

To Participate or Not in the Physician Quality Reporting Initiative (PQRI); That Is the Question

Brett Elliott, M.D.

Abstract

The Tax Relief and Health Care Act of 2006 authorized the establishment of a physician quality reporting system which would tie a reimbursement incentive to compliance with benchmarks that are considered proxies of quality patient care. The Centers for Medicare and Medicare Services (CMS) has called this the Physician Quality Reporting Initiative (PQRI). A brief historical background about how this program evolved, how one participates in this initiative, and the strengths and weaknesses of current and new benchmarks is presented.

INTRODUCTION

In December of 2006 when legislation was passed to rescind the Medicare Part B cutbacks, part of the bill authorized that CMS institute a payment incentive for providers who can document that they provided quality of care as defined by specific benchmarks. Medicare has called this the Physician Quality Reporting Initiative (PQRI)¹.

Eligible providers include all physicians defined as such by Medicare: Doctor of Medicine or Osteopathy, Podiatrist, Optometrist, Oral Surgeon, Dentist and Chiropractor. Other eligible health care providers include Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Clinical Social Worker,

Clinical Psychologist, Registered Dietician, Nutrition Professional, and Physical, Occupational and Speech Therapists.

The reporting benchmarks for the PQRI project were those that were used for the Physician Voluntary Reporting Program (PVRP) as published by Medicare in 2006 and modified as needed. The standards were finalized in January 2007: however subsequent to this date new ones have been added. The benchmarks were reviewed by the Performance Measures Advisory Group (PMAG). The Agency for Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), The Joint Commission, formally Joint Commission on Accreditation of Healthcare Organizations (NCQA), and the Physician Consortium for Performance Improvement (PCPI) all had input into finalizing these benchmarks. When appro-

Brett Elliott, M.D. is an ophthalmologist who practices in Milford and Dover, Del.

priate the PMAG partnered with specialty academies for benchmarks germane to their specialty. Most of the benchmarks are process indicators as opposed to outcome indicators, and generally when a benchmark calls for a test or procedure, the documentation that an order or referral is made will satisfy the standard. Consequently if a physician were caring for a particularly complex or noncompliant individual, the doctor would not be penalized by a less than optimal outcome or if a patient did not follow up as instructed. There are notable exceptions to this generalization, as some standards require specific numbers, such as the ones for blood pressure, lipid, and HgBA1c control. The list of the finalized benchmarks can be downloaded from CMS² and is as follows:

2007 Physician Quality Reporting Initiative (PQRI) Physician Quality Measures as of March 10, 2007

1. Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus

Description: Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had most recent hemoglobin A1c greater than 9.0%

2. Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus

Description: Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had most recent LDL-C level in control (less than 100 mg/dl)

3. High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus

Description: Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had most recent blood pressure in control (less than 140/80 mm Hg)

4. Screening for Future Fall Risk

Description: Percentage of patients aged 65 years and older who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months

5. Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and left ventricular systolic dysfunction (LVSD) who were prescribed ACE inhibitor or ARB therapy

6. Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease

Description: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease who were prescribed antiplatelet therapy

7. Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI)

Description: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease and prior myocardial infarction (MI) who were prescribed beta-blocker therapy

8. Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have left ventricular systolic dysfunction (LVSD) and who were prescribed beta-blocker therapy

9. Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression

Description: Percentage of patients aged 18 years and older diagnosed with new episode of major depressive disorder (MDD) and documented as treated with antidepressant medication during the entire 84-day (12 week) acute treatment phase

10. Stroke And Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports

Description: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) or intracranial hemorrhage undergoing CT or MRI of the brain within 24 hours of arrival to the hospital whose final report of the CT or MRI includes documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction

11. Stroke and Stroke Rehabilitation: Carotid Imaging Reports

Description: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) whose final report of the carotid imaging study performed (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) in which an internal carotid stenosis is characterized in the 30-99% range, includes direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

