



# Before We Get Started, Let's Make Sure We are All Connected

## Online via Webinar:

- 2 Options for Audio: “Use Mic & Speakers” or “Use Telephone”
- If you plan or hope to speak, please use a telephone for audio quality purposes. A land line works better than a cell phone.
- There will be opportunities to submit comments/questions online and verbally. Please be prepared to speak if you would like to comment during the public comment period.
- **Please keep your phone line muted unless it is time for you to speak.**

# Performance Measures Coordinating Committee

Thursday, December 15, 2016



# Welcome and Introductions



*Better Health, Better Care, Lower Costs*



# Housekeeping

- Today's meeting also available via webinar
- Please silence your electronics
- Restrooms
  - Women's: turn left before elevators
  - Men's: turn left after elevators



# Public Process

- Maintaining a transparent process important
- Public comment opportunities
  - ✓ Performance Committee meetings open to the public
  - ✓ Time on the agenda for public comment prior to action
  - ✓ All documents posted on Healthier WA website
  - ✓ Comments can be submitted to HCA anytime



# Performance Measures Coordinating Committee

## Today's Objectives:

1. Review public comment on proposed changes to the Common Measure Set
2. Receive final recommendations from the Pediatric Measures Work Group
3. Take final action to modify the WA State Common Measure Set for 2017
4. Review results for the 2016 Community Checkup and Common Measure Set

**Proposed Changes to the Common Measure  
Set for Pediatric-Related Measures  
Summary of Public Comment**

# Overall Low Response Rate

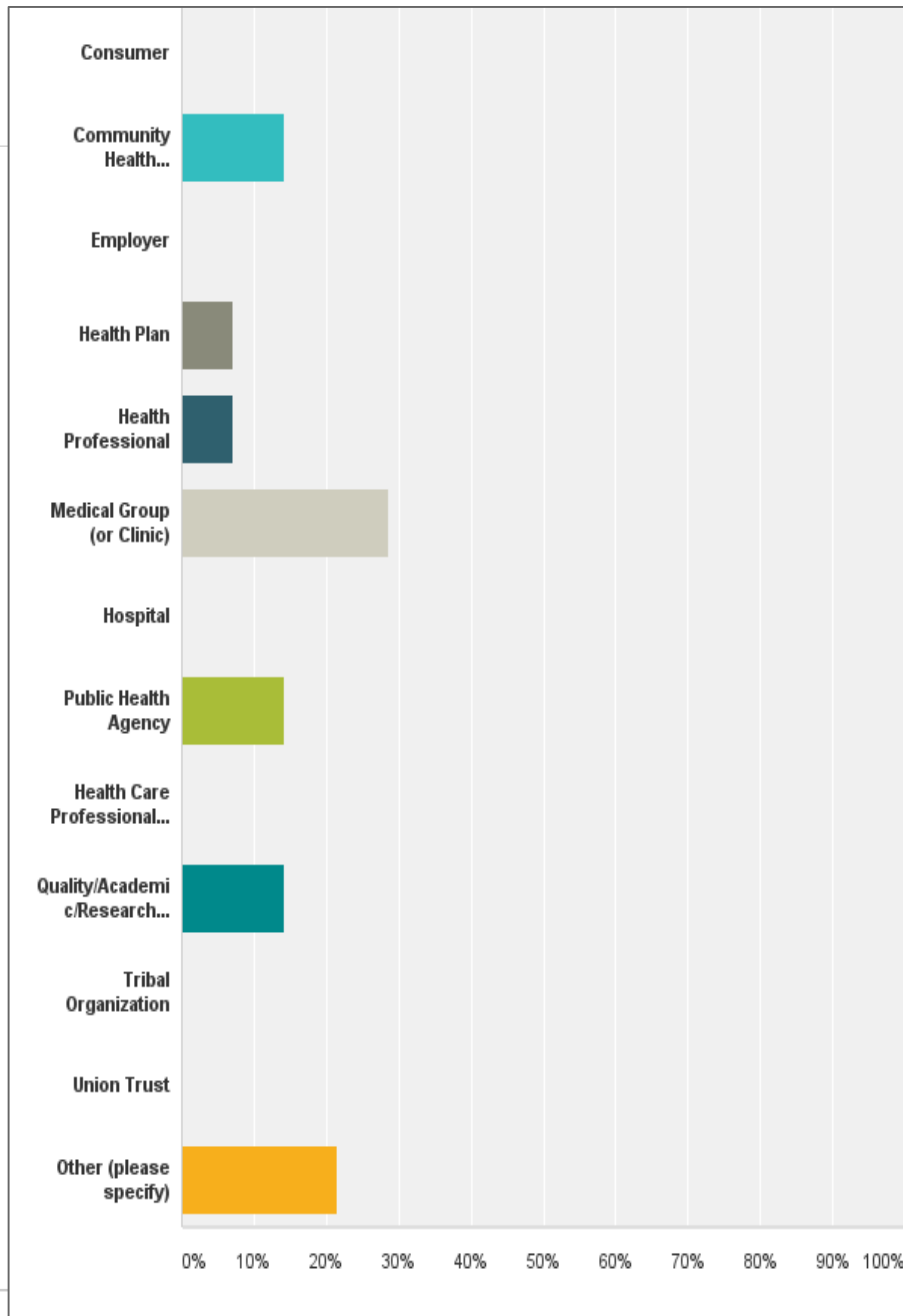
## 14 Total Responses

The survey was fielded for 2 ½ weeks during November 2016.



## Q2: What type of group do you represent?

Answered: 14



Other:

1. FQHC
2. State Employee
3. Specialty Insurer

## Themes from written comments

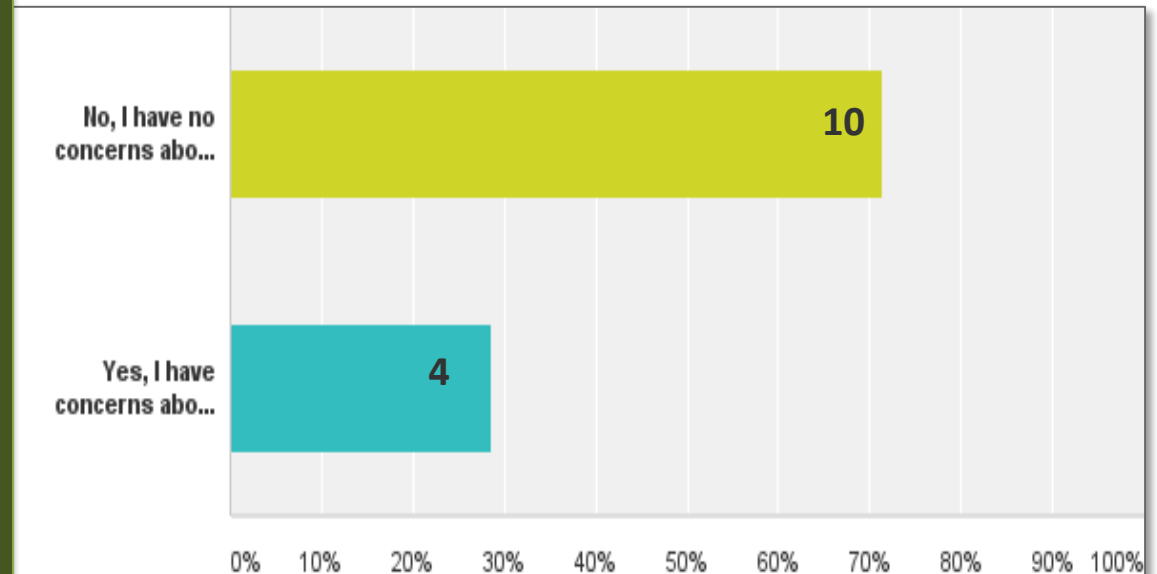
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- Among those who responded with written comments, there is generally a lack of support for non-NQF/ non-nationally endorsed measures.
- Measures in the Common Measure Set should align with state and national reporting requirements as much as possible.
- Some expressed concern about a reporting burden to providers, specifically those that already report a large number of quality measures to the federal government and other public/private payers.
  - *Note: This comment may reflect a lack of understanding about how results are derived for public reporting results for the Common Measure Set in Washington. Clinic-based providers are not required “to report” results for the Common Measure Set. That said, to the extent that measures are included in the Common Measure Set and/or provider contracting, there is a burden to have clinic workflow and systems in place to ensure a high level of performance in areas that are measured and publicly reported.*

**Q3: The following seven pediatric quality measures, already approved for the Common Measure Set, were reviewed and it is recommended that they CONTINUE TO BE A PART OF the Common Measure Set in 2017. Do you have any concerns?**

Answered: 14

1. Childhood Immunization Status by Age 2 (Combo 10)
2. Immunizations for Adolescents by Age 13
3. Oral Health: Primary Caries Prevention as Part of Primary Care Visit (*Medicaid population only*)
4. Child and Adolescent Access to Primary Care Practitioners
5. Appropriate Testing for Children with Pharyngitis
6. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
7. Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life



**Q3: The following seven pediatric quality measures, already approved for the Common Measure Set, were reviewed and it is recommended that they **CONTINUE TO BE A PART OF** the Common Measure Set in 2017. Do you have any concerns?**

1. **Childhood Immunization Status by Age 2 (Combo 10)**
2. **Immunizations for Adolescents by Age 13**
3. **Oral Health: Primary Caries Prevention as Part of Primary Care Visit (*Medicaid population only*)**
4. **Child and Adolescent Access to Primary Care Practitioners**
5. **Appropriate Testing for Children with Pharyngitis**
6. **Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**
7. **Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life**

**Specific comments related to this question:**

1. Appropriate testing for Pharyngitis: as the measure is defined, emergency room visits are included - and thus, if an ER does not test for strep before scripting antibiotics, it counts adversely against the local PCP.
1. All are fine. My only comment relates to the oral health measure. I think we should work towards being able to report this measure at the health plan and clinic level. To accomplish this goal would require further development of the specifications. I think this measure is ripe for use in value-based purchasing (VBP). Fluoride application is highly correlated to lower incidence of caries, concomitant improved quality of life/care and lower health care costs. We need measurement at the plan/clinic level to be able to add this measure to VBP arrangements, as well as underscore the importance of this well-validated public health intervention.

