WA State Performance Measures Coordinating Committee (PMCC)

March 25, 2016, 1:00 – 3:30 pm

Meeting Summary

I. Welcome and Introduction:

Ms. Dorothy Teeter, Administrator of the Washington State Health Care Authority, and Nancy Giunto, Executive Director of the Washington Health Alliance, welcomed attendees and thanked them for participating in the meeting. Ms. Giunto reminded everyone of the importance of keeping this a transparent process, allowing for public input and opportunities for participation, sharing all meeting materials and summaries on the Healthier WA website at: http://www.hca.wa.gov/hw/Pages/performance_measures.aspx.

Ms. Giunto reviewed the objectives for the meeting which included: (1) Quick Update: Patient Experience, Behavioral Health Measures; (2) Discuss Overall Size of Common Measure Set and potential assumptions/criteria we may use going forward to ensure it is kept to a manageable size over time; (3) Finalize a recommendation to the HCA for one new topic area for ad hoc workgroup in 2016 (for measurement/ reporting in 2017); and, (4) Seek advice about effective ways to promote use of the Common Measure Set to health plans, purchasers and providers, including a role for PMCC members.

II. Update: Patient Experience and Behavioral Health Measures

Ms. Dade provided an update on the patient experience survey conducted during fourth quarter 2015 with final results reported during first quarter 2016. She reported that the Alliance used the CG-CAHPS survey (version 3.0, released in June 2015). The survey was mailed to 181,000 people in a 14-county area. Data collection was closed in early December and there was a 31% response rate that permitted public reporting of patient experience results for 75 primary care medical groups with clinics in 266 locations. Five measures were publicly reported, including four composite measures and one overall satisfaction question. Ms. Dade noted that there is significant room for improvement to achieve our overall goal of being a top performer nationally. Results for the 14-county area are as follows (note: there is no benchmark for the third measure as it was new in 2015):

Measure	State Average	National 90th Percentile
Getting Access to Timely Care	58%	78%
How Well Providers Communicate with Patients	83%	91%
How Well Providers Coordinate Care	71%	N/A
Helpful and Respectful Office Staff	73%	91%
Overall Rating of the Provider	74%	90%

Ms. Dade also provided a brief update regarding implementation of the newly approved behavioral health measures, all of which must be implemented by health plans (commercial and Medicaid). She reported that a very productive meeting was held with the health plans in early March. Ms. Dade reported that agreement was reached to proceed in 2016 with two of the three new measures, including the Mental Health Service Penetration and Substance Use Disorder Treatment Penetration measures. Agreement was also reached, with the Health Care Authority's approval, to delay implementation of the third measure for one year. This delay is intended to permit time for NCQA to conclude their deliberations regarding whether or not to include this measure in the 2017 HEDIS measure set, along with final measure definitions/specifications. This measure has received endorsement from NQF, however, it is currently out for public comment as a potential HEDIS measure and it is expected that the detailed measure specifications will change to reflect this input. At this point, we do not know how much the specifications will change but several health plans here in Washington have stated that they are submitting numerous proposed changes to NCQA so the changes may be significant. It was apparent that these potential changes would create significant re-work (and expense) for health plans. At this time, we do plan to implement this measure in 2017 regardless of whether it is approved as a HEDIS measure.

PMCC-Approved Measure	Units of Analysis in 2016			Proceed in 2016?
	Health Plan/ Commercial	Health Plan/ Medicaid	County/ACH	
Mental Health Service Penetration (Broad Version)	**Yes**	**Yes**	**Yes**	**Yes**
Substance Use Disorder Treatment Penetration	**No**	**Yes**	**Yes**	**Yes**
Follow-up after Discharge from ER for Mental Health, Alcohol or Other Drug Dependence within 30 days				**No**

III. Group Discussion: Overall Size of the Common Measure Set

Ms. Teeter led off this discussion by noting that there was no intent to make a decision at this meeting, but rather to have a discussion to gather members' opinions and perspectives. Ms. Teeter asked Ms. Dade to review several considerations regarding size of the Common Measure Set including: (1) overall purpose of the Common Measure Set; (2) how the current measure set breaks down by different focus areas and units of analysis; (3) the selection criteria that has been used to select and keep measures. The following is a brief outline of the discussion points considered by the PMCC:

- *Most measures are focused on primary care and/or hospital care, rather than specialty care.* This is because we do not yet have a fully built specialty provider roster for the state of Washington which is needed to attribute care to specialty medical groups. Further, specialty measures are focused on smaller subsets of the population, resulting in small cell sizes that hamper public reporting.

