of this measure, which could happen if it is removed.
        - "I worry about kicking the can down the road for the DRR-E measure."
        - "Sophie's choice": Both DSF-E and DRR-E are going to be challenging.
    - <u>Behavioral Health Follow Up Measures (FUA, FUM, FUH):</u>
        - David recommended that the committee consider the addition of FUA and FUH to a core set, as we have begun to make progress in those areas, but there is still much work to be done.
        - David does believe the measures are actionable and meaningful at the plan regional scale.
            - Recommendation seconded by other committee members.
    - Will need to discuss which remaining BH measures will be removed versus moving to a sub-set at summer meetings.
- Drew suggested that as we continue to review the list of measures it would be good to prioritize ones with the largest gap in care and have the most impact. This can help where there is a difficult decision about which measure(s) should be prioritized.

- <u>Next Steps:</u>
    - The Committee was not able to complete their review of the WSCMS during the May meeting.
    - Committee members will convene during the summer for additional meetings to complete their review of the remaining measures and final recommendations.
    - Final recommendations will be brought to the PMCC at the Fall meeting for voting.
    - HCA will maintain lens on State and Federal updates that may impact measure set.

<u>4.) Public Comment</u>:

- No comments from members of the public during the meeting.

Next Meeting:

- Additional workgroup dates for the summer have been sent out:
    - June 26, 1:00 – 3:00 pm
    - July 21, 1:00 – 3:00 pm
    - August 20, 9:00 – 11:00 am (If needed)
- Questions regarding the biennial review or the summer meeting dates may be sent to hcapmcc@hca.wa.gov.
- Agenda topics:
    - Finalize the selection of core measures for the WA State Common Measure Set.
        - Updates from State, CMS and NCQA regarding quality measures in 2026.
        - Please note: If you have not completed the required PMCC membership application and OPMA training, you will not be able to vote.