MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, August 10, 2016
Meeting Minutes

Members Present: Cara Broich, Peter Dehnel, Howard Epstein, Matt Flory, Stefan Gildemeister, Tim Hernandez, David Homans, Janet Keysser, Sue Knudson, Bill Nersesian, Chris Norton, Rahshana Price-Isuk, Jeff Rank, Jonathan Rose, Allan Ross, Laura Saliterman, David Satin, Kris Soegaard, Mark Sonneborn, Brian Whited (guest)
Alternate: Jeff Schiff
MNCM Staff: Tina Frontera, Amy Krier, Anne Snowden
Members Absent: Ariam De Leon, Jordan Kautz, Bruce Penner, Robert Lloyd

Topic	Discussion
Welcome & Introductions	Howard Epstein called the meeting to order and welcomed committee members and observers. Howard introduced Dr. Robert Jacobson from Mayo Clinic. Dr. Jacobson is a professor of pediatrics at the Mayo Clinic College of Medicine. He is also the Medical Director of Employee and Community Health and the Southeast Minnesota Region Immunization Program. He's was invited to join MARC for this meeting as an immunization subject matter expert, with particular knowledge about the Human Papilloma Virus (HPV) vaccine. Howard noted that Dr. Jacobson disclosed that he serves on two safety review committees for research funded by Merck, and he also serves on a Data Monitoring Committee for a series of trials involving an experimental 15-valent pneumococcal conjugate vaccine funded by Merck. He is paid for his time reviewing data, teleconferencing and reviewing minutes. Howard reminded those present that Dr. Jacobson is not a voting MARC member but in attendance as a guest to share information on immunizations and answer questions. All MARC members and observers introduced themselves. Howard reminded everyone that the committee strives to make their meetings and decisions as transparent as possible, but noted that only official MARC members can participate during the meeting discussion. If there are any questions or comments following the meeting, guests can email info@mncm.org.
Approval of Minutes	The committee reviewed minutes from the June 2016 meeting. **Peter Dehnel made a motion to accept the minutes; Sue Knudson seconded the motion. Motion passed.**
Recommendation to report Childhood Immunization Status (CIS) HEDIS measure Combo 10 – for approval	Howard introduced the topic of a recommendation brought forth by MN Community Measurement (MNCM) staff to move from publicly reporting Childhood Immunization Status (CIS) HEDIS measure - Combo 3 to Combo 10, which adds Hepatitis A, Rotavirus, and influenza vaccinations to the composite measure. Howard provided background explaining that MNCM has been reporting Combo 3 since 2006 and explained that the primary reasons for the recommendation to move to Combo 10 are to align with current preventive care guidelines and with federal programs. Howard introduced Anne Snowden, MNCM Director of Performance Measurement, Validation and Reporting, who presented the staff recommendation. Anne used the SBAR framework to outline the Situation, Background, Assessment and Recommendation. **Situation** It's important for measurement in Minnesota to stay up-to-date with guidelines and aligned with measures used nationally. Evidence and national consensus support the recommendation for children to receive all vaccines encompassed in the HEDIS Childhood Immunization Combo 10 measure. Currently, MNCM reports results for the Childhood Immunization Status Combo 3 measure. Three additional vaccines are included in Combo 10: Hepatitis A, Rotavirus, and influenza, all of which are included in state and national preventive care guidelines, both from ICSI and the USPSTF. The Combo 10 measure is also included in Meaningful Use Stage 2, the Physician Quality Reporting System (PQRS), and is one of the proposed quality measures for Medicare reporting as part of Merit-Based Incentive Payment System (MIPS). **Background** MNCM has been reporting Combo 3 for over 10 years and it's included in the Health Care Quality Report, the Health Care Disparities Report and on MNHealthScores.org.

Assessment

There has been a sharp decline in incidence of hepatitis A since the introduction of the hepatitis A vaccine in the mid 1990's. In 2005, the US Food and Drug Administration changed the youngest approved age of administration of hepatitis A from 24 to 12 months of age, which facilitated incorporation of the vaccine into the recommended childhood immunization schedule. In May, 2006, the Advisory Committee on Immunization Practices (ACIP), recommended routine vaccination of all children ages 12-23 months, regardless of risk category or location. And there is national consensus – the CDC and multiple physician organizations recommend the Hepatitis A vaccine.

Rotavirus disease among infants and young children have decreased significantly in the United States since the vaccine became available. In February 2006, the Advisory Committee on Immunization Practices recommended routine vaccination of all U.S. infants. A child should get 2 or 3 doses of the vaccine, depending on which brand is used. The CDC and multiple physician organizations recommend the Rotavirus vaccine.

Each year, seasonal flu places a large burden on the health and well-being of children and families. Severe influenza complications are most common in children younger than 2 years old. The CDC acknowledges that the single best way to protect against seasonal flu and its potential severe complications in children is to get a seasonal influenza vaccine each year. Children are most likely to get sick because their immune systems aren't strong enough to fight off the infection. CDC recommends that all children ages 6 months and up to their 19th birthday get a seasonal flu vaccine. Children 6 months up to 8 years of age getting a flu vaccine for the first time will need two doses of vaccine the first year they are vaccinated. The first does primes the immune system; the second dose provides immune protection. Children who only get one dose but need two doses can have reduced or no protection from a single dose of flu vaccine. Two doses are necessary to protect these children. The CDC and multiple physician organizations recommend the flu vaccine.

