MN Community Measurement
Measurement and Reporting Committee
Wednesday, 13 February 2013
Meeting Minutes

Members Present: Tim Hernandez (co-chair) Howard Epstein (co-chair), Ann Robinow, Betsy Clough, Chris Norton, David Homans, Deb Mielke, Jeff Rank, Kris Soegaard, Laura Saliterman, Linda Walling, Mark Sonneborn, Robert Lloyd, Stefan Gildemeister, Sue Knudson
MNCM Staff: Alison Helm, Anne Snowden, Collette Pitzen, Erika Vetta, Nate Hunkins, Tina Frontera
Members Absent: Craig Christianson, Darin Smith, David Satin, Ernie Valente, John Frederick, Mark Nyman, Matt Flory, Terry Cahill
Guests (work group members): Anne Edwards, Emily Emerson, Glenace Edwall, Katy Schalla Lesiak, Marie Maes-Voreis, Terri Lloyd, Sudha Setty

Topic	Discussion
Welcome & Introductions	Howard Epstein welcomed the committee. Committee members introduced themselves. Deb Mielke has resigned from her position at Open Cities meaning she will no longer be able to be on MARC as the safety net clinic rep; however, she will be with MARC for the February and March meetings. To fill this opening, MNCM will be soliciting nominations from safety net clinics through an upcoming article in Measurement Minute, MNCM's e-newsletter.
Approval of Minutes	The committee reviewed and approved the minutes from the December 2012 meeting.
Review conflicts of Interest	As part of the continuous quality improvement process, MNCM has developed a new Conflict of Interest policy for committees and work groups. COIs will be reviewed on an annual basis or when there is a new committee member. All MARC members were asked to sign and return a copy of the new COI policy disclosure form. A joint MNCM/ICSI Conflict of Interest (COI) committee reviewed disclosures. The charge of this committee is to review all COI declarations and make recommendations about the management or mitigation of declared conflicts to the MNCM board. This joint committee met 2/12/2013 to review the declared conflicts from MARC members. Anne Snowden stated that the new COI policy states any potential conflicts will be shared with members of the committee and documented in the meeting minutes. As a matter of background, this joint committee was formerly an ICSI-only COI committee. MNCM and ICSI have been exploring and testing the idea of combining efforts over the last several months. ICSI's committee has accumulated lots of experience and "case law" with conflicts of interest and MNCM can benefit from this knowledgebase. The boards of both organizations support this partnership. A document was distributed at the meeting listing all COI disclosures from MARC members. The joint MNCM/ISCI COI committee found no issues with these disclosures because most of the declarations were associated with the person's employer or other committees or board associations. Although there were no issues found with any of the disclosures, Anne shared discussion from the committee meeting pertaining to two MARC members for transparency purposes only.
Care Coordination measurement specifications – For approval	Upon MARC's approval of the Care Coordination Impact document, MN Community Measurement along with the Health Care Homes program invited a wide range of stakeholders to participate in the measure development process. The work group consisted of representatives from certified health care homes, hospitals, state agencies and various professional organizations. Nate Hunkins stated that development of a Care Coordination measure was unlike the typical measure development process because there was not a specific disease or outcome to help guide the direction of the discussions. Rather, care coordination is meant to impact and improve facilitation of the various facets of the health care delivery process. To strengthen this point, a recent AHRQ literature review found over 60 different care coordination measures, and in 2012, the National Quality Forum (NQF) endorsed 12 different care coordination measures. The broad landscape of potential care coordination measures meant that the work group started with some very high level discussions about where to focus our development efforts and how care coordination fit into the overarching health care homes program. In the end, the work group reached consensus on two different care coordination measures. The care coordination measures are intended for quality improvement and program evaluation purposes of health care home clinics and there are no plans for use in public reporting. MNCM is under contract to conduct a pilot of the new care coordination measures for the MN Department of Health (MDH) for health care homes. Following the pilot, there may be interest for inclusion of these measures in other programs, such as the Statewide Quality Reporting and Measurement System; however, there are no such plans at this time. The measures were discussed separately: **Advance Care Plan Measure** The first care coordination measure Nate Hunkins presented was the Advance Care Plan measure. This measure captures the percentage of patients age 65 or greater at the start of the measurement year with evidence of advance care planning in their medical record at a health care home clinic. Upon the consultation of the MN Honoring Choices program, the work group decided that it is

critical that a patient has a written advance care plan in the chart with the following documented:

- The patient's wishes are outlined AND
- The patient's decision-maker is defined

From a technical standpoint this measure is straightforward and, based on the public comments, will not add significant burden to health care home clinics because advanced care planning is currently part of the health care home standards. Additionally, this measure aligns with existing or forthcoming requirements under CMS's Meaningful Use program. Given Meaningful Use, these two data elements are expected to be collected in a standardized way. Advanced Care Planning is also 1 of the 12 care coordination measures endorsed by NQF.