**Theme:**

- Not NQF/nationally endorsed (pertains only to the oral health measure)

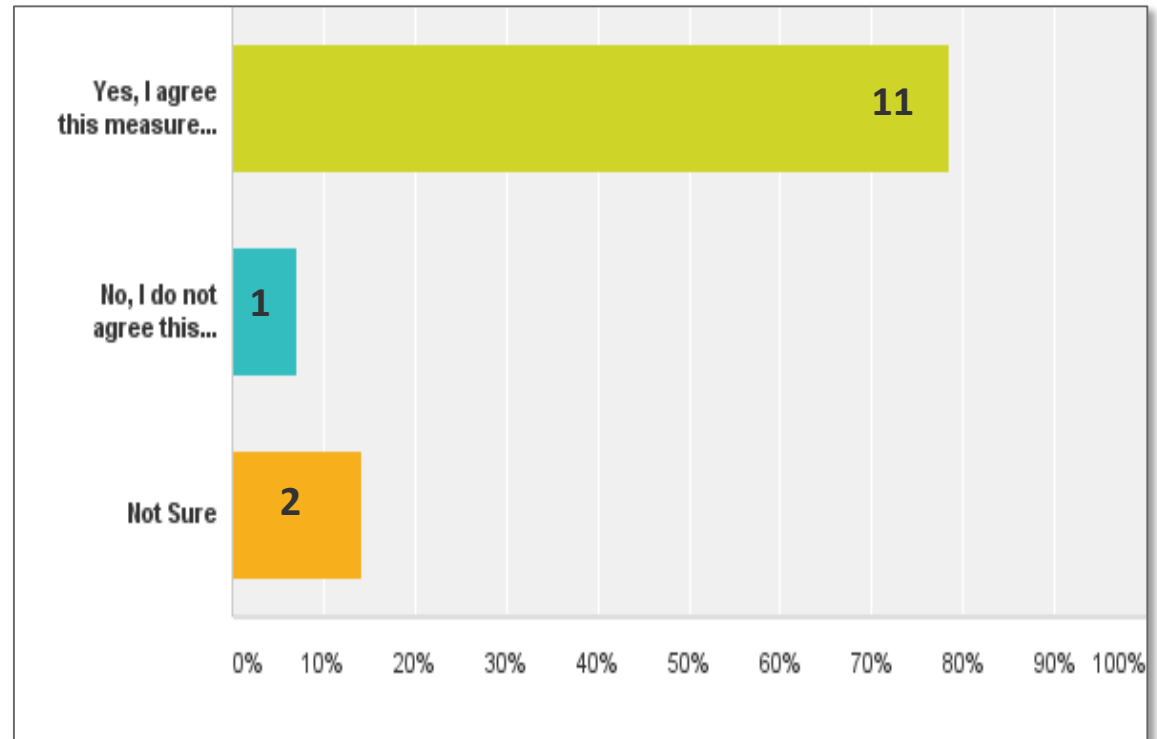
## Q4: It has been recommended that the following pediatric quality measure be **NEWLY ADDED** to the Common Measure Set in 2017. Do you agree?

Answered: 14

**Well Child Visits in the First Fifteen Months of Life**

**[Measure Steward: NCQA HEDIS, not NQF-Endorsed]**

**Results would be available for the state, counties, ACHs, medical groups/clinics and health plans.**



## Q4: It has been recommended that the following pediatric quality measure be **NEWLY ADDED** to the Common Measure Set in 2017. Do you agree?

**Well Child Visits in the First Fifteen Months of Life**

**[Measure Steward: NCQA HEDIS, not NQF-Endorsed]**

**Results would be available for the state, counties, ACHs, medical groups/clinics and health plans.**

### **Specific comments related to this question:**

1. This depends where the data is coming from. Many patients come to us well after birth and we do not have records of their well child visits with different organizations. If the data comes from the health plans, then the WCC's will be counted. If it is self-reported from providers, our numbers will look lower than they should.

### **Themes:**

- Not NQF/nationally endorsed
- Concern re: reporting burden for providers

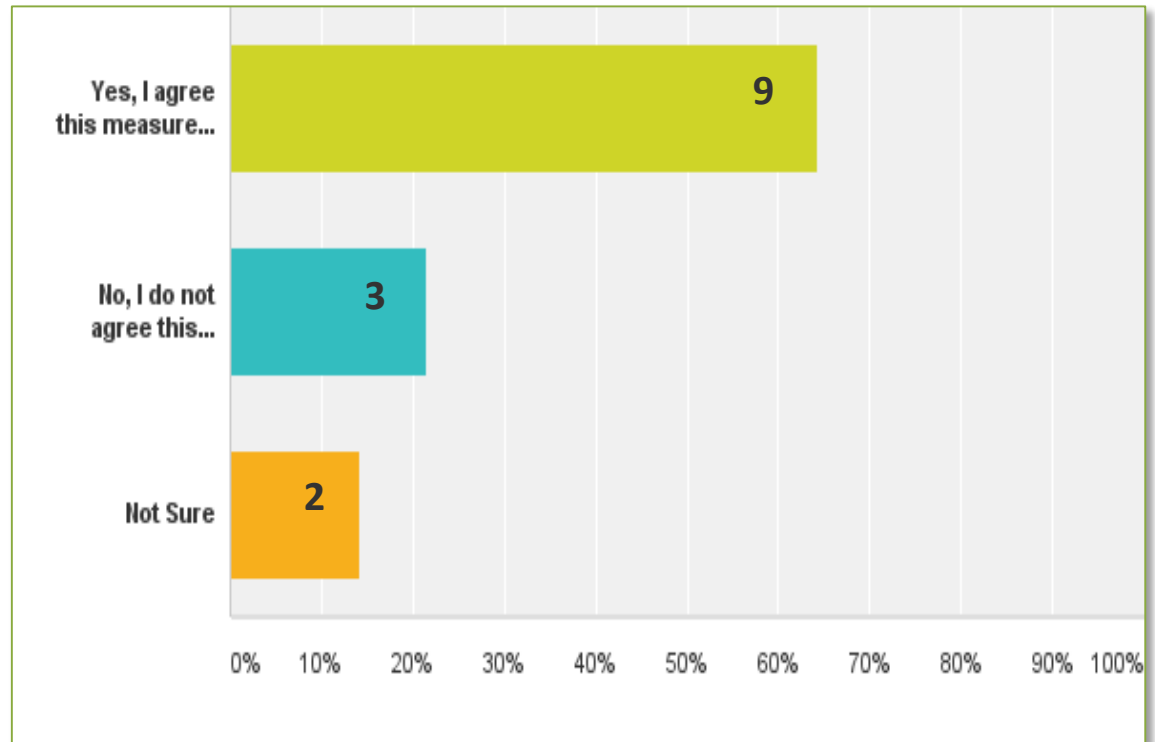
## Q5: It has been recommended that the following pediatric quality measure be **NEWLY ADDED** to the Common Measure Set in 2017. Do you agree?

Answered: 14

**Follow-up Care for Children  
Prescribed ADHD Medication -  
Continuation and Maintenance**

**[Measure Steward: NCQA HEDIS,  
NQF-Endorsed #0108]**

**Results would be available for  
the state, counties, ACHs,  
medical groups/clinics and  
health plans.**



## **Q5: It has been recommended that the following pediatric quality measure be NEWLY ADDED to the Common Measure Set in 2017. Do you agree?**

**Follow-up Care for Children  
Prescribed ADHD Medication -  
Continuation and Maintenance**

**[Measure Steward: NCQA HEDIS,  
NQF-Endorsed #0108]**

**Results would be available for  
the state, counties, ACHs,  
medical groups/clinics and  
health plans.**

### **Specific comments related to this question:**

1. The HEDIS definition actually increases the number of visits to the PCP unnecessarily requiring 4 in one year (3 face to face). For Initiation Phase: Visit #1 new diagnosis & new med scripted, Visit #2 new med FU within 30 days; then ongoing Continuation Phase Visits #3 & Visits #4 - two additional visits before year end. Additionally, only one of the Continuation Phase visits can be a provider telephone encounter. This is unnecessary utilization of resources - especially when one is already challenged with access issues.
2. Similar to the depression medication measures for adults, I am skeptical as to whether tracking follow up and continuation of medication for children is an actually indicator of quality of care. Therefore I do not think it should be included.
3. Should we not first look at prescribing practices to assess if ADHD medications are prescribed in similar patterns across providers?

### **Theme:**

- Concern re: reporting burden for providers



## Q5: It has been recommended that the following pediatric quality measure be NEWLY ADDED to the Common Measure Set in 2017. Do you agree?

This comment is not entirely correct. The 2017 version of the HEDIS measure specifies three visits (not four). The first has to be within 30 days of the medication being prescribed. Two additional visits must occur within 9 months (after the first 30 days). One of these two follow-up visits may be a telephone encounter. Claims data may unreliably pick up these telephone encounters.

### Specific comments related to this question:

1. The HEDIS definition actually increases the number of visits to the PCP unnecessarily requiring up to 4 in one year (3 face to face). For Initiation Phase: Visit #1 new diagnosis & new med scripted, Visit #2 new med FU within 30 days; then ongoing Continuation Phase Visits #3 & Visits #4 - two additional visits before year end. Additionally, only one of the Continuation Phase visits can be a provider telephone encounter. This is unnecessary utilization of resources - especially when one is already challenged with access issues.
2. Similar to the depression medication measures for adults, I am skeptical as to whether tracking follow up and continuation of medication for children is an actually indicator of quality of care. Therefore I do not think it should be included.
3. Should we not first look at prescribing practices to assess if ADHD medications are prescribed in similar patterns across providers?

### Theme:

- Concern re: reporting burden for providers

## Q6: It has been recommended that the following pediatric quality measure be **NEWLY ADDED** to the Common Measure Set in 2017. Do you agree?