The comparison of statewide performance between Combos shows a 22 percentage point difference between Combo 3 and Combo 10. When looking at performance variation between medical groups, Combo 10 shows greater variation. When comparing Combo 3 to Combo 10 by population (commercial and Medicaid), there are still significant and meaningful differences in the rates between the populations, but the gap is greater for Combo 10.

Anne asked Dr. Jacobson to share information on current research and evidence around the benefits of childhood vaccinations with particular detail about rotavirus, hepatitis A and influenza vaccines.

Howard shared a letter from Katherine Cairns, Executive Director of the Minnesota Chapter of the American Academy of Pediatrics which, on behalf of the pediatricians in the State of Minnesota, expressed support of the proposed changes in public reporting of these immunization measures, particularly the change for the Immunizations for Adolescents (IMA) HEDIS measure to be upgraded to Combo 2.

Recommendation

For the Childhood Immunization Status (CIS) HEDIS measure – Combo 10; recommendation for public reporting in the 2017 report year (2016 dates of services) to align with current preventive care guidelines, NCQA accreditation and federal programs. It is proposed that CIS Combo 10 results will be privately reported to medical groups in the 2016 report year (2015 dates of service) and publicly reported in report year 2017 (2016 dates of service).

Questions/Comments/Discussion

Laura Saliterman inquired whether clinics that have a policy of refusing to see patients that decline immunizations could be flagged to indicate this status and its impact on their results. Anne explained that, as a HEDIS measure based on claims data, the health plans would need to have information about whether a particular clinic had such a policy. Health plan representatives on the committee noted that this information is not available via claims data and addressing this would require a larger discussion. Stefan Gildemeister expressed support for the proposed change from public health perspective and suggested that the issue of clinics that refuse to see patients that decline immunizations be addressed after one year of private reporting after collecting information to determine the extent to which this issue is arising in the community. Chris Norton asked how widespread this issue is. Committee members indicated they were unsure of the extent of the issue. Dr. Jacobson commented that in his research with practices that implement policies to not see patients that refuse all vaccines the primary impact is that the patients eventually change their minds and move forward with receiving the vaccines, although on a delayed schedule. He went on to state that only 0.6 percent of children in the U.S. aged 19 to 35 months have received no vaccines.

Jonathan Rose brought up the question of how to address the anxiety some parents feel in regard to immunizations. Rahshana Price-Isuk noted that her hope that one of the benefits of publicly reporting this measure would be the development of evidenced based parental education aids to help effectively counsel on risk benefits. Laura noted some current education outreach efforts.

	Tim Hernandez expressed general concern about combination metrics in that there is no opportunity for partial credit, citing issues with obtaining influenza vaccines and recent recommendations against using FluMist, the nasal spray influenza vaccine. He felt it important to keep this in mind when considering how to present the results. Mark Sonneborn asked about the timeline for beginning public reporting in 2017. Anne explained that the state and national preventive care guidelines, both from ICSI and the USPSTF, on which the Combo 10 is based have been in place for many years. She noted that the sooner public reporting begins the more prepared our community will be for alignment with national incentive programs. **Janet Keysser made a motion to approve the recommendation as presented. Matt Flory seconded the motion. Motion passed.**
Recommendation to report Immunizations for Adolescents (IMA) HEDIS measure Combo 2 – for approval	Chris introduced the topic of a recommendation brought forth by MNCM staff to move from publicly reporting Immunizations for Adolescents HEDIS measure – Combo 1 to Combo 2, which adds the HPV vaccination to the composite measure. Chris noted that MNCM has been reporting Combo 1 since 2012 and explained that the primary reasons for moving to Combo 2 is to align with current preventive care guidelines and to support state and national cancer prevention efforts. Chris turned over the discussion to Anne to present the recommendation. Anne again used the SBAR framework to outline the Situation, Background, Assessment and Recommendation. **Situation** It's important for measurement in Minnesota to stay up-to-date with guidelines and aligned with measures used nationally. Evidence and national consensus support the recommendation for adolescents to receive all vaccines encompassed in the HEDIS Immunization for Adolescents Combo 2 measure. In the 2017 report year, NCQA will introduce Combo 2 for this measure – an update that will include the HPV vaccine for males and females. The addition of the HPV vaccine is supported by state and national preventive care guidelines – ICSI and the USPSTF respectively. **Background** MNCM has been reporting Combo 1 for over 5 years and it's included in the Health Care Quality Report, the Health Care Disparities Report and on MNHealthScores.org. **Assessment** HPV is a sexually transmitted infection that is known to cause several cancers including cervical, vulvar, vaginal, penile, oropharyngeal, and rectal cancer. Prior to the HPV vaccine, it is estimated that the prevention and treatment of HPV-related disease imposed a burden of $8 billion dollars or more in costs in the U.S. The HPV vaccine can prevent infection with HPV types that cause cancer at cervical and other sites. HPV vaccines are most effective and offer the best protection if they are administered before exposure to HPV to allow time to develop an immune response, which is why the recommended age of vaccination is 11-12 years. There is national consensus for recommending the HPV vaccine. Anne again asked Dr. Jacobson to share information on current research and evidence around the benefits of adolescent vaccinations with particular detail about the HPV vaccine and the limited implementation of HPV vaccination use in the U.S. compared to other countries. Dr. Jacobson noted that the inclusion of the HPV vaccine in the measure and the public reporting of results would help drive more extensive implementation of HPV vaccination. **Recommendation** For the Immunizations for Adolescents (IMA) HEDIS measure – Combo 2; recommendation for public reporting in the 2018 report year (2017 dates of services) to align with current preventive care guidelines, NCQA accreditation and to support state and national cancer prevention efforts. It is proposed that IMA Combo 2 results will be privately reported to medical groups in the 2017 report year (2016 dates of service) and will be publicly reported in report year 2018 (2017 dates of service) or in alignment with NCQA's reporting timeline. **<u>Questions/Comments/Discussion</u>** Rahshana expressed concern around aligning recommendations with shared decision making and encouraging families to make an educated decision about vaccination. Dr. Jacobson noted that studies have shown that patients who received strong physician recommendations were more likely to have had HPV vaccination. Additionally, prompting at the point of care and reminder re-call were also successful. Rahshana commented that those methods work for the majority of parents, but she would be interested to find out the reasons that hesitant parents have for refusing the vaccines. David Homans noted the importance of empathetic relationships in communicating recommendations.