Questions/Comments/Discussion:

Linda Walling asked for clarification regarding the denominator and asked if the denominator criteria are for any patients over the age of 65 at a HCH certified clinic or any patient over the age of 65 and enrolled as a HCH patient? Nate Hunkins stated that most HCH standards are implemented at a system-wide level for the whole clinic rather than just for HCH patients. Given that, the denominator would be any patient over the age of 65 at a HCH certified clinic.

Deb Mielke asked for clarification on the numerator and whether both elements need to be present for a patient to meet numerator criteria. Nate Hunkins stated that documentation of discussion regarding both elements is needed in order for a patient to meet numerator criteria. Collette Pitzen clarified that both elements need to be addressed within the documentation, but that they do not need to be separately submitted as individual fields to meet numerator criteria. It will be a simple "Yes/No" field indicating that advanced care planning exists in the medical record for each eligible patient. Collette Pitzen stated the work group did not want to be prescriptive about all the elements that the advance care plan should contain nor introduce burden by requiring additional fields for submission. Instead, the validation process would be relied upon to assure that documentation addressed the two key elements. It was also clarified that if there was documentation a patient did not want to name a decision maker, this would qualify as having that element "addressed." Linda Walling stated Meaningful Use (MU) does not require the advance care plan to be part of the record. Collette Pitzen stated this information would be required to be part of the medical record in accordance with the work group's goal of having the documentation accessible in the medical home providing a means to transfer the document in times of need/ crisis.

Stefan Gildemeister asked if it needed to be clear what wishes were addressed or if the elements were intentionally left broad. Nate Hunkins stated that it was intentionally left broad to allow for flexibility. He stated that flexibility is important for reporting this measure because there are various types of advanced care plans and different methods for collecting this information from patients. **Mark Sonneborn made a motion to approve MNCM recommendation to pilot the Advance Care Planning measure, Chris Norton seconded the motioned. Motion passed.**

Follow-up after Hospital Discharge Measure

The second care coordination measure was Follow-up after Hospital Discharge for patients with heart failure, pneumonia, ischemic vascular disease, and COPD. This measure captures the percentage of patients with selected clinical conditions who have a follow-up telephonic/electronic contact within three days of discharge OR a follow-up face-to-face visit with a health care provider (physician, physician assistant, nurse practitioner, nurse, care-coordinator) within seven days of hospital discharge.

This measure aligns with the goals of MN's Reducing Avoidable Readmission Effectively (RARE) campaign, as well as with the Health Care Home certification Care Coordination standard, which requires that clinics must have processes in place to timely post discharge planning according to a protocol for patients discharged from hospitals, skilled nursing facilities or other health care institutions.
This measure underwent several iterations based on lengthy work group discussions and public comments. Initially the measure would have required a follow-up visit for all discharged patients age 65 or older; however, there was pushback because work group members pointed out that not all patients 65 or older need to have a follow-up visit within 7-days of discharge. With the help of the MN Hospital Association, MNCM identified 4 conditions that are associated with a higher risk of being readmitted to the hospital. The work group then narrowed the scope of the measure only to require follow up for patients with the four conditions. The final alteration of the measure came after the public comment period. Based on public comment obtained in November 2012, the work group reconvened to explore expanding the visit type to include electronic and telephonic contact with the selected conditions. Initially, the measure was expressed as only a face-to-face visit with seven days following hospital discharge.

After reconvening the work group, it was agreed that the measure should be expanded to include telephonic/electronic contacts with the patient; thus, the numerator is expressed as the number of patients with telephonic or electronic contact within three days or face-to-face visit within seven days following hospital discharge. The work group felt that this represented the balance needed for 1) allowing innovation in care coordination and 2) not creating unintended consequences of increasing costs unnecessarily by requiring a face-to-face visit.