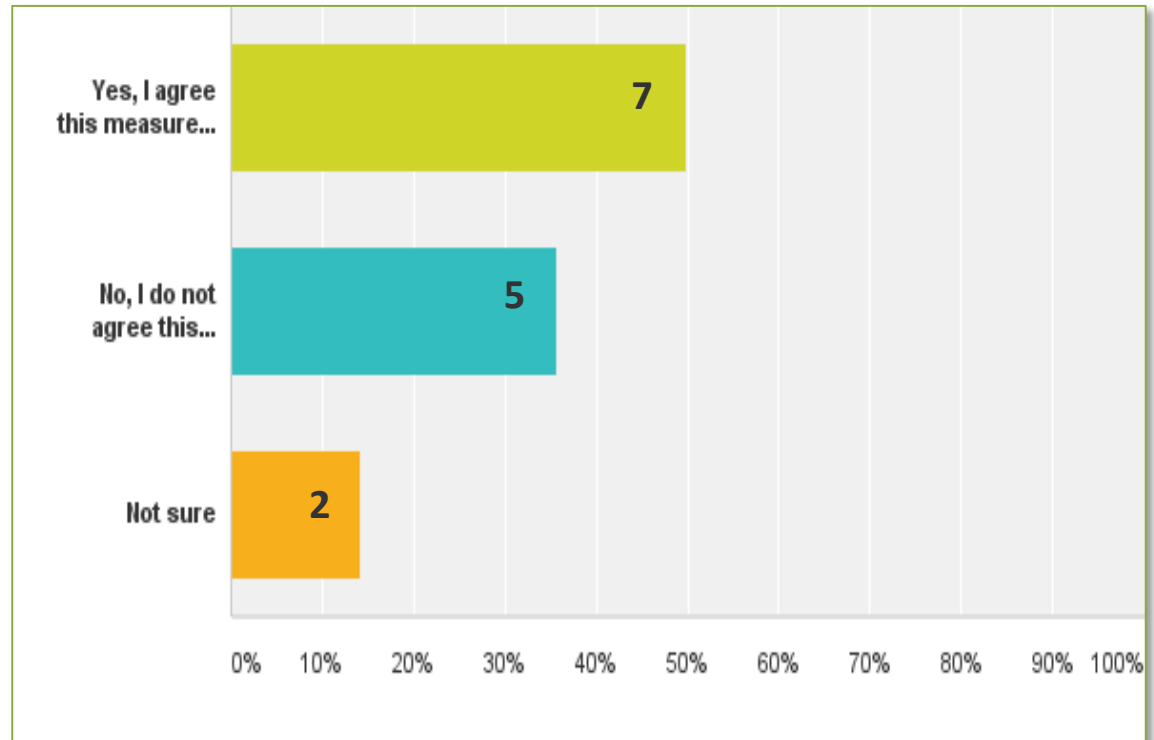
Answered: 14

**Lead Screening in Children**

**NCQA-approved for  
Medicaid population only**

**[Measure Steward: NCQA  
HEDIS, not NQF-Endorsed]**

**Results would be available  
for the state and health  
plans.**



## Q6: It has been recommended that the following pediatric quality measure be **NEWLY ADDED** to the Common Measure Set in 2017. Do you agree?

### Lead Screening in Children

**NCQA-approved for  
Medicaid population only**

**[Measure Steward: NCQA  
HEDIS, not NQF-Endorsed]**

**Results would be available  
for the state and health  
plans.**

### Specific comments related to this question:

1. Again, unnecessary utilization of resources. . . especially when parents/families will have little control over their home environment. Lead screening should be based on high risk environments and/or clinical presentation.
2. This is a HEDIS measure, so will be included and required to be collected by Medicaid managed care organizations. That said, it's important to know that the Health Care Authority (Medicaid) currently collects lead screening through another mechanism (and is required to continue to do so) to meet federal reporting requirements.
3. State's Department of Health is still providing guidance as follows: <http://www.doh.wa.gov/Portals/1/Documents/Pubs/334-394.pdf>. This guidance says to administer the test at 12 and 24-months. However, for this measure to be compliant, you must administer the test BEFORE 24 months.
4. Lead is not a financially based contaminant.

### Themes:

- Not NQF/nationally endorsed
- Concern re: reporting burden for providers

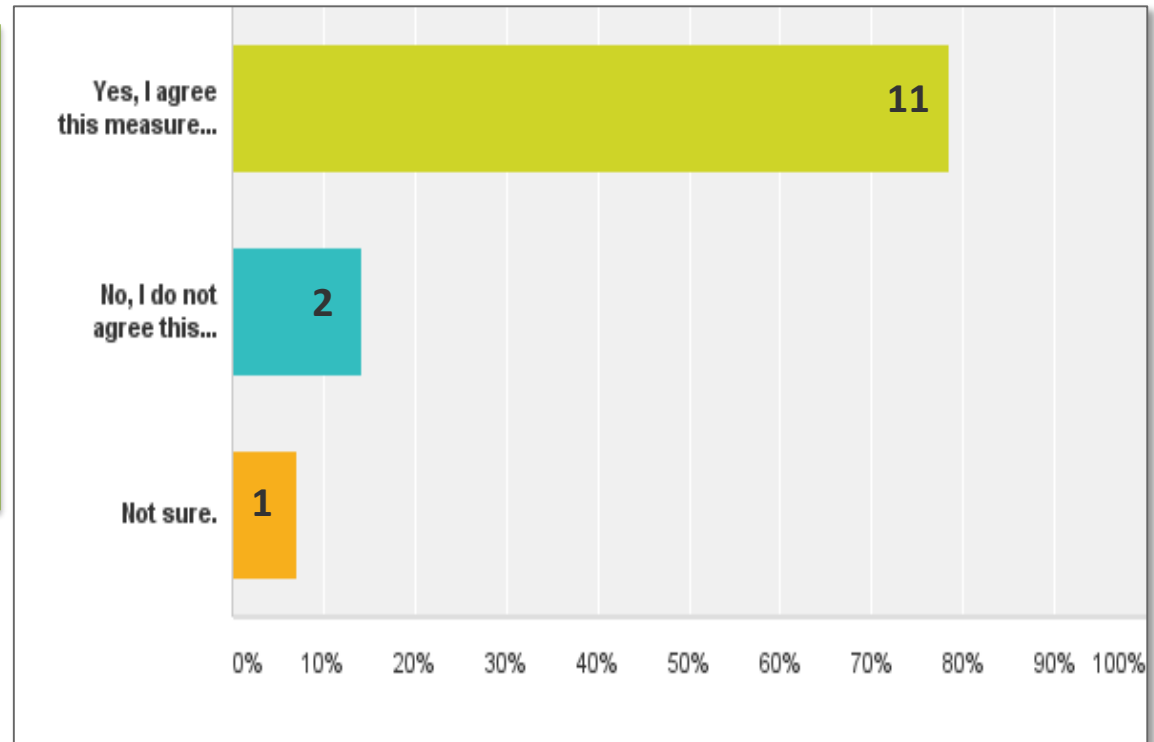
## Q7: It has been recommended that the following pediatric quality measure be **NEWLY ADDED** to the Common Measure Set in 2017. Do you agree?

Answered: 14

**Audiological Evaluation No Later Than Three Months**

**[Measure Steward: Centers for Disease Control, NQF-Endorsed #1360]**

**Results would be available for the state, counties, and ACHs.**



**Q7: It has been recommended that the following pediatric quality measure be NEWLY ADDED to the Common Measure Set in 2017. Do you agree?**

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**Audiological Evaluation No Later Than Three Months**

**[Measure Steward: Centers for Disease Control, NQF-Endorsed #1360]**

**Results would be available for the state, counties, and ACHs.**

**Specific comments related to this question:**

1. Ok as DOH appears to be the data source for measure.
2. Code sets that qualify for this measure are not specified as of yet; in addition a new specification has been issued and is to be in effect by January 2017, meaning trending between years won't be possible until 2019 for years 2017, and 2018.
3. Too many measures spoils the pot.

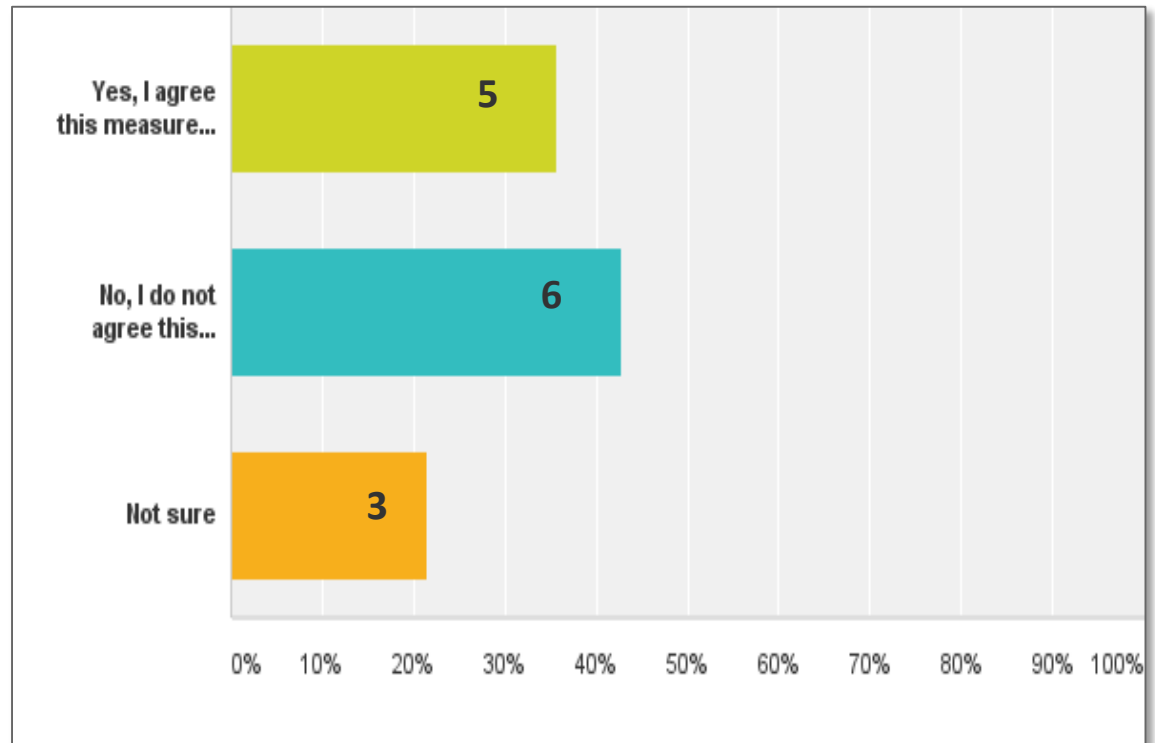
## Q8: It has been recommended that the following pediatric quality measure be **NEWLY ADDED** to the Common Measure Set in 2017. Do you agree?

Answered: 14

**PCP Visit After ER Visits for Asthma**

**[Measure Steward: PQMP, not NQF-Endorsed]**

**Results would be available for the state, counties, and ACHs.**



## Q8: It has been recommended that the following pediatric quality measure be **NEWLY ADDED** to the Common Measure Set in 2017. Do you agree?

Answered: 14

### PCP Visit After ER Visits for Asthma

[Measure Steward: PQMP, not NQF-Endorsed]

Results would be available for the state, counties, and ACHs.

#### Specific comments related to this question:

1. This measure may be technically difficult to calculate as it requires knowing the provider type and provider taxonomy is often not a reliable field in the Medicaid claims data. Generally it is easier to look at type of visit than type of provider.
2. This should allow for visits telephonically as well as in person, if possible.
3. Again, when one already has access challenges, this eliminates the opportunity for us to use alternative visits (nurse visit and/or provider telephone call) as follow up on low acuity asthma ER visits. We triage ER follow up visits by phone initially to assess need for a face to face encounter.
4. I like the measure; I would like to see it collected at the health plan level of analysis.
5. The evidence of the cost effectiveness of this measure and the PCP interaction being able to deter future ER visits is not significant.

