

Quality Alliance Steering Committee – Episodes of Care Workgroup
Meeting Notes – February 5, 2010

Workgroup co-chair Chuck Cutler provided opening remarks for the meeting. Adam Wilk of Brookings walked the workgroup through the call's agenda. He also provided general updates regarding the status of the C3 Project and of related developments at CMS and the National Quality Forum (NQF).

- Project staff continue to work on developing and testing the remaining measures of the 22 established by physician workgroups over the prior year. The work to test many of these episodes is nearing completion. Project staff will certainly be prepared to submit the measures for the NQF Call for Measures when it is released. It is now expected that this Call for Measures will take place in July or August of 2010.

Adam Wilk also provided a brief update on the status of efforts in Detroit (with Save Lives Save Dollars) and Wisconsin (with the Wisconsin Collaborative for Healthcare Quality) to test readmission measures in their communities, as representatives from these efforts were unable to join the call.

- In both regions, efforts are in place to finalize the specifications of the measures to be tested in collaboration with the local organizations implementing the measures (hospital systems in Wisconsin and health plans in Detroit). Both efforts are expected to begin the process of submitting data and producing initial results within the next month to two months. QASC/Brooking staff have been providing technical support to both efforts and are optimistic about these continued efforts.

Adam Wilk then walked the workgroup through the first several sections of a PowerPoint presentation highlighting many of the C3 Project's recent episode-based analyses, including some for the asthma episode that had been originally intended for the workgroup's review on the previous call. The presentation also included analyses for episodes related to the conditions of congestive heart failure, diabetes, low back pain, and colon cancer. Workgroup members provided feedback on the layout of the analyses as well as the content of individual slides.

- One workgroup member noted that it seemed somewhat strange that such a large proportion of the asthma episodes took place in Texas. Niall reminded the workgroup that in terms of the episodes' distributions across states, the data are reflective of the Marketscan database and the market positioning of the Thomson Reuters organization than the distribution of the disease nationally.
- In reviewing the distributions of rates of resource use across states, one workgroup member noted it would be useful to know how many standard deviations each state was from the mean. That this information would be useful for understanding the significance of the distributions observed.
- One workgroup member pointed out that it would be useful for those looking at the analyses for the first time to know more about the data underlying the presented distributions. In particular, footnotes should be included noting whether the costs

presented were standard costs (and how they were standardized), whether they were risk adjusted, and whether outliers were included or excluded.

- In looking at the distributions of resource use in asthma episodes by the attributed providers' specialties, one workgroup member noted that internists may be attributed as often as the data suggest because of a miscoding problem, given that COPD and asthma are often miscoded for one another. Adam Wilk clarified that for any patients being considered for inclusion in the cohort who are over the age of 50, any evidence of COPD in the patient's record would be cause for exclusion – this should help alleviate some of these miscoding issues.
- One workgroup member was surprised to see some of the CTs and endoscopy procedures currently being grouped as “related” to the asthma episodes. A similar comment was made about cholecystectomy procedures. It was clarified that these procedures were captured as related very infrequently, but when they were captured as related it was because they had an asthma diagnosis in the first or second diagnosis code field of the data. Niall suggested that in future revisions of these episodes it would certainly be possible to go back and explicitly exclude certain procedures from ever being considered related despite the associated ICD-9 codes – this may be part of the revision process undertaken through the pilot testing process required as part of the requirements for full NQF endorsement.
- In considering the analyses presented as an attempt to identify “cost-driving” services for these episodes (i.e., those services that appear to be most highly correlated with high-cost episodes), workgroup members suggested that the final presented results should be more focused, highlighting those types of service that would be of greatest importance to physicians managing the condition (e.g., ER use and high-cost drug therapies). Niall indicated that project staff are working to improve the usefulness of these “Level II” analyses.
- Several workgroup members commented that the analyses being presented are very helpful and very much in line with what needs to be done more widely in health care.
- The workgroup was unable to review slides summarizing findings for the diabetes, low back pain, and colon cancer episodes. These will be discussed with the workgroup on a later date.

Comments or questions regarding the content of this meeting may be sent to Niall Brennan (nbrennan@brookings.edu) or Adam Wilk (awilk@brookings.edu).