The work group also reviewed a second issue raised during public comment, which was an ambulatory clinic's difficulty in capturing information about hospitalizations that occur outside their care system. While the work group was understanding of the technical nature of data and data systems, the fragmentation of care, which in part contributes to hospital readmissions, is the reason for

	coordination of care efforts. To exclude these patients or to not go forward with this measure for quality improvement purposes to seems counter-intuitive. Nate Hunkins also shared that HCH standards is to have the discharge plan in place and that payers are moving in this direction as CMS recently approved two new CPT codes for transition care. Marie Maes-Voreis from MDH also shared that HCH clinics will receive Medicaid/Medicare data starting this spring in a monthly report as a resource to evaluate utilization. There may also be an opportunity for clinics to receive mini-grants from MDH to assist with technical support. **Questions/Comments/Discussion:** Deb Mielke stated a concern that hospitals do not provide timely discharge summaries to clinics. Nate Hunkins responded that the work group discussed this issue and that part of the measure would be to collect hospital name and length of time between discharge and clinic receipt of discharge information. Nate Hunkins also stated that this measure is reflective of care coordination of hospitals and clinics. Collette Pitzen also noted that collecting the name of the discharge hospital and the timeframe between discharge and clinic receipt of the discharge orders would provide the ability to complete analysis on how the hospitals and clinics interface. Sue Knudson stated that getting this information about the hospital timeline could also be powerful in piloting/implementing this measure. Sue Knudson stated she has serious concerns about the various moving parts and missing data for this measure, but she is appreciative of how the work group has addressed these issues. She proposed the idea of asking the health plans to submit claims information during the pilot to assess how many hospital discharges are missing from the medical group pilot data. She feels this would be necessary before any public reporting could happen and that it would provide a test of accuracy of the measure. The approach could inform the integrity of the measure during the pilot phase only. Stefan Gildemeister mentioned that it may be possible for the state to share information about the Medicare/Medicaid population for the pilot, but that it may be a while before the 2013 data is available. Sue Knudson shared that the state data would be an even better source given that the four conditions affect primarily the elderly population. Tim Hernandez shared a concern that testing for completeness by reviewing health plan data prior to implementing the pilot may extend the timeline significantly. Collette stated that reviewing data from health plans could be considered during the pilot phase, understanding that there would be many steps before these measures were considered for a wider implementation and/or public reporting. Mark Sonneborn stated that hospitals are also concerned about readmissions and that there are penalties for hospitals with high readmission rates, so they (MHA) see the necessity of clinic follow up visits. Tim Hernandez reminded MARC that the measure would again be presented to MARC after the completion of the pilot. Collette Pitzen and Nate Hunkins shared that the pilot would help address and inform the concerns raised during the meeting. Tina Frontera stated that if it was decided to go forward with this measure, MNCM could explore getting data from health plan regarding hospital discharges to determine the gap. **Linda Walling made a motion to accept the recommendation with the amendment to pursue collection of additional data elements from health plans and/or the state. Jeff Rank seconded the motion. 13 voted in favor of the motion, 1 voted against motion. Motion passed.** **Other issues discussed:** Deb Mielke asked if there is a standard way to assess burden of data collection for new measures when a clinic is smaller and has less ability to pull the data. Linda Walling suggested that the list of pilot clinics include small clinics who are certified for meaningful use, but do not have an EMR in order to assess burden and how their data could be collected in a structured way. Jeff Rank shared this concern and agreed that the size and diversity of the clinics is also important for pilot purposes. Nate Hunkins and Collette Pitzen agreed that these are important issues to review during a pilot. Collette reminded the committee that participation in a pilot is voluntary for medical groups/clinics and that having good participation is needed for a well-rounded pilot.