#### Themes:

- Complexity of tracking
- Not NQF/nationally endorsed

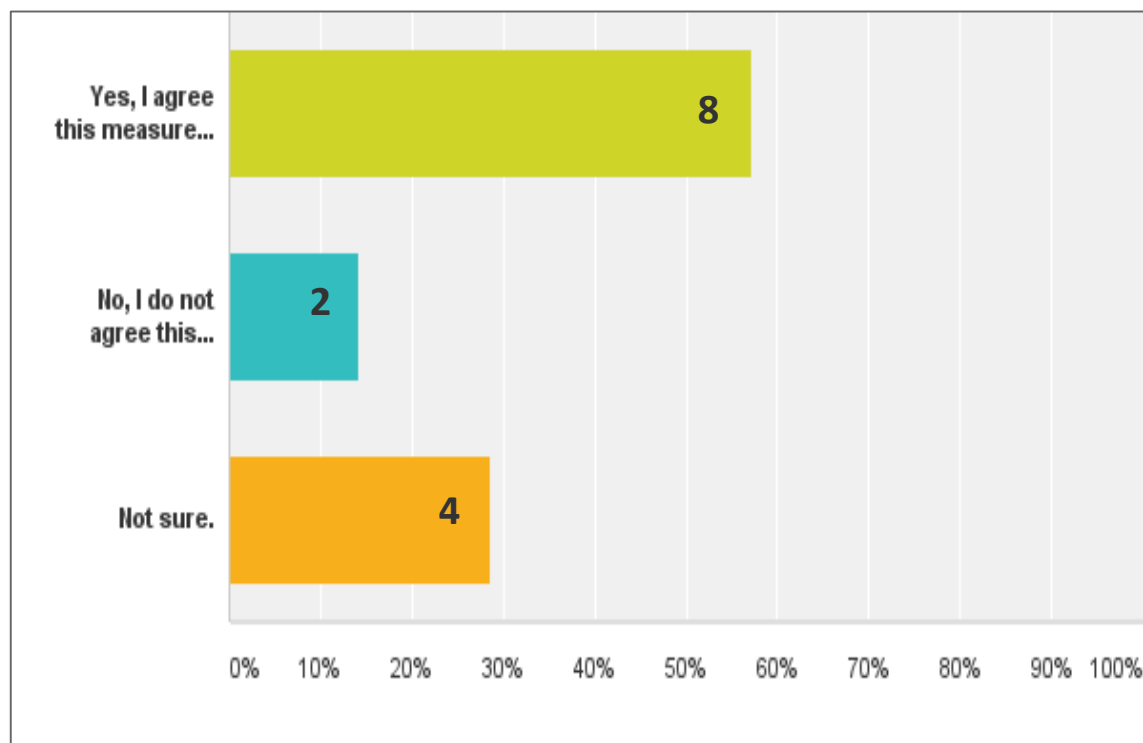
## Q9: It has been recommended that the following pediatric quality measure be **NEWLY ADDED** to the Common Measure Set in 2017. Do you agree?

Answered: 14

**Pediatric All-Cause Hospital Readmissions**

**[Measure Steward: Center of Excellence for Pediatric Quality Measurement, NQF-Endorsed #2392]**

**Results would be available for the state and hospitals.**





**Q9: It has been recommended that the following pediatric quality measure be NEWLY ADDED to the Common Measure Set in 2017. Do you agree?**

## **Pediatric All-Cause Hospital Readmissions**

**[Measure Steward: Center of Excellence for Pediatric Quality Measurement, NQF-Endorsed #2392]**

**Results would be available for the state and hospitals.**

### **Specific comments related to this question:**

1. The case-mix adjustment makes this measure very complicated to calculate and the value of this measure is unclear. Are there savings to be captured with pediatric readmissions? This measure makes more sense for plan and hospital-level reporting, but not so much for statewide reporting. The denominator would be quite small and it's not clear how useful/actionable this info would be at a statewide or ACH level.
2. All-cause readmissions are already measured. Breaking out specific populations seems pedantic.

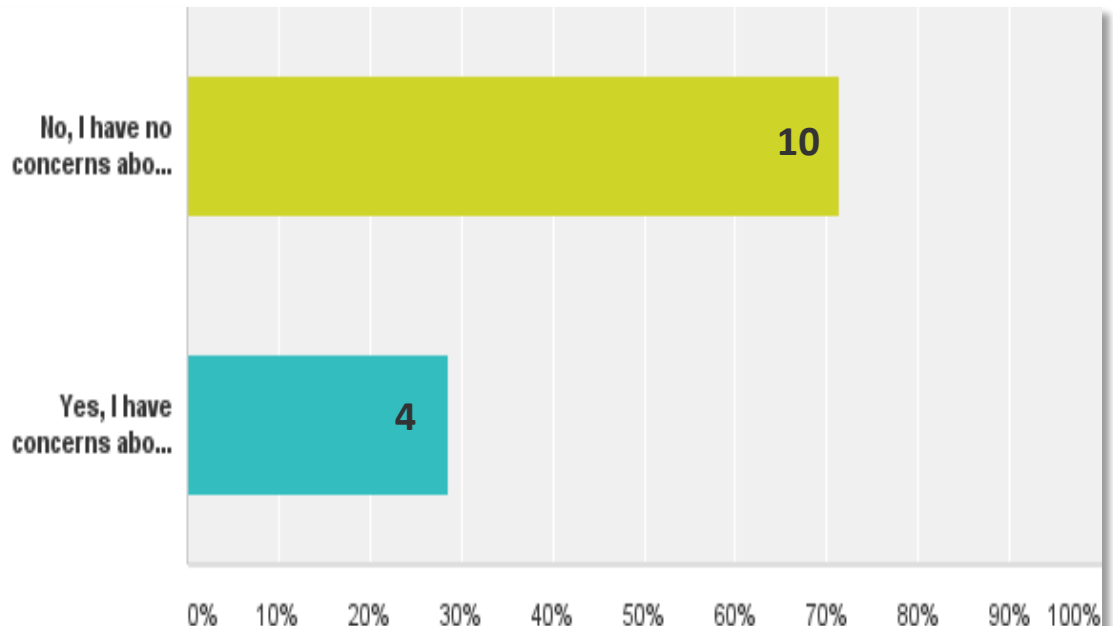
### **Themes:**

- Concern re: reporting burden for providers

**Q10: The following five quality measures that pertain to both pediatrics and adults, already approved for the Common Measure Set, were reviewed and it is recommended that they CONTINUE TO BE A PART OF the Common Measure Set in 2017. Do you have any concerns?**

Answered: 14

1. Immunization for Influenza
2. Chlamydia Screening for Women
3. Mental Health Service Penetration
4. Substance Use Disorder Service Penetration
5. Follow-up After Hospitalization for Mental Illness @ 7 days and 30 days



**Q10: The following five quality measures that pertain to both pediatrics and adults, already approved for the Common Measure Set, were reviewed and it is recommended that they **CONTINUE TO BE A PART OF** the Common Measure Set in 2017. Do you have any concerns?**

- 1. Immunization for Influenza**
- 2. Chlamydia Screening for Women**
- 3. Mental Health Service Penetration**
- 4. Substance Use Disorder Service Penetration**
- 5. Follow-up After Hospitalization for Mental Illness @ 7 days and 30 days**

**Specific comments related to this question:**

1. Both measures 3 and 4 are not comparable to standardized rates. These measures do have plan-level equivalent measures, including: Item: 3 - "Mental health utilization: number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or emergency department (ED)." This is NQF endorsed – endorsement #NQMC:006260. It is a standard HEDIS measure (Mental Health Utilization (MPT)) with national and regional percentiles to compare to for each product type. Item 4 - "Identification of alcohol and other drug services: summary of the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED." This is NQF endorsed -- endorsement #NQMC:010616. It too is a standard HEDIS measure (Identification of Alcohol and Drug (IAD Services)) with national and regional percentiles to compare to for each product type.
2. Service penetration is not an intuitively understandable concept. As long as it's clear to the stakeholders and clinicians what this means, I think it's fine to include them. But even with an extensive background in health care and measurement, this term is pretty opaque. Might be important to consider how to describe this for reporting purposes.
3. With the various quality performance reporting requirements, alignment needs to occur between the state and federal reporting. I do not endorse #3 and #4.

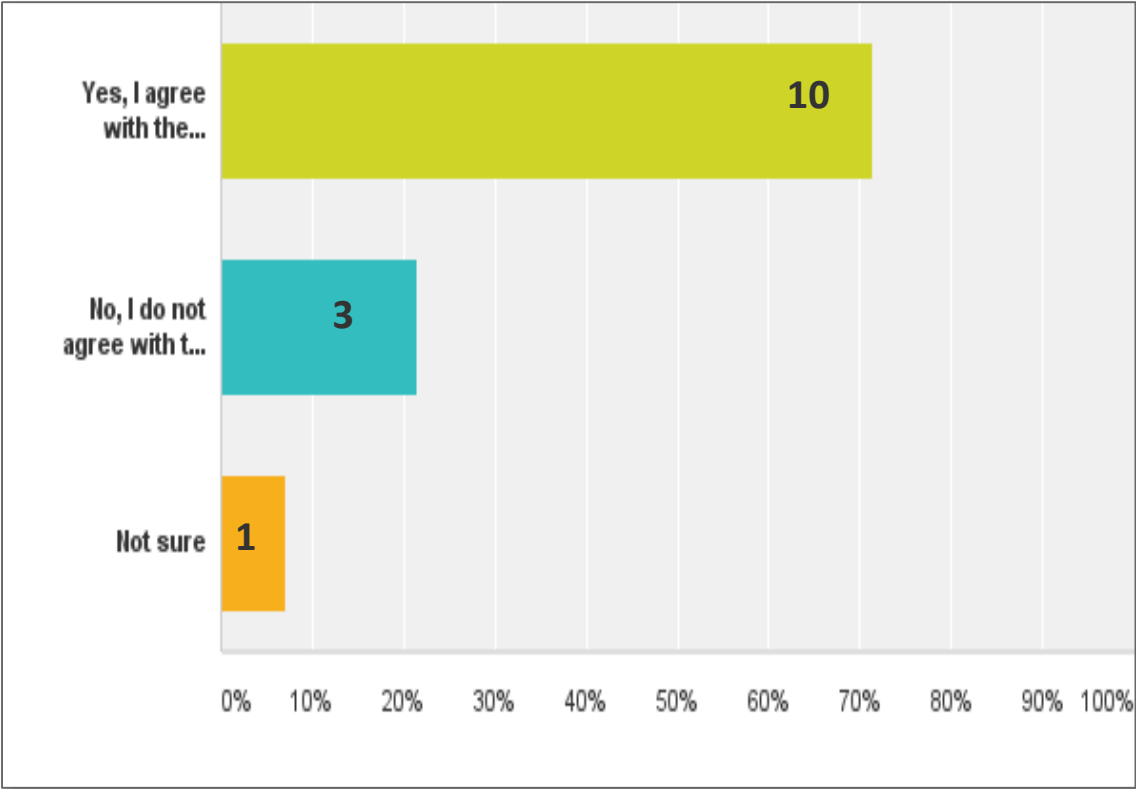
**Q11: It has been recommended that the following measure, already approved for the Common Measure Set, BE MODIFIED IN THE FOLLOWING MANNER. Note: this measure applies to both the pediatric and adult populations. The reason for the change is to align Washington State's use of the measure with CMS and the availability of national benchmark data. Do you agree?**

Answered: 14

**Medication Management for People with Asthma**

[Measure Steward: NCQA HEDIS, NQF-Endorsed #1799]:

Percentage of members 5-85 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least **50%** **75%** of their treatment period.