- *Most measures are focused on process rather than outcomes. Overtime, there will be a need to consider broad outcomes and a population level.* We are not yet including many outcome measures because we do not yet have a fully functional clinical data repository in the state that aggregates clinical data to support performance measurement and public reporting.
- *As we consider measures to keep, remove/replace or add, we should look to other national measure sets to ensure we are keeping pace and standardizing as much as possible.* The group generally agreed and it was noted that we do that now.
- The question was raised as to *how we measure the administrative burden and cost associated with implementing the Common Measure Set*.
- We need *to ensure that we are aligning practice transformation efforts within the state as well as provider payment/contracting with the Common Measure Set* to gain the most traction and to reduce variation in how we are measuring quality/value in health care. Making a difference in performance (i.e., achieving significant improvement) is much harder than selecting the measures. We need to understand *performance interdependency*, e.g., health plans cannot achieve better performance scores on measures without improvement by the delivery system.
- Once we have a little more experience with the Common Measure Set, we need to discuss *specific targets for each measure* so that we will know when good is good enough.
- The focus of the Common Measure Set is heavily focused on clinical processes. How will we *track other social determinants of health that impact populations and overall health*?
- The suggestion was made to limit the overall size of the Common Measure Set and then focus more intently on two to three measures where we think have a high potential for impact (improve quality and lower cost).

IV. Evolving the Common Measure Set in 2017

Laura Pennington with the Health Care Authority led this portion of the agenda. She noted that the PMCC is being asked to recommend ONE topic area for additional work in 2016 (via ad hoc workgroup led by the Alliance) to determine whether one or more measures in that topic area may be added to the Common Measure Set in 2017. Ms. Pennington noted that the HCA considered a number of things while formulating their recommendation, including: (1) the original High Priority Development List (aka Parking Lot) developed during the original measure selection process in 2014; (2) informal stakeholder feedback about the Common Measure Set and potential gaps; and (3) other considerations such as the Department of Health's Plan for Population Health and the 50 measures being considered for that measure set. A number of the potential topic areas, as shown on page 4, rely upon the availability of clinical data for measurement and reporting. As noted earlier, we do not yet have a fully functional clinical data repository in the state to support measurement in this area.

Health Care Authority Recommendation: Focus on Pediatrics

High Priority Topic Area	Data Source Likely Available in 2017	Robust Data Source NOT Likely Available in 2017*
1. Pediatric care (prevention, chronic illness)	☑	
2. Depression screening; depression response/remission		☑
3. Continuity of care and care transitions		☑
4. Medication reconciliation		☑
5. Assessment of functional status		☑
6. Advanced care planning		☑

The PMCC discussed the HCA recommendation, particularly in light of the earlier discussion about overall size of the Common Measure Set. A number of other potential topics were mentioned briefly, including (1) Choosing Wisely and overutilization, (2) Opioid prescribing, and (3) other measures pertaining to specialty care.

Dr. Franklin suggested a strong focus on opioid prescribing particularly among individuals under the age of 20. He suggested a specific measure: Percent of children <20 years receiving a prescription for opioids for an acute condition who receive </= 3 days of a short acting opioid. Dr. Franklin noted that it is highly likely that the acute prescribing for children is contributing significantly to the heroin epidemic in the 18-25 year age group. He also noted that this measure would align with work of the Bree Collaborative and that it would be highly measurable via prescribing data at the public and private plans.