Pediatric Preventative Care measurement specifications – For approval	The measure concept of "Pediatric Preventive Care" was reviewed and approved for measure development by MARC in May of 2011. These measures, following successful pilot, are intended for inclusion in the Statewide Quality Reporting and Measurement system. The measure development work group, an actively engaged work group that is passionate about illness prevention and providing excellent care for children, met over the last 18 months. The work group was given the charge to develop measures of pediatric prevention and specifically directed to not focus on any acute or chronic disease. Although outcome measures are typically preferred over process measures, measures of prevention imply a healthy population with potential for screening and/or delivery of services that tend to measure processes. An outcome measure (the ability to measure the impact of prevention), which would be avoidance of disease or increased risk, would come much later in the continuum of care. There are many opportunities to influence and impact the healthy growth and development of children. One of the challenges that the work group faced was selecting a few areas of potential measure development from the vast array of recommended services according to ICSI and AAP guidelines. The work group started with all of the Level I (must) and Level II (should) preventive services guidelines for children and adolescents. After much discussion and additional subgroup meetings, the topics were narrowed to mental health/depression, obesity and childhood immunization. The work group brought forth two measures to seek approval to move forward to a pilot phase. The work group brought forth the third measure to seek MARC discussion around recommendation for a pilot phase as the work group had difficulty reaching consensus following the public comment period. **Measure 1: Adolescent Mental Health and/or Depression Screening** It is estimated that between 14 and 20% of children and adolescents experience a mental, emotional or behavioral disorder. In addition, annually in the US, over 2 million adolescents age 12 to 17 have an episode of major depression, and suicide is the third leading cause of death for young adults. Additionally, it is estimated that 21% of US children and adolescents have a diagnosable mental health disorder that causes at least some impairment. In the discussion of potential topics for measure development, the work group felt that issues surrounding mental health and depression were too important to set aside, and despite the challenges, wanted to develop a screening measure for this population. Denominator • Age 12 to 17 at the start of the measurement year and • One well-child visit during that year (CPT preventive services codes for an initial or periodic preventive medicine exam for adolescents age 12 to 17) Unlike other measures, this denominator does not have multiple visit criteria to determine that the patient is established to the practice. Because adolescents are not seen as regularly as a younger pediatric population and may not visit on an annual basis, the standard criteria of two visits in two years would significantly limit the intended target population. Likewise, the work group had extensive discussions about the risks and benefits of including all types of visits (injury, acute illness) versus a well-child visit. While the work group believes that every visit presents an opportunity for assessment, they did not want to implement a measure that would require mental health/depression screening at every visit, which may cause undue burden. Extensive discussion also occurred over value of screening at younger ages, which the work group strongly encourages, but desiring to target areas of greatest impact and reduce burden, the work group agreed to limit the measure to ages 12 to 17. Additionally, the work group did not want to require administering a screening tool when known mental illness exists. Exclusions from this measure are: Schizophrenia, bipolar disorder, major depression, depression NOS and personality disorders. The numerator for this measure is the documentation of screening of eligible patients for mental health issues and/or depression by indicating which tool was used for this purpose and the date it was administered. Even though some national measures (NCQA) are leaning towards screening for depression of adolescents, the work group members felt strongly about screening for other mental health conditions as well as depression. Therefore, numerator credit for this measure is the administration of one of the 21 listed tools, which include a mix of publicly available tools, and some proprietary tools. The development work group wanted to provide a fairly exhaustive list of validated tools for screening adolescents for mental health and or depression and did not want to limit a provider's choice to use a proprietary tool if that was their preference. Some tools screen only for depression, others screen for additional conditions as well. Tool selected must be appropriate for the age of the child. It is recommended to medical groups that are selecting a tool for use, to use a tool that is publicly available (free), not too lengthy, and translates well into electronic implementation in an EMR. This measure is viewed as a first step and does not have an associated action like counseling or referral. As an optional field, ability to capture the resulting score of the tool will also be included in the pilot. Of the numerous public comments that MNCM received for the preventive pediatric measure set, the fewest comments received were related to this measure. There were some concerns expressed about the potential harm of screening without "having systems in place

to diagnose and treat." The work group felt that this preventive screening area that was too important not to address.

Questions/Comments/Discussion:

Chris Norton asked about the validity of the tools - would different tools yield the same results? Laura Saliterman shared that the tools are validated and standardized and should have reasonable sensitivity and specificity for the conditions they are assessing, so there should be agreement between them. One of the major issues that the work group discussed was whether clinics should be required to screen for depression only, which would narrow the number of tools on the list. Since many clinics are screening for multiple mental health issues, and it may be a step backwards to only screen for depression by using a depression-only tool.

Sue Knudson asked if the tools would be available in a variety of languages. Collette Pitzen stated that many of the tools are available in different languages and that a guide will be provided to clinic and will include a short description of each tool, the languages available, links to tools, and the appropriate age range.

Deb Mielke stated that her clinic's EMR has questions built-in so they can orally ask patients questions in order to complete a fast screening. She shared her concern that requiring clinics to use a different tool may not be indicative of the care patients receive since the required tools and workflows may not fit into clinic's practice and population. It was noted that the PHQ-2 is an option for screening. Laura Saliterman stated that clinics can do above what is required in the measure and that the intent is to screen asymptomatic patients for mental health and/or depression.

