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Evaluating Performance: The Physician Quality Reporting Initiative

PHYSICIAN QUALITY REPORTING INITIATIVE

You are listening to ReachMD XM 157, The Channel for Medical Professionals. Welcome to GI Insights where we cover the latest clinical issues, trends, and technologies in gastroenterological practice. GI insight is brought to you by AGA Institute and sponsored by Takeda Pharmaceuticals North America. Your host for GI insight is Professor of Medicine and Director of Digestive Disease Center at the Medical University of South Carolina Dr. Mark DeLegge.

The physician quality reporting initiative for PQRI may seem like a massive investment of time and money, but its value to your practice cannot be underestimated. Joining us to discuss the physician quality reporting initiative its Ms. Mary Igo CEO of Minnesota Gastroenterology and an MBA in Medical Group Management.

DR. DELEGGE:

Welcome Mary.

MS. MARY IGO:

Hi.

DR. DELEGGE:

Mary I have to ask first of all, what is PQRI?

MS. MARY IGO:

PQRI is sort of CMS attempted getting at reporting of data to define what quality is. Unfortunately, I think there is mixed feelings about what quality is, and if you go around the room you are going to end up with 20 different viewpoints on it. There actually doing it in a way, initially what these measures to get at health management and costing utilization issues I believe, so that they can hopefully define what quality or as I would like to refer value is some more down in the line.

DR. DELEGGE:

What for the gastroenterologist if we are looking at quality reporting or initiative, from your perspective what will be the best measure for us to you? I know there could be a lot of them, but what do you think?

MS. MARY IGO:

You really want to look out what are your top codes, what are things you do all the time, things that you feel confident and that relate to the measures. I believe there are hundred and some measures in 2008. The measures you should pick are the once that you can get people to buy and to sell for us really the once that was sort of safe and comfortable for everybody, because we do a lot of patients were the GERD ones and how they relate to patients care also seem to be the easiest. Selection of those was a great discussion point with physician to really get them to understand PQRI. To understand why we should go forward with it and really felt comfortable with what the measures were.

DR. DELEGGE:

With regards to GERD measurement were the specific questions or issues that you were looking at?

MS. MARY IGO:

Yes. A couple of the PQRI initiative one in particular was assessment of GERD symptoms and really putting down what medications were they taking or these particular things done for them for the patient. Fortunately, CMS and the AMA both have a web site, but actual questions that need to be asked for each one of those measures, so it would helps to understand where to go with it and how to implement it.

DR. DELEGGE:

For my experience, I am a physician so I am in that pack. I know that if you ask a physician to document anything else they are going to be renascent, so how do you engage the gastroenterologist or the physician in your practice to actually participate?

MS. MARY IGO:

First of all the understanding of what PQRI is and where its going and I think in the market place and particularly where in Minnesota where it is a very consumer-oriented market and very consolidated mature market we are not going to be just doing PQRI. Performance based measurements are going to be coming from all the payers sorted to find what you getting paid and your credential for care and probably where you fit in the stratification as they start to layer things if you are into 1, or 2 or 3. So it really is getting all of you to understand that it is something that has to be done, will be done, and either we get involved in it and test it and try it, they have some input with the measures of their success or failure or they can be imposed up on you. So that was part of it. I think the other part of it is with your whole documentation thing. I understand completely when you ask for one more thing to be sold out. I think it is very onerous and difficult if you do not have an EMR. We are fortunate enough to have an EMR so we could program it, so that the codes would signal when the doctors had to fill something out that went along with that patient. We did not make that capability when we first did it in 2006, and we had for two other measure, we had less than 4% of our patients the data was filled out and so we didn't get the money, but it was a great learning experience. You know, if you can tell me how to get people to fill out more papers than they already have, it would be wonderful addition to my knowledge banks.

DR. DELEGGE:

It sounds like the pocket book is the way to go me in if it impacts on what should actually be paid for the officer or procedure then you can get compliant. Would you agree with that?

MS. MARY IGO:

Yes the pocket book and your referrals in the future are going to be covering by some of these quality measure need to get involved at the front line.

DR. DELEGGE:

Mary. If it is becoming publishable, may these be patients being able to go and look up how their physician is appropriate for specific disease?