**Q11: It has been recommended that the following measure, already approved for the Common Measure Set, BE MODIFIED IN THE FOLLOWING MANNER. Note: this measure applies to both the pediatric and adult populations. The reason for the change is to align Washington State's use of the measure with CMS and the availability of national benchmark data. Do you agree?**

### **Medication Management for People with Asthma**

**[Measure Steward: NCQA HEDIS, NQF-Endorsed #1799]:**

**Percentage of members 5-85 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 50% 75% of their treatment period.**

#### **Specific comments related to this question:**

1. While I appreciate the measure intent, we have no mechanism to track this measure at the clinic level to assess progress or lack of progress. Med compliance is claims based data that is not conveniently available; additionally, lets start with 50% before jumping to 75%.

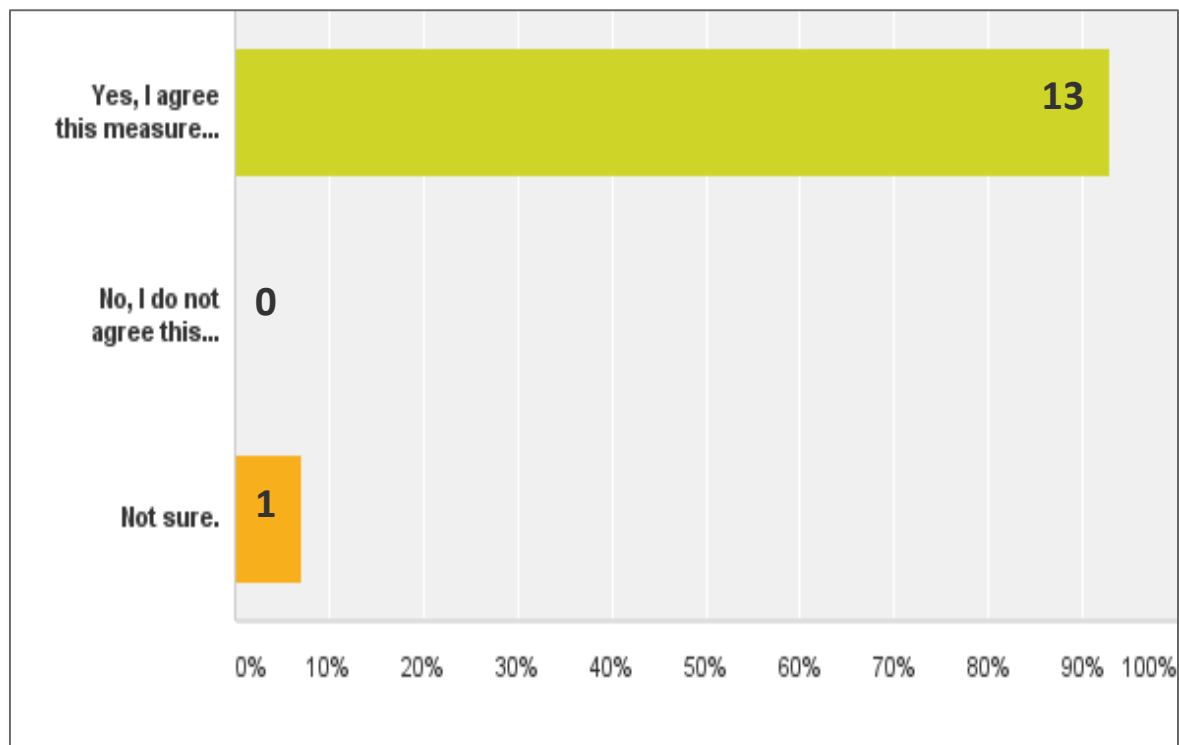
#### **Theme:**

- Concern re: reporting burden for providers

**Q12: It is recommended that the FOLLOWING MEASURE BE REMOVED from the Common Measure Set in 2017. [Note: This measure has been retired by NCQA and there will no longer be national benchmark data for this measure. Beginning in 2017, the HPV vaccine is now included in the "Immunizations for Adolescents by Age 13" measure, including both female and male adolescents.] Do you agree?**

Answered: 14

**Human Papillomavirus  
Vaccine for Female  
Adolescents by Age 13**



**Q12: It is recommended that the FOLLOWING MEASURE BE REMOVED from the Common Measure Set in 2017. [Note: This measure has been retired by NCQA and there will no longer be national benchmark data for this measure. Beginning in 2017, the HPV vaccine is now included in the "Immunizations for Adolescents by Age 13" measure, including both female and male adolescents.] Do you agree?**

**Human Papillomavirus  
Vaccine for Female  
Adolescents by Age 13**

**Specific comments related to this question:**

1. It will still be helpful to report out by male/female when possible.

## Q13 Do you have ANY OTHER COMMENTS regarding the Common Measure Set?

### # Response

- 1 Pertaining to the chlamydia measure, HEDIS ignores persons covered by a HCO that seek no care. In other words, if an 18 year old female gets no care in a year, she is not in denominator. That runs counter to a public health approach. From our perspective, a HCO should try to ensure all of their patients receive recommended preventive services, not just the patients who seek care on their own. As the PMCC moves to population measures, we would like to see an indicators on breastfeeding initiation/duration and maltreatment risk factor screening in pediatric practices.
- 2 No additional comments besides what has already been provided. Our most significant concern is the additional reporting burden given that--of the 19 measures under review--we are only currently reporting on five of them.
- 3 Please remember to keep it as simple as possible. We appreciate aligning with CMS measures and encourage that to continue.
- 4 Continuously adding and modifying measures may result in a lack of attention, as the provider community at some point may fail to remember that a measure was added, modified, subtracted, no longer measured, etc. I believe it might be more effective to pick a few measurements, solidify them, make everyone aware of them, then track them. Having ever more and ever different measures will lead to burnout. I would urge fewer, meaningful measures.



## **Recommendations re: Pediatric Measures in the Common Measure Set**

# Pediatric Measures Selection Work Group

1. Nwando Anyaoku, MD, Swedish Medical Group
2. Michael Barsotti, MD, Sacred Heart Children's Hospital
3. Jared Capouya, MD, MultiCare Health System
4. Frances Chalmers, MD, Washington Chapter of the American Academy of Pediatrics
5. Tanya Dansky, MD, Amerigroup-Washington
6. Sallie Davis-Kirsch, PhD, RN, Seattle Childrens'
7. Debra Lochner Doyle, MS, LGCG, Department of Health
8. Michael Dudas, MD, Virginia Mason Medical Center
9. Howard Jeffries, MD, Seattle Childrens'
10. Stuart Minkin, MD, Allegro Pediatrics
11. Angela Riley, MD, Molina Healthcare of Washington
12. Gina Sucato, MD, Group Health Adolescent Center
13. Carol Wagner, RN, Washington State Hospital Association

# Summary of Final Recommendations

The Work Group is recommending:

- Keep 12 quality measures (already approved for the Common Measure Set) that relate to a pediatric-only population (ages 17 and younger) or a mixed pediatric-adult population
- Keep a 13<sup>th</sup> quality measure (already approved for the Common Measure Set) but with modification
- Add 3 new quality measures that relate to the pediatric-only population
- Remove one measure currently approved for the Common Measure Set

The Work Group is withdrawing 2 measures from consideration.

The Work Group was unable to come to conclusion on 1 measure.

# Final Recommendations

**KEEP the following measures -- comply with current specifications, otherwise no modifications:**

1. Childhood Immunization Status by Age 2
  2. Immunizations for Adolescents by Age 13
  3. Oral Health – Primary Caries Prevention in Primary Care
  4. Child and Adolescent's Access to Primary Care (4 rates)
  5. Appropriate Testing for Children with Pharyngitis
  6. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
  7. Well Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life
- 
8. Immunization for Influenza
  9. Chlamydia Screening for Women
  10. Mental Health Service Penetration
  11. Substance Use Disorder Service Penetration
  12. Follow-up After Hospitalization for Mental Illness



# Final Recommendations

KEEP the following measure as is (with modification):

**13. Medication Management for People with Asthma**  
(ages 5 – 85 years)

- **Report 75% adherence** (rather than 50%)
  - This will align with NCQA benchmark availability and CMS use of this measure



# Final Recommendations

**ADD the following measures to the Common Measure Set:**

## **14. Well Child Visits in the First Fifteen Months of Life**

- Steward: NCQA HEDIS
- Alliance – Data Source for State, County, ACH, Medical Group Results (Claims Data)
- NCQA – Data Source for Health Plan Results
- Report one rate: children w/ six or more visits

## **15. Follow-up Care for Children Prescribed ADHD Medication**

- Steward: NCQA HEDIS, NQF-Endorsed #0108
- Alliance – Data Source for State, County, ACH, Medical Group Results (Claims Data)
- NCQA – Data Source for Health Plan Results

## **16. Audiological Evaluation No Later Than 3 Months of Age**

- Steward: CDC, NQF-Endorsed #1360
- DOH – Data Source (Registry Data)
- Report results at State, County and ACH levels



# Final Recommendations

**REMOVE the following measure:**

- **Human Papillomavirus Vaccine for Female Adolescents by Age 13**
  - This measure has been retired by NCQA.
  - HPV vaccine now included in “Immunizations for Adolescents” measure (both girls and boys)



# Final Recommendations

The Work Group has withdrawn its earlier recommendation to add the following two measures:

- Lead Screening in Children
- PCP Visit After ER Visits for Asthma

The Work Group was unable to agree upon a recommendation regarding the following measure:

- Pediatric All-Cause Hospital Readmissions



# Other Recommendations to Modify Common Measure Set

## Follow-up After Discharge from the ER for Mental Health, Alcohol or Other Drug Dependence @ 30 days

It is recommended that we **DELAY IMPLEMENTATION** for one more year.