Chris Norton made a motion to accept MNCM recommendation. Laura Saliterman seconded the motion. 13 voted in favor of the motion, 1 voted against motion. Motion passed.

Measure 2: Obesity/ BMI and Counseling

The percentage of overweight and obese children and adolescents in MN ages 10 to 17 is estimated at 23.1%. [2007 state health facts national survey of children's health]

In the review of the potential preventive screening topics during the selection process, a screening measure for overweight and obesity ranked high on the work group's list of desired topics. Meaningful Use (MU) Stage 2 objectives include capturing height, weight, BMI value and plotting and displaying growth curves including BMI for ages 0 to 20. Although MU requires these vital signs, the work group did not simply want to collect these values to "check the box", they wanted to associate an appropriate action related to a high screening value.

Denominator

- Age 3 to 17 at the start of the measurement year AND
- One well-child visit during that year (CPT preventive services codes for an initial or periodic preventive medicine exam for age ranges between 3 and 17).

Similar to the mental health depression screening measure, inclusion in the denominator does not require multiple visit criteria. There was a desire to remain aligned with the national NCQA/MU2 measure (NQF # 0024) where possible and this measure is currently specified for ages 3 to 17. The work group believes that every visit is an opportunity for assessment but did not want to require assessment and potential counseling at every visit.

There are two measures contained within the specifications, the first is that the screening is accomplished by providing height, weight, BMI value and BMI percentile. There were some comments expressed related to the BMI percentile field not currently residing in a reportable field, rather floating on a display in the EMR. The work group was well aware of this issue, but felt strongly that for the pediatric population any definition of overweight or obesity was dependent on the percentile and not the BMI value.

The second part of this measure relates to actions related to the BMI assessment; if a child's BMI percentile is greater than or equal to 85%; then there is documentation of both counseling for nutrition and physical activity.

This measure is aligned with the NCQA/ HEDIS/ MU2 for age range and definition of documentation of counseling for physical activity and nutrition, but deviates in terms of 1) using well-child visits to identify the population (NCQA relies on a continuously enrolled population) and 2) would not requiring counseling for all children regardless of BMI percentile.

Public comments expressed concern in regards to this being a "check box" measure and will only serve to identify those medical groups with better EMR systems. Other concerns expressed were an inability to make an impact on obesity with brief counseling in the office. "Strategies that encourage healthy eating behaviors, regular physical activity, and reduced sedentary behaviors (e.g., watching television, videotapes, or DVDs, or using the computer) are essential to helping children and adolescents achieve and maintain a healthy weight" – AAP Bright Futures Guidelines.

Questions/Comments/Discussion:
Sue Knudson asked for clarification if the measures were aligned or identical to NCQA/HEDIS/MU2 measures. Collette Pitzen clarified that the specifications are aligned, but not identical. The NCQA HEDIS measure looks for documentation of counseling for nutrition and physical activity for every child, regardless of their BMI percentile. The proposed measure only looks for counseling when the BMI percentile is ≥ 85, a subset of the total population. The other deviation relates to the population being identified as those with a well-child visit as opposed to any and every visit. Sue Knudson then asked if it would be possible for medical groups/clinics to provide a percentile. Collette Pitzen said this was addressed in the work group and that it is possible as medical groups can calculate the percentile "behind the scenes" replicating what is displayed on the chart for the visit. This is completely acceptable and notations explaining this option will be included in the detailed field specifications. MNCM will also review building data portal programming that could calculate the value based on the incoming data (height, weight, birth date and gender) if medical groups are unable to calculate the BMI percentile. Collette Pitzen noted that this is a first step to addressing BMI/Obesity. Laura Saliterman agreed and stated that high BMI/obesity is complex and there are many reasons for it including but not limited to familial issues. More health plans coverage for specific services may assist in addressing BMI/Obesity
Chris Norton made a motion to accept MNCM recommendation. Laura Saliterman seconded the motion. Motion passed.

Measure 3: Childhood Immunizations by Age 2
This was one of the first measures that the work group recommended, believing that immunizations are one of the single most effective strategies to prevent illness. It is an attempt to improve a current claims-based measure using a new, more complete source of data, the MN Immunization Information Connection (MIIC) registry. Current methodology involves a claims-based hybrid sample for commercial and Medicaid patients. This hybrid uses administrative claims, then if immunizations are missing, MIIC is accessed, and then if needed, the medical record is reviewed. The work group believed that in promoting data submission to the MIIC registry, where a common vaccine history for each child resides regardless of where the vaccination occurred, that not only would it serve as a basis for better and perhaps more flexibility in measurement (like catch-up measures), but would also better serve the community in keeping children up-to-date.

