

Episodes of Care Work Group Conference Call Notes
April 17, 2009

The following is a high-level review of the discussion points that were touched upon during today's Episodes of Care Work Group conference call.

Ongoing Discussions with Regional Collaboratives

1. Adam Wilk indicated that discussions have been ongoing with regional collaborative organizations in Wisconsin, Michigan, and Pittsburgh, and efforts to begin implementing and testing readmission measures with those organizations are at various early stages of development. Further discussions are planned with each, and presentations by QASC staff to local stakeholders are planned for two of the three. Current efforts are primarily centered on determining which data elements would need to be collected in order to calculate the measures and whether there would be a sufficient number of hospitalizations for conditions like AMI and CHF within the commercial population to calculate the measures.
2. A question was raised about the possibility of working with these regional collaboratives to aggregate measure results (both readmission and cost-of-care measures) at levels higher than individual physicians or hospitals. Kevin Weiss agreed that this level of study would produce interesting results. Project staff will lead a discussion of this issue with the Technical Advisory Committee in the coming months.

Update Regarding the Overall Status of the Cost-of-Care Measure Development Efforts

1. A document was provided to workgroup members that demonstrates the progress that has been made with respect to each condition's measures. This document will be updated and provided to workgroup members as part of the meeting materials for subsequent calls.
2. In general, project staff have started to develop measure specifications for 18 measures, having convened 10 physician workgroups for in-person meetings. An agreement has been reached with the Robert Wood Johnson Foundation to fully develop these 18 measures as well as the measures that emerge from the 11th and 12th physician workgroups (for sinusitis and colon cancer, to be held in June), though efforts will not be made with current funding to convene workgroups and produce measures for additional conditions beyond these 12.

Pneumonia Work Group Decisions

1. Kevin Weiss provided an overview of the key decisions made by the Pneumonia workgroup during their in-person meeting.
2. Kevin explained that the goal for both of these measures was to measure variation in resource use, particularly with respect to areas where it was perceived there might be significant overutilization of resources by some physicians – diagnostic imaging services and antibiotics. The two measures are separated from one another so as to distinguish between less severe pneumonia cases that can be treated in an ambulatory care setting from the most rapidly progressing cases of pneumonia that require hospitalization.

3. Gregg Meyer indicated that he has seen results of research efforts indicating that in cases like this, radiology groups very often make the final determination about whether or not to conduct additional imaging studies – not the primary care physician to whom episodes such as the ambulatory pneumonia episode would be attributed. He may be able to provide data to further illustrate this point. Project staff agreed to raise this issue to the physician workgroup during a future discussion.
4. One workgroup member suggested that for many pneumonia cases it may be most appropriate to attribute the case to the physician who orders the initial x-ray or other imaging study. This procedure often sets off the subsequent cascade of resource use. The implication here is that the initial imaging study and/or much of the subsequent service cascade would be considered inappropriate service utilization. Unfortunately, while measures of “appropriateness” would be highly desirable, they are very sophisticated and typically rely on more information than is available through administrative claims data.
5. The question of attribution was raised in several of the workgroup members’ comments. While discussions will be ongoing among project staff, the Episodes Workgroup, the TAC, and the physician workgroup regarding the most appropriate attribution models, this discussion will be increasingly informed by results calculated in testing the measure specifications. Further efforts were suggested to propose to the QASC that a pilot project be undertaken to more explicitly and directly answer some of the key questions related to attribution.
6. One workgroup member suggested that it would be worthwhile to compare these pneumonia measures to the measure currently used by hospitals regarding the appropriate use of antibiotics. She indicated she will look more deeply into that measure and provide additional related feedback to project staff offline.

On Angina/CAD Work Group Decisions

1. Kevin Weiss provided an overview of the key decisions made by the Angina/CAD workgroup during their in-person meeting.
2. One workgroup member indicated that he had found in previous studies that claims for aortic valvular disease do not necessarily appear with sufficient regularity for patients previously diagnosed with the condition that it would be captured within the 12 month period preceding the episode’s onset. Project staff will raise this point to the physician workgroup during a future discussion.
3. In comments related to the previous discussion of attribution, one workgroup member suggested that the project team’s and the TAC’s struggles with attribution rules, typically designed to attribute at the individual physician level, may be alleviated somewhat if the measures were to be attributed at a “higher” level, such as a hospital referral region or a county. Kevin suggested that health plans and consumer advocates have been the most vocal supporters of individual physician attribution.
4. Another workgroup member indicated that he had seen studies of resource use measures suggesting that the sample size necessary to observe statistically reliable variation may also inhibit the project’s capacity to attribute at the individual physician level. Project staff will plan to evaluate the effectiveness and usefulness of the attribution models as

defined and to present findings regarding observed sample size and how results compare if the attribution rules were to be altered.

Because of insufficient time, the Episodes Workgroup will plan to review the key decisions of the Asthma physician workgroup during the Workgroup's next meeting. In addition, Workgroup members were invited to provide input via e-mail on the draft measure specifications prepared by project staff for the measures of breast cancer, hiatal hernia/GERD, and COPD.

Further comments on these measure specifications and decisions can be sent to Robin Wagner (rwagner@abms.org) or Niall Brennan (nbrennan@brookings.edu).