In 2018, proceed with public reporting of state and health plans results (using data from NCQA Quality Compass).

Background Info:

- Measure approved in 2016 but tabled because not yet included in NCQA HEDIS measure set
- Measure now approved for HEDIS, starting in 2017
- Because a “first year HEDIS measure” 2017 results will not be released publicly



## “Parking Lot”

Topics/measures that Work Group was very interested in but are not recommended at this time\*:

- Depression screening by age 13 years of age
- Maternal depression screening
- Dyslipidemia screening for patients aged 12 years
- Developmental screening in the first three years of life
- Opioid prescribing for children and adolescents
- Lead Screening in Children
- *Possible Addition of Pediatric All-Cause Readmissions*



# Discussion Questions

# Public Comment



# Public Comment

**Please limit your comment to  
2 minutes or less**

**ACTION**



# Performance Measures Coordinating Committee Vote

**TAKE ACTION:**  
**Approve recommendations for  
modifying the Common Measure Set  
for 2017**

## **2016 Community Checkup/Common Measure Set Results**



# Improving Health Care in Washington State: 2016 Community Checkup and Common Measure Set Results



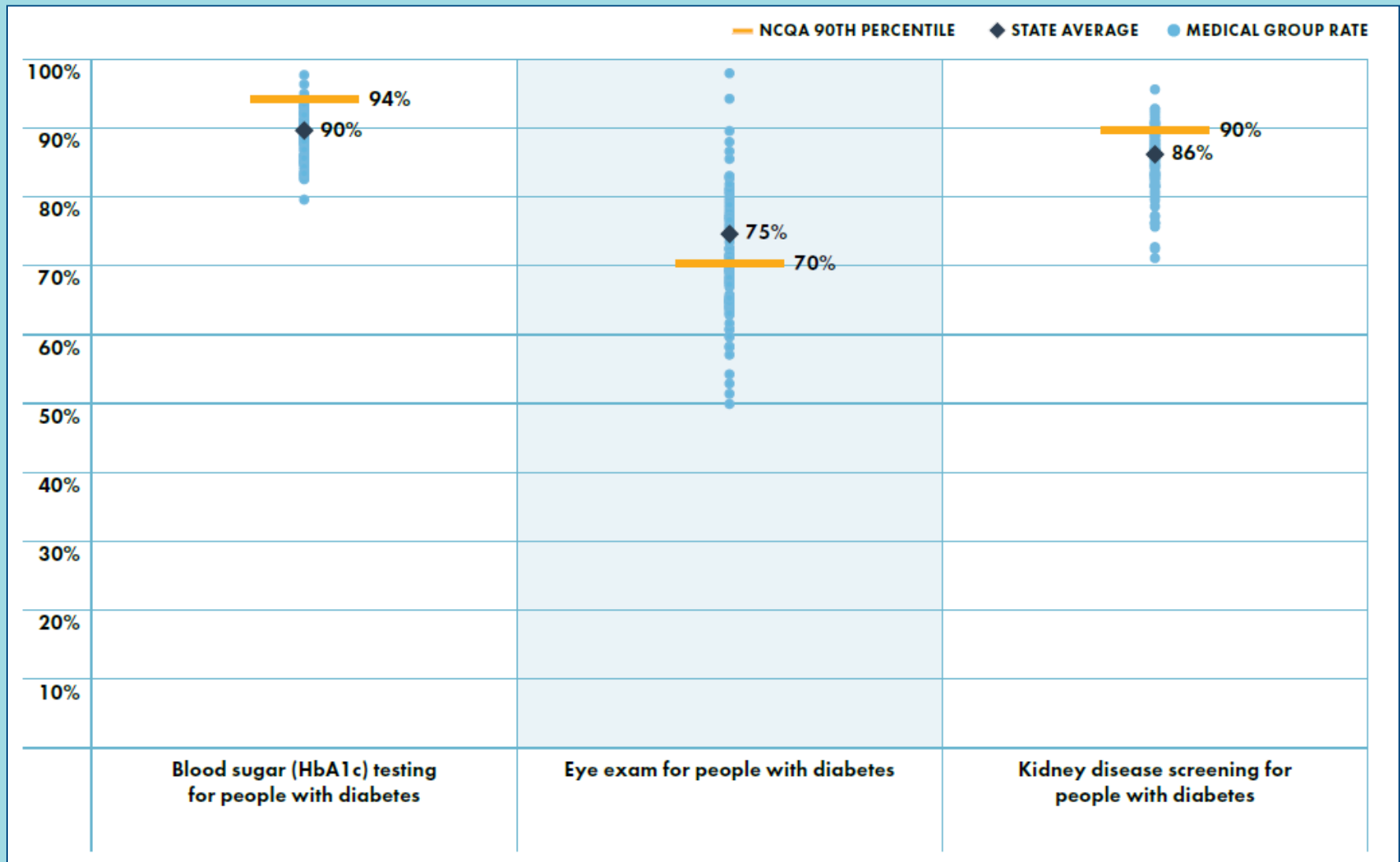
# 2016 Community Checkup: What's New

- For the first time, results will be 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.
  - Approximately 190 medical groups and 700 clinics
- 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 and substance use disorder service penetration.

# Key Findings

- Variation, variation, variation.
- We have a long way to go to achieve our goal of top 10% of performance nationally.
- Too many patients in Washington are not receiving the evidence-based care they need and deserve.
- Local successes prove top quality health care is achievable.

# Variation in Diabetes Care (Commercially Insured)



Room for  
Improvement:

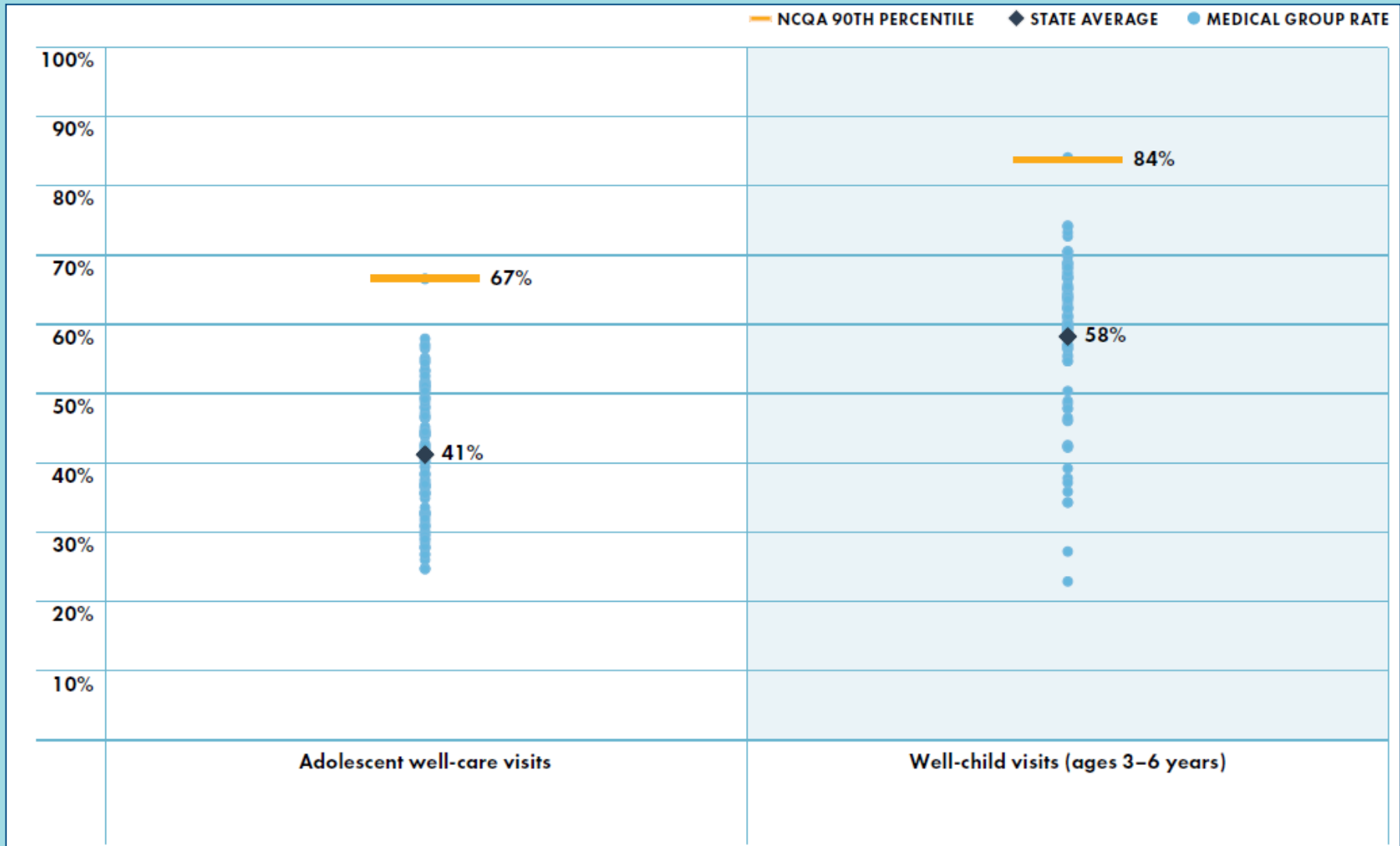
Diabetes Care  
HbA1c Poor Control  
(>9%)

State Average: 37%

A Lower Rate  
is Better!