Measures proposed for pilot included 1) percent of eligible population that is matched in MIIC and 2) percent of eligible children who are up-to-date with combo three by their second birthday, reflecting an immunized population. MN HealthScores has been reporting the HEDIS claims/hybrid combo 3 measure for the last several years.

Using this new method, clinics would identify patients using visit criteria that establish the patient to the clinic site and provide clinic site level data.

- Three well-child visits before the patient age of 25 months and
- At least one well-child visit between the patient age of 13 and 25 months
- 2nd birthday during the measurement period

MNCM would certify denominators, but the clinics would upload eligible patient lists to MIIC for rate calculation. The MIIC portal is equipped to handle the PHI (last name, middle initial, first name, date of birth, etc.) and is programmed to match patients in the registry and to calculate many kinds of rates.

Benefits of using MIIC include more representative sample than current method, clinic site level reporting, flexibility in reporting future iterations of measures (who is caught up by 30 months, for example) and community benefit for having complete immunization histories despite transfer of care or setting of vaccination.

During the measure development process, there was some discussion of medical groups having difficulty with the interface between their EMR and the MIIC registry, but this was not perceived as a significant barrier at the time. Following public comment, in which several comments from many medical groups indicated problems with the MIIC interfaces, the work group engaged in an email discussion about whether to recommend this new method as a measure at all. Although, there was initial consensus previously, following public comments the work group no longer achieved consensus. The work group is asking MARC for their discussion and resolution of the issue of proceeding forward with a pilot.

Questions/Comments/Discussion:
Laura Saliterman stated that it seems everyone agrees about the importance of immunization and the use of MIIC as a central repository and that it seems people are willing to work together and are motivated to work on this issue. She stated she also believes the pilot should not move forward until these issues are addressed. Emily Emerson from MDH/MIIC stated that MIIC is willing to address the issues if this moves forward and could offer more staff time dedicated to technical issues.

Howard Epstein outlined the possible options for MARC: 1. Not move forward with a pilot of the immunization measure; 2. Move forward with pilot; or 3. Revisit in the future after either a re-evaluation of the issues or allowing some time for the technical issues to be resolved. Tim Hernandez reminded the committee that this initial approval is to move to pilot only and that process will yield data instead of personal opinions on how the interfaces are working.

	Anne Snowden stated that analysis would occur following pilot to determine if the measure was ready to move to full implementation. She also shared that if the measure was included in the MDH Rule, there would more time to prepare for implementation. She noted that there is a precedent that if information comes to bear during the pilot that a measure is not ready for implementation, there is an option to not move forward with full implementation. Sue Knudson stated there seems to be a concern about source data that could have been contemplated before moving forward with pilot and believes it is reasonable to look at these issues up front before a pilot starts. She commented that there is a need to pause about moving forward when there are source data issues that can lead to concerns about the quality of the measures. Tim Hernandez stated that pilots may help clarify problems moving forward in a positive way or act as a deterrent causing buy-in to disappear due to lack of credibility. Sudha Setty from MDH/MIIC stated that these comments have spawned a macro-level discussion about the interface between clinics and MIIC. MDH/MIIC does not view these issues as a lack of credibility of MIIC, but rather as a case-by-case situation depending on the clinic system and EMR. Sudha Setty also acknowledged the difficulty of establishing the link between the system and MIIC. She feels that there may be a silent majority in which MIIC does work for medical groups and they are able to successful submit to MIIC. MDH Is confident that many systems can be used with MIIC and that MIIC can be used to measure this data accurately. She also stated that MIIC captures information about uninsured children whereas HEDIS does not as well as Wisconsin and other border states. Stefan Gildemeister suggested tabling the discussion until more information could be gathered about the challenges and successes of MIIC. Jeff Rank agreed. Stefan Gildemeister offered to pull together additional information about the accuracy and completeness of the MIIC registry data from an MDH perspective. Howard Epstein clarified that the suggestion is to further explain the issues that are perceived to make the immunization data from MIIC unreliable and illustrate the full extent of the issues. This information will be brought to MARC for more discussion at a future meeting.

Next Meeting: Wednesday March 13, 2013