MS. MARY IGO:

I do more from a cost perspective rate now and we actually have that in Minnesota. Its www.mainstreetmedica.com is website that publishes the cost differences between different facilities and different physician and different system and that's going to be out there from the third party payers and eventually from the employers, certainly is an issue with some of the self-insured peoples, who are ready handing out their employees in our particular area. Cards that say if you need a colonoscopy you go here because it's less expensive and they have a great reputation.

DR. DELEGGE:

What certainly sounds like a means to pain what I could call best practices?

MS. MARY IGO:

You know, yes, best practices as long as the questions are meaningful.

DR. DELEGGE:

A lot of physician would tell me we listen, you know, sure with GERD there are proven ways you should be taking care of patient, but what about the patient with abdominal pain. Now how you are going to tell me what's the right way to go about approaching that patient?

MS. MARY IGO:

You know, I was around in the air when there was “cookbook medicine” and its really going to be to define protocol and processes in evaluating and working that patient up to what diagnosis you should get. I think one of the dangerous and abdominal pains; for example, is if you sent an abdominal pain patient to gastroenterologist, you may get a whole different set of diagnostic studies that are done than if the patient is with primary care and I think that's going to be the hard part to sort of understand where are the primary care roles where are the specialist roles, so patients don’t have to get so sick and have much more expense before they get to specialist or to actually the diagnosis. So I think that’s going to be tricky.

DR. DELEGGE:

If you are just tuning in, you are listening to GI Insights on ReachMD XM 157, The Channel for Medical Professionals. I am your host, Dr. Mark DeLegge and joining me to discuss PQRI is Ms. Mary Igo, CEO of Minnesota Gastroenterology and MBA in Medical Group Management.

DR. DELEGGE:

Mary I have to ask you, it sounds to me like you are going to have to have a physician buy in for this and therefore a champion at a practice. First am I correct and secondly how would go about doing that?

MS. MARY IGO:

Oh, absolutely. You know this a physician-to-physician discussion. I think we cannot as administrative people, although we can send up and implement it, we can't deliver it. You lose credibility because we really don’t understand what goes on in the exam room and the pressures around seeing patients. I think physician champion again the first year we did not have a physician champion in 2006. We put it out there. We put into the EMR. There was box that came up that said, need to fill these questions out. Somebody said, Oh, you can disregard that and pretty soon we only had, you know, 4.3% of the papers filled out. You too really sat down with the doctors and said here is what this means, here is where it to going, here is the dollar amount, here is the report that you are going to get, and here is why you need to do it. We have very physician-directed professionally managed organization. So it isn't hard for me to find a champion, who will take the on and I think we have some people that are very committed and defining-quality standard.

DR. DELEGGE:

You had mentioned earlier that having an electronic medical record on EMR, it is easier because you have a screen pop up to ask you various PQRI like questions, but what if say you have a paper chart or a practice that just beginning to do this, how would they implement the process?

MS. MARY IGO:

As I said what the AMA and CMS they have what I would call sheets just little forms look very much like kind of a survey, a Goggle-type survey and they have this so it can be put in the physician area where you are doing your charting. You would probably have to do one of two things. So it is two different ways to submit data. You can submit in a more focused pool of patients like 15 in a row, which will give you sort of the same thing as doing 80% and there is different methodology for some of the measures, but you would have to have something on coding slip that if you check this CPT code and this CPT code then you need to fill out that form. It would have be something that tempt out. I think to help the physicians understand when to fill it out and it would be important to do with all of the patients that fit into that category not just the Medicare or Medicaid patients.

DR. DELEGGE:

I know there is number of advantage of the electronic medical record with regards to data collection and accuracy of data, sounds to me from what you just said that moving to an electronic medical record would make this whole process a heck of a lot easier.

MS. MARY IGO:

It would and it really can start a simple as getting your practice management system to be able to trigger electronic chart ticket for you on outpatient that would give you a better idea when you need to submit this data. There is so many advantages with an EMR if you implemented in the right order that will help you with this and was quality data in general.

DR. DELEGGE:

I would like to thank my guest, CEO of Minnesota Gastroenterology and MBA in Medical Group Management, Ms. Mary Igo.

Ms. Igo, thank you very much for being our guest this week on GI Insight.

MS. MARY IGO:

Oh! My pleasure. Thank you.

DR. DELEGGE:

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