Commercial Health Plan	Rate	Score
Aetna	49%	WORSE
Asuris Northwest Health	38%	WORSE
Cigna	36%	AVERAGE
Group Health Cooperative	26%	AVERAGE
Group Health Options	33%	AVERAGE
Kaiser Permanente NW	23%	BETTER
LifeWise Health Plan	55%	WORSE
Premera Blue Cross	67%	WORSE
Regence Blue Shield	30%	AVERAGE
UnitedHealthcare	29%	AVERAGE

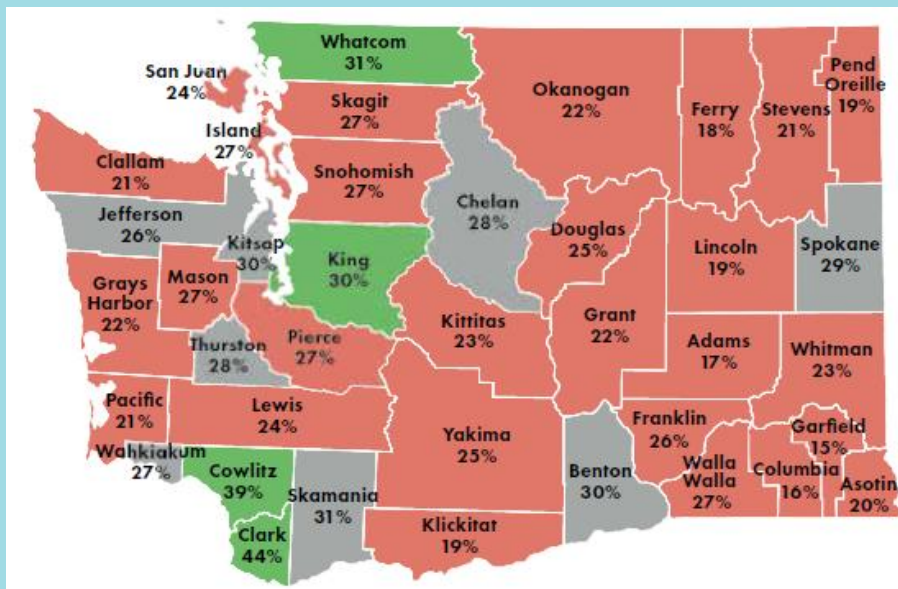
# Significant Variation in Well-Child Visits (Medicaid)



# New Behavioral Health Measures

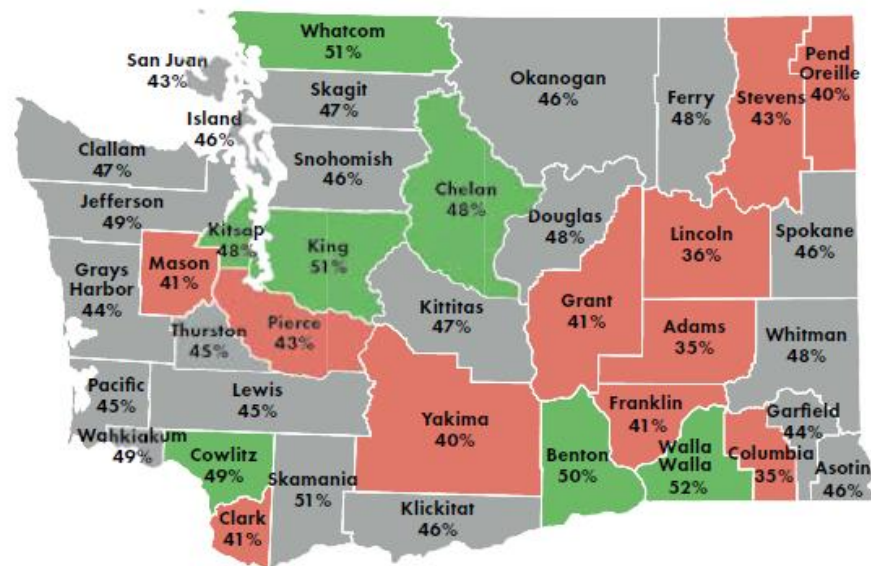
- Two new measures added to Common Measure Set:
  - Mental Health Services Penetration
  - Substance Use Disorder Services Penetration
- Measure how often follow-up care comes after a diagnosis of either a mental health or substance use disorder need.
- Important addition to the Common Measure Set for three reasons:
  1. Key driver of health care utilization;
  2. Conditions are key risk factors affecting patient experiences and quality of life; and
  3. Historically underfunded in relation to physical health care.

# Mental Health Service Penetration for Adults, 18-64 years



**BETTER** **AVERAGE** **WORSE**

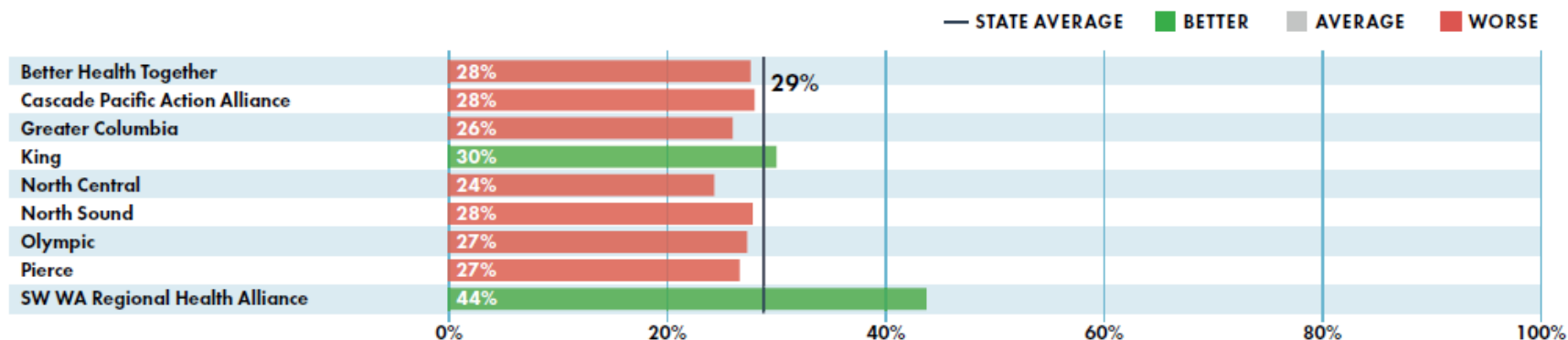
**Medicaid-Insured  
State Average = 46%**