	Janet made a motion to strike the portion of the recommendation that places public reporting in alignment with NCQA. Anne commented that, though rare, NCQA may find an issue with the measure that may affect the accuracy of the results and therefore would delay public reporting of results. The intent of the caveat in the recommendation is to ensure that the results being reported are correct. The motion did not receive a second. Tim shared the potential for provider angst from adding another primary care measure. Additionally he commented that adding HPV to the list of school mandated vaccinations would help raise the vaccination rates noting that adolescents aren't in the office for routine follow-ups as frequently as younger children. Laura asked whether retail-based clinics were sharing vaccination information with the Minnesota Immunization Information Connection (MIIC) Registry. She felt having this information would better assist providers with ensuring patients were on track in their vaccination schedule. Cara Broich noted that the health plans have not seen that as an issue when receiving data from the MIIC Registry to calculate these measures. Cara explained that they generally see the retail-based clinics used for sports physicals and not for vaccinations. **Rahshana Price-Isuk made a motion to approve the recommendation as presented. Laura Saliterman seconded the motion. Motion passed.**
Update on pilot testing of two diabetes HEDIS measures	Chris again turned over the floor to Anne to provide an update on two diabetes HEDIS measures being piloted with health plans. Anne provided background on the topic stating that in 2015, MNCM held a meeting with the health plans to discuss their reporting priorities and what MNCM can do to support those priorities. Key themes emerged, including harmonization and alignment, aggregation and public reporting of Star Ratings measures, the leveraging Total Cost of Care (TCOC) data for additional measurement activity, and the utilization of multiple data sources in the development of measures. Since that time, MNCM has worked to explore these themes and identify possible approaches to addressing the topics. A written strategic plan to address alignment is in progress and MNCM is also preparing for the next iteration of TCOC reporting: relative resource use (RRU). MNCM has also developed a plan for pilot testing of two HEDIS measures that are in the Part C & D Star Ratings, a CMS program that measures how well Medicare Advantage and prescription drug plans perform. These measures are: *Comprehensive Diabetes Care: Eye exams and Medical Attention for Nephropathy*. Anne noted that feedback from health plan members has indicated that public reporting is the most valuable activity to promote measureable improvement. As all public reporting activity is overseen and approved by MARC, MNCM, in partnership with the health plans, is conducting a pilot test in order to bring a recommendation to MARC in late 2016. Anne explained that it has been reported that Minnesota is not a leader in the nation when it comes to eye exams and nephropathy screening for diabetes patients, in fact, there is much opportunity for improvement. The eye exam measure is not well suited to provider data collection as eye exams are often performed outside of a medical group's system. Claims data provide a much more comprehensive picture. All participating health plans have agreed to submit both administrative and hybrid methods for testing. MNCM will include a medical group review of the pilot results. It was recognized that any discussion that includes additions to public reporting will need to consider retirement of existing measures. Health plans have indicated a desire to look at additional measures next year. If there appears to be support and tolerance for it in the provider community, MNCM may look at additional measures, but are proceeding with caution. MNCM would need to confirm that the previously identified measures (Osteoporosis Management and Disease-Modifying Anti-Rheumatic Drug Therapy for RA) continue to be priorities, consider attribution methodologies and challenges, and collect and test. Anne noted there was no action necessary from MARC at this time. There were no comments from the committee on this update.
Meeting Adjournment	Chris announced that the next meeting will be Wednesday, September 14, and adjourned the meeting.

Next Meeting: Wednesday, September 14, 2016