Measurement and Reporting Committee (MARC)
Meeting Minutes

Tuesday, May 6, 2025

Committee members present: Matt Flory, Jamie Galbreath, Kate Hust (co-chair), Steven Inman*, Craig Johnson, David Johnson, Sue Knudson (co-chair), Sterling Kowalski, David Kurtzon, Jennifer Lamprecht, Tim Miller*, Christine Norton, Angela Olson, Bridget Olson, Carmen Parrotta, Laura Pelaez, Angie Pokharel, Denise Schneekloth, Meetul Shah, Sean Wherry

Committee members absent: Cara Hull, Clarence Jones, David Satin, Anne Stephen, Amanda Strom

Staff members present: Lexie Adams, Liz Cinqueonce, Jess Donovan, Rowan Mahon, Ma Xiong

Observers: Mallory Cummings, Celia Hemmerich*, Andrea Hickle*, Magdalynn Kayfes, Mary Meyer*, Teri Middendorf*, Diana Nix, Elizabeth Placzek, Chuck Sachs, Tara Walz*

Welcome – Sue Knudson

Sue Knudson convened this special meeting of the committee, which was held to review the proposed changes to the Optimal Asthma Control measure recommended by the asthma redesign workgroup.

A roll call of committee members was completed. Observers were welcomed and reminded that only official members of the committee can participate in the discussion. Several members of the asthma workgroup were present as observers as denoted by an asterisk (*) above.

ACTION ITEM: Asthma Workgroup Recommendations – Jess Donovan

Jess Donovan provided an overview of the workgroup, including purpose and structure of the workgroup.

The measure was reviewed by MARC in June 2024, and the committee voted to convene a workgroup due to concerns with the usefulness to providers and the proprietary nature of the Asthma Control Test (ACT).

The workgroup was comprised of two groups –

1) **Specification Engineering Group (SEG):** 4 clinicians with specialties in pediatrics, pulmonology, and asthma/allergy medicine. This group reviewed the measure specifications in-depth.
2) **Technical Expert Panel (TEP):** Included the members of the SEG, with 8 additional members with representation in family medicine, quality improvement, and government.

Jess reviewed the summary of recommendations and rationale for each:

1) **Remove ACQ from list of PRO tools**
   Rationale: Analysis of tool use showed that the ACQ has not been used by medical groups over the last five years for either the adult or child populations.

2) **Add AIRQ to list of PRO tools for calculation of well-controlled component (score of 0 or 1 indicates control)**

Rationale: Several advantages of AIRQ, including its: validated ability to assess impairment and risk; ability to more accurately estimate risk of exacerbations; non-proprietary nature and accessibility; ease of incorporation into EMRs.

3) **Add AIRQ score to definition of low risk of exacerbation component (score of 0 or 1 indicates low risk of exacerbation)**
Rationale: Several advantages of AIRQ, including its: validated ability to assess impairment and risk; ability to more accurately estimate risk of exacerbations; non-proprietary nature and accessibility; ease of incorporation into EMRs.

4) **Stratify statewide and medical group/clinic results by PRO tool used**
Rationale: Scoring ranges differ across tools, with the AIRQ being more stringent in its scoring than others. Stratification can ensure fair comparisons.

5) **Within 3-5 years, transition to only AIRQ as acceptable tool**
Rationale: AIRQ tool has significant advantages including its validity, accessibility, and clinical value. Time will allow health systems to integrate tool into workflows and educate providers/staff on use. Using one tool in the measure will ensure fair comparisons across medical groups.

Jess also provided a summary of the public comments received: Notice of comment period was provided through MNCM's newsletter, *Measurement Minute*, and through social media channels. The comment period ran from April 4, 2025 – April 17, 2025, and comments were submitted via publiccomment@mncm.org email. MNCM received four comments during this period. The comments were generally in support of the proposed recommendations, with some concerns raised about the timeline of transitioning to only using the AIRQ tool, noting IT demands and training needs. However, comments did appreciate the tool's open access and benefits of the tool's integration into EMRs.

NOTE: Currently, only the adult version of the AIRQ tool is available. However, there is a child version of the tool that will be released this spring. Manuscripts have been reviewed and support its validity in the child population.

Highlights of committee discussion:

- Steve Inman, who acted as chair of the workgroup, provided additional insights into the rationale behind the recommendations:
    - AIRQ tool has a shorter recall window of two weeks (compared to four weeks for the ACT/C-ACT), which makes it easier for patients to more accurately report their asthma control.
    - AIRQ tool uses yes/no questions instead of a Likert scale, simplifying the process for patients and providers.
    - For the child version of the AIRQ, parents complete the questionnaire with input from the child, as applicable, which results in more reliable results. This is unlike the C-ACT, which is completed by the child and uses pictures of facial expressions to assess asthma control.
    - AIRQ does a better job at predicting risk compared to the ACT/C-ACT. There are some scenarios in which a patient may have multiple exacerbations throughout the year, but still score as if being in control on the ACT/C-ACT.
- Recommendations 4 & 5 had the most discussion by the committee:

- Clinician uptake: The proposed timeline of 3-5 years may be too short for widespread adoption of the tool, and uptake across clinicians may vary for those who work with adults versus those who work with children. Additionally, committee members felt that understanding the uptake of the tool by clinicians is essential before committing to transitioning to only using one tool in the measure and the timeline of doing so.
- Medical group performance: Because the AIRQ is more stringent than the ACT/C-ACT, medical groups using the AIRQ will likely have lower results compared to those using the ACT/C-ACT. While the measure is not included in federal incentive programs, it is included in the state IHP program. As a result, more lead time may be needed to re-base.
- Public reporting: MNCM privately reports measure results for at least one year following any significant measure changes. Public reporting of the stratified results may help with "clinical inertia" of the uptake of the tool by clinicians. Instead of stratifying by each of the tools, the committee suggested stratifying by two categories – the tools that currently exist in the measure (ACT/C-ACT, ATAQ) and the AIRQ. Public reporting statewide results is recommended; however, public reporting of medical group/clinic results would need to be evaluated by the committee after the private reporting period.

The committee voted on the following, modified recommendations (modifications are denoted in red):

1. Remove the ACQ from list of acceptable tools for well-controlled component.
2. Add AIRQ to list of PRO tools for calculation of well-controlled component (score of 0 or 1 indicates control).
3. Add AIRQ score to definition of low risk of exacerbation component (score of 0 or 1 indicates low risk of exacerbation).
4. Stratify results into two rates for each population – current tools (ACT, C-ACT, ATAQ) and AIRQ. Statewide and medical group/clinic level results will be privately reported for one year. Following the private reporting period, MARC will evaluate uptake of AIRQ use and determine appropriateness of the level of results that are publicly reported (e.g., statewide results only, statewide results and medical group results).
5. Over three to five years, MARC will evaluate the uptake of AIRQ use among clinics. Based on this evaluation, MARC will determine if it is appropriate to transition to calculating components with only the AIRQ tool.

MOTION by Christine Norton to approve the modified recommendations above, seconded by Jennifer Lamprecht. The motion passed unanimously.

NOTE: The changes for recommendations 1 through 4 will occur beginning in 2026 measurement year (2026 dates of service), pending Board approval.

Next Steps

The recommendations will be presented to the Board of Directors during the May 21st Board meeting for review.

Next MARC Meeting: Wednesday, June 11, 2025 – 7:30-9:00am