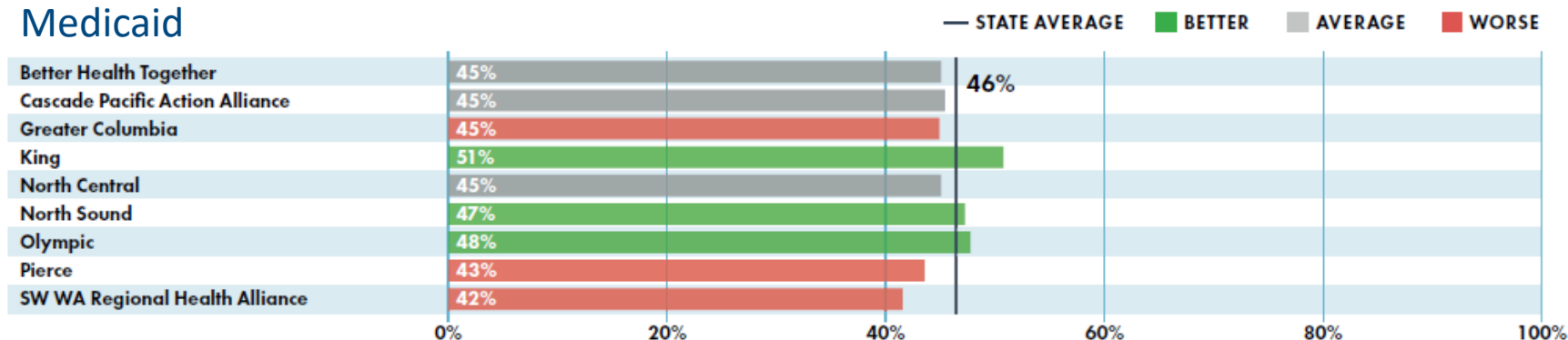


# Mental Health Services for Adults (ACH results)

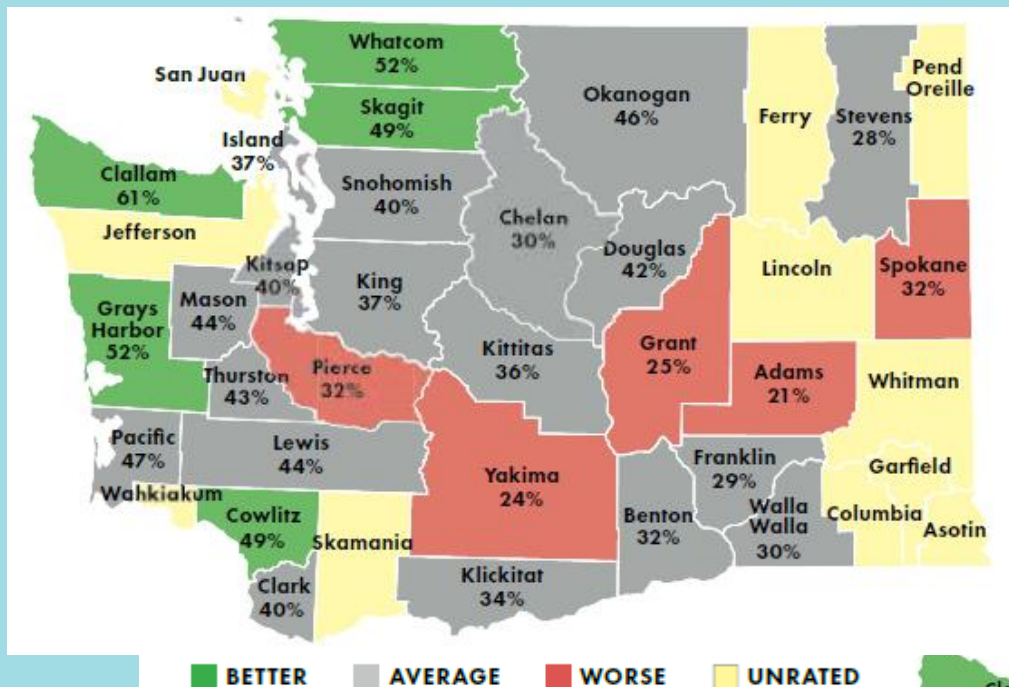
## Commercially Insured



## Medicaid

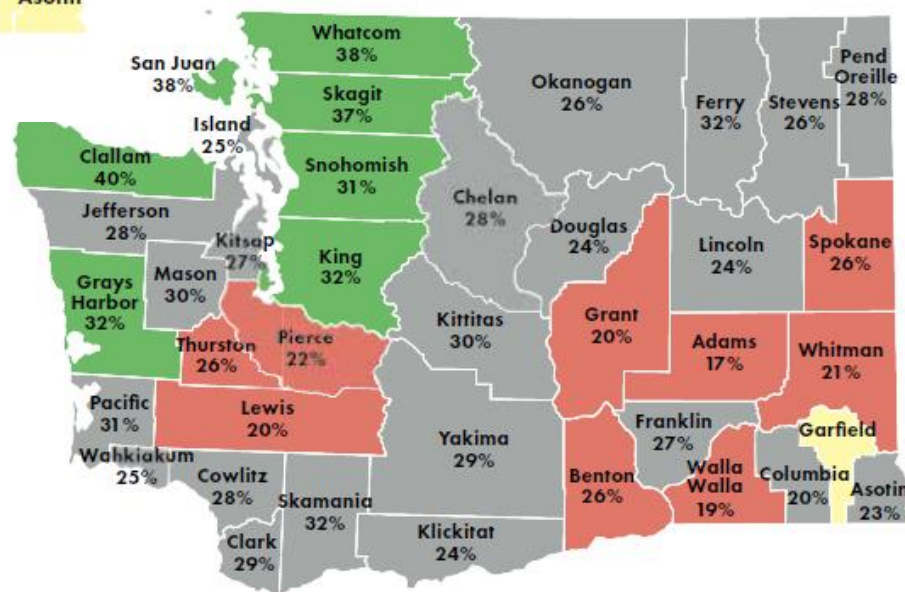


# Substance Use Disorder Service Penetration



**Medicaid-Insured Children 6-17 years**  
State Average = 36%

**Medicaid-Insured Adults 18-64 years**  
State Average = 28%



# Variation Among Counties for Immunizations by Age 2

STATE AVERAGE: 33%

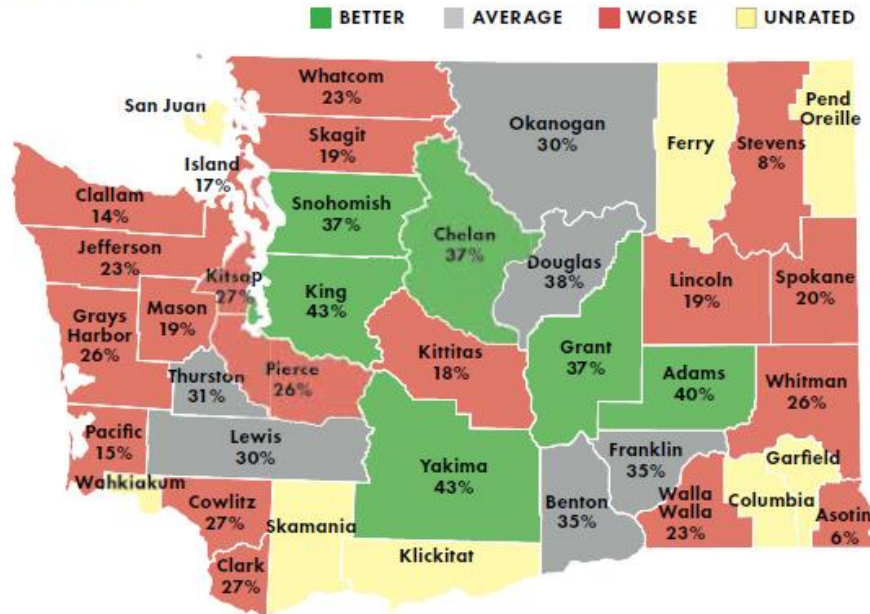
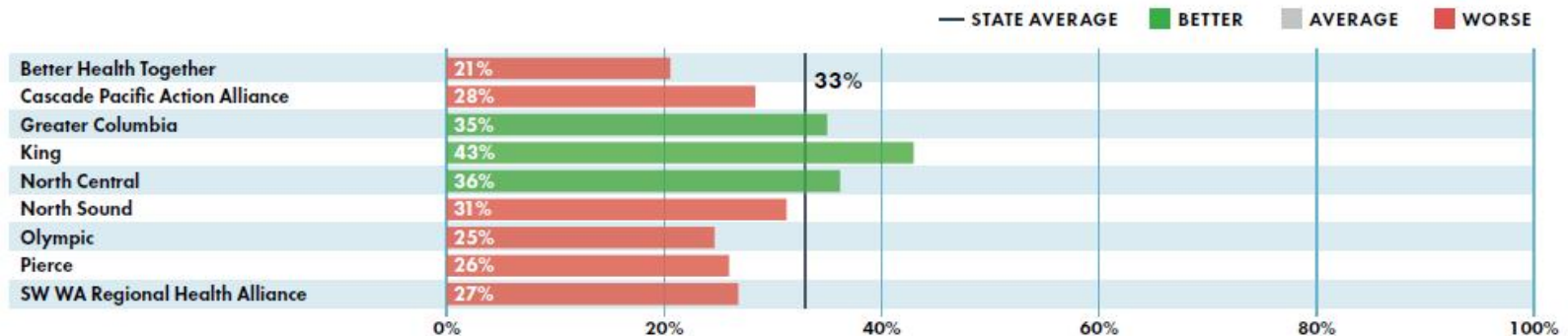
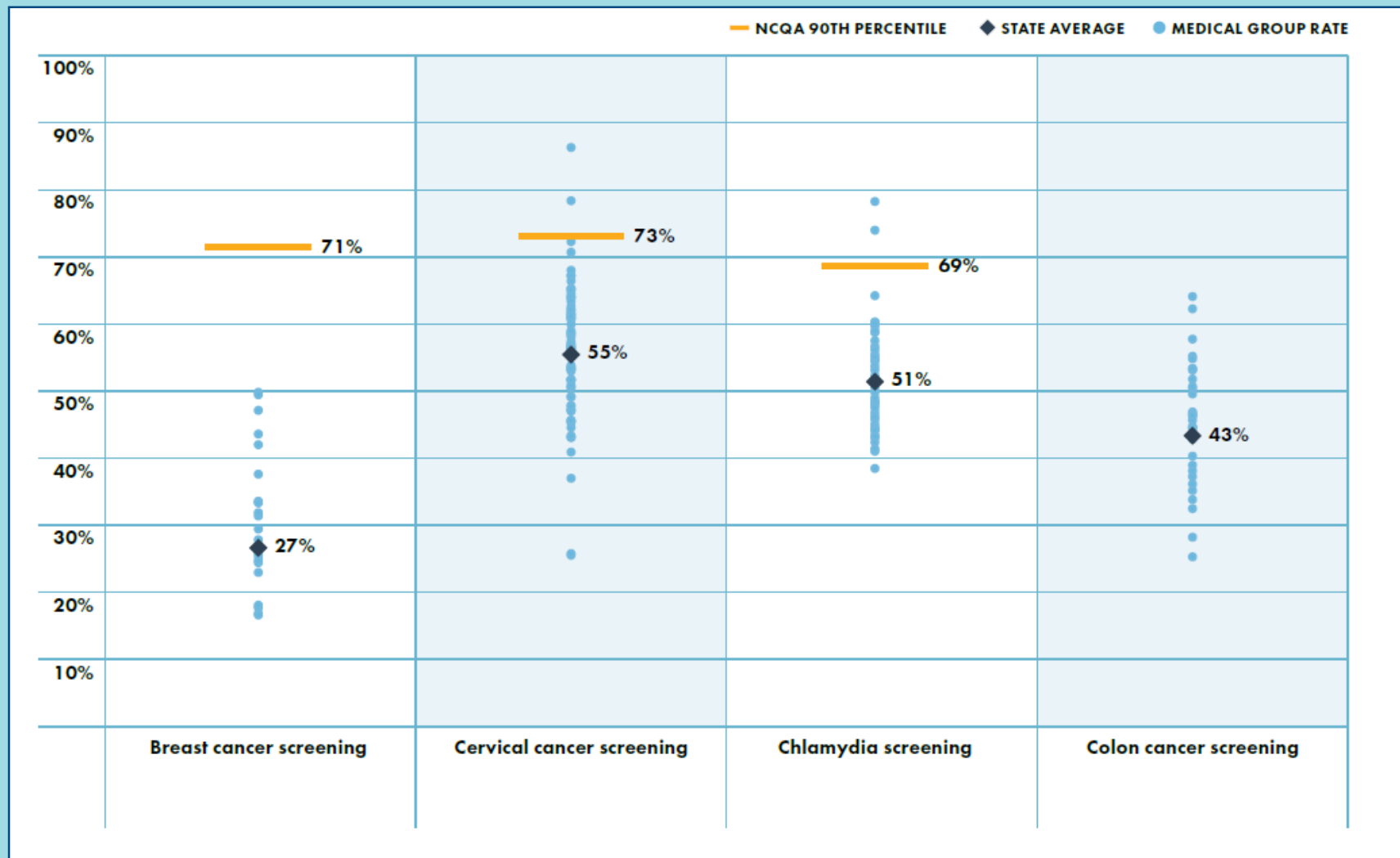


Figure 24: Variation among Accountable Communities of Health for Childhood Immunization Status by Age 2

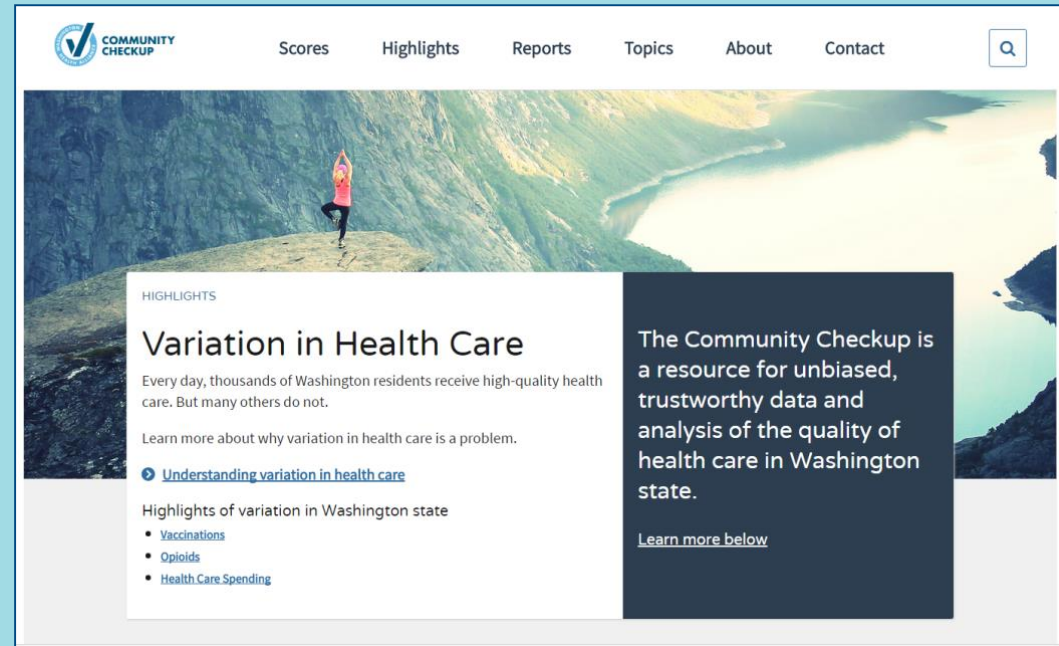


# Variation Among Medical Groups, Cancer Screenings (Medicaid-Insured)



# The New Community Checkup Website

- The new Community Checkup will be a major leap forward in presenting data results
- Powered by Tableau
- Much greater interactivity
  - Ability to sort and filter dramatically enhanced
- Built with input from Alliance stakeholders





# Wrap UP

1. High level summary of today's discussion available within 2 weeks on HCA website
2. Next PMCC meeting:  
1<sup>st</sup> Quarter 2017, Date TBD

**THANK YOU!**