During the public comment period, Jody Daniels, representing GlaxoSmithKline and ViiV Healthcare, requested that the PMCC consider adding measures concerning HIV and in particular a measure on HIV Viral Load Suppression (NQF #2082). Written comments were provided for the PMCC and distributed prior to the March 25th meeting.

PMCC ACTION: In 2016, convene an ad hoc workgroup of subject matter experts with expertise in the area of measuring pediatric health care quality. Ask this workgroup to consider all of the 14 pediatric-related measures in the current Common Measure Set and to make a recommendation regarding which measures to keep, remove and/or replace, or add, noting that the total number of pediatric-related measures should not exceed 17 measures. The workgroup should use the same selection criteria used by previous workgroups.

V. Promoting the Common Measure Set

Ms. Giunto led this discussion, indicating that she and Dorothy Teeter were seeking the advice of the PMCC about effective ways to promote the Common Measure Set to health plans, providers and purchasers. She began the discussion by asking PMCC members to talk about how they are currently using the Common Measure Set in their own work.

A number of suggestions were made about how to more effectively promote the Common Measure Set, including:

- Standardize the language that we use to describe the Common Measure Set.

- Be sure to tie our Common Measure Set to the development of national measure sets (e.g., CMS, AHIP) so that it's clear we are primarily selecting from among nationally vetted measures rather than developing "one-off" measures here in Washington.
- Work with the health plans in Washington to align the measures they use in contracting with the Common Measure Set to the greatest extent possible. Make sure purchasers understand what the Common Measure Set is and ask them to use their health plan relationships to further use of the Set.
- Ensure that practice transformation efforts (e.g., through Healthier Washington) are aligned with the Common Measure Set to the greatest extent possible.
- Align the work of AIM and the Accountable Communities of Health with the Common Measure Set to the greatest extent possible.
- Use stories to promote the Common Measure Set. Develop educational pieces on a smaller subset of measures (e.g., prevention screening or diabetes) and tie to larger context, i.e., what would it mean for our state to improve in these areas.

VI. Next Steps

- A high-level meeting summary will be available within ten days on HCA's website.
- The date for the next PMCC meeting to be determined.

The meeting adjourned at 3:20 pm.

ATTENDANCE: March 25, 2016

			Attendance on: March 25, 2016	
			Present	Absent
Chris	Barton	SEIU Healthcare 1199NW		X
Craig	Blackmore	Virginia Mason Medical Center		X
Gordon	Bopp	NAMI-Washington (NAMI-WA)		X
Patrick	Bucknum	Columbia Valley Community Health		X
Ann	Christian	Washington Community Mental Health Council		X
Victor	Collymore	Community Health Plan of Washington		X
Patrick	Connor	National Federation of Independent Business (NFIB)		X
Jessica	Cromer	Amerigroup Washington	X	
Sue	Deitz	National Rural Accountable Care Consortium		X
John	Espinola	Premera Blue Cross		X
Gary	Franklin	Labor and Industries	X - Phone	
Teresa	Fulton	Western Washington Rural Health Collaborative		X
Nancy	Giunto	Washington Health Alliance	X	
Anne	Hirsch	Seattle University	X	
Larry	Kessler	UW School of Public Health, Department of Sciences	X - Phone	
Byron	Larson	Urban Indian Health Institute		X
Daniel	Lessler	Washington State Health Care Authority	X	
Kathy	Lofy	Washington State Department of Health	X	
Susie	McDonald	Group Health Cooperative	X - Phone	
Sheri	Nelson	Association of Washington Business	X - Phone	
Scott	Ramsey	Fred Hutchinson Cancer Research Center		X
Dale	Reisner	Washington State Medical Association (WSMA)	X - Phone	
Marguerite	Ro	Public Health - Seattle and King County	X	
Rick	Rubin	OneHealthPort	X	
Torney	Smith	Spokane Regional Health District	X	
Cheryl	Strange	Benefits Trust	X	
Jonathan	Sugarman	Qualis Health	X	
Dorothy	Teeter	Washington State Health Care Authority	X	
Carol	Wagner	Washington State Hospital Association	X	