12. Primary Open Angle Glaucoma: Optic Nerve Evaluation

Description: Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

13. Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Formulation Prescribed/Recommended

Description: Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had the AREDS formulation prescribed/recommended within 12 months

14. Age-Related Macular Degeneration: Dilated Macular Examination

Description: Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular

degeneration severity during one or more office visits within 12 months

15. Cataracts: Assessment of Visual Functional Status

Description: Percentage of patients aged 18 years and older with a diagnosis of cataracts who were assessed for visual functional status during one or more office visits within 12 months

16. Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation

Description: Percentage of patients aged 18 years and older who had cataract surgery who had the pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation performed and documented within 6 months prior to the procedure

17. Cataracts: Pre-Surgical Dilated Fundus Evaluation

Description: Percentage of patients aged 18 years and older who had cataract surgery who had a fundus evaluation performed within six months prior to the procedure

18. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months

19. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes regarding the findings of the macular or fundus exam at least once within 12 months

20. Perioperative Care: Timing of Antibiotic Prophylaxis - Ordering Physician

Description: Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

21. Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin

Description: Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis

22. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)

Description: Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time

23. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)

Description: Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time

24. Osteoporosis: Communication with the Physician Managing Ongoing Care Post Fracture

Description: Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

25. Melanoma: Patient Medical History

Description: Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who had a medical history taken that included being asked if they have any new or changing moles at least once within 12 months

26. Melanoma: Complete Physical Skin Examination

Description: Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who had a complete physical skin exam performed at least once within 12 months

27. Melanoma: Counseling on Self-Examination

Description: Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who were counseled at least once within 12 months to perform a self-examination for new or changing moles

28. Aspirin at Arrival for Acute Myocardial Infarction (AMI)

Description: Percentage of patients with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay

29. Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)

Description: Percentage of patients with a diagnosis of AMI who had documentation of receiving beta-blocker within 24 hours before or after hospital arrival

30. Perioperative Care: Timing of Prophylactic Antibiotic - Administering Physician

Description: Percentage of surgical patients aged 18 years and older who have an order for a parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) for whom administration of prophylactic antibiotic has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

31. Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage

Description: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who received DVT prophylaxis by end of hospital day two

32. Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy

Description: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or TIA who were prescribed antiplatelet therapy at discharge

33. Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge

Description: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or TIA with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge

34. Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered

Description: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours who were considered for t-PA administration

35. Stroke and Stroke Rehabilitation: Screening for Dysphagia

Description: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who underwent a dysphagia screening process before taking any foods, fluids, or medication by mouth

36. Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services

Description: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom consideration of rehabilitation services is documented

37. Dialysis Dose in End Stage Renal Disease (ESRD) Patients

Description: Percentage of patients aged 18 years and older with a diagnosis of end-stage renal disease undergoing hemodialysis with a documented urea reduction ratio (URR) value greater than or equal to 65% (or a single-pool Kt/V greater than or equal to 1.2)

38. Hematocrit Level in End Stage Renal Disease (ESRD) Patients

Description: Percentage of patients aged 18 years and older with a diagnosis of end-stage renal disease undergoing hemodialysis with a documented hematocrit value greater than or equal to 33 (or a hemoglobin value greater than or equal to 11)

39. Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older

Description: Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

40. Osteoporosis: Management Following Fracture

Description: Percentage of patients aged 50 years and older with fracture of the hip, spine or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed

41. Osteoporosis: Pharmacologic Therapy

Description: Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months

42. Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise

Description: Percentage of patients, regardless of age, with a diagnosis of osteoporosis who are either receiving both calcium and vitamin D or have been counseled regarding both calcium and vitamin D intake, and exercise at least once within 12 months

43. Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG) Surgery

Description: Percentage of patients undergoing coronary artery bypass graft (CABG) surgery using an internal mammary artery (IMA)

44. Pre-Operative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery

Description: Percentage of patients undergoing coronary artery bypass graft (CABG) surgery who received a beta-blocker pre-operatively

45. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)

Description: Percentage of cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time

46. Medication Reconciliation

Description: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented

47. Advance Care Plan

Description: Percentage of patients aged 65 years and older with documentation of a surrogate decision-maker or advance care plan in the medical record

48. Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

Description: Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months

49. Characterization of Urinary Incontinence in Women Aged 65 Years and Older

Description: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months

50. Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

Description: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months

51. Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation

Description: Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry evaluation results documented

52. Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy

Description: Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/

FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator

53. Asthma: Pharmacologic Therapy

Description: Percentage of patients aged 5 to 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment

54. Electrocardiogram Performed for Non-Traumatic Chest Pain

Description: Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had an electrocardiogram (ECG) performed

55. Electrocardiogram Performed for Syncope

Description: Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had an ECG performed

56. Vital Signs for Community-Acquired Bacterial Pneumonia

Description: Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed

57. Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia

Description: Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed

58. Assessment of Mental Status for Community-Acquired Bacterial Pneumonia

Description: Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed

59. Empiric Antibiotic for Community-Acquired Bacterial Pneumonia

Description: Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed

60. Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms

Description: Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, who were assessed for the presence or absence of the following alarm symptoms: involuntary weight loss, dysphagia, and GI bleeding

61. Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms

Description: Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, with at least one alarm symptom who were either referred for upper endoscopy or had an upper endoscopy performed

62. Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus

Description: Percentage of patients aged 18 years and older with a diagnosis of GERD or heartburn whose upper endoscopy report indicates a suspicion of Barrett's esophagus who had a forceps esophageal biopsy performed

63. Gastroesophageal Reflux Disease (GERD): Barium Swallow- Inappropriate Use

Description: Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, who did not have a Barium swallow test ordered

64. Asthma Assessment

Description: Percentage of patients aged 5 to 40 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

65. Appropriate Treatment for Children with Upper Respiratory Infection (URI)

Description: Percentage of children aged 3 months to 18 years with a diagnosis of upper respiratory infection (URI) who were not dispensed an antibiotic prescription on or 3 days after the episode date

66. Appropriate Testing for Children with Pharyngitis

Description: Percentage of children aged 2 to 18 years with a diagnosis of pharyngitis, who were prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode

67. Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow

Description: Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenetic testing performed on bone marrow

68. Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

Description: Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy

69. Multiple Myeloma: Treatment With Bisphosphonates

Description: Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12 month reporting period

70. Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry

Description: Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed

71. Hormonal Therapy for Stage IC-III, ER/PR Positive Breast Cancer

Description: Percentage of Stage IC-III, estrogen receptor (ER) or progesterone receptor (PR) positive, female breast cancer patients aged 18 years and older who are receiving tamoxifen or aromatase inhibitor (AI) at the time of the office visit

72. Chemotherapy for Stage III Colon Cancer Patients

Description: Percentage of stage III colon cancer patients aged 18 to 80 years for who were prescribed chemotherapy within 4 months of the first office visit

73. Plan for Chemotherapy Documented Before Chemotherapy Administered

Description: Percentage of cancer patients for whom a plan for the amount of chemotherapy to be given was documented before the chemotherapy was administered

74. Radiation Therapy for Invasive Breast Cancer Patients Who Have Undergone Breast Conserving Surgery

Description: Percentage of invasive breast cancer patients greater than 18 and less than 70 years old who have undergone breast conserving surgery and who have received radiation therapy within 12 months of the first office visit

DETAILS

The PQRI program is for fee for service providers and is voluntary. There is a financial incentive for those who participate from July 1, 2007 through December 31, 2007, by reporting these quality benchmarks. The payment would be either a maximum of 1.5% of total, allowed Medicare charges for covered Medicare services, or less than 1.5% depending on the number of eligible providers. The determination of how much will be paid should be made by CMS in early 2008, and the payment would be in a lump sum made most likely during the summer of 2008. Payments would be made to the Taxpayer Identification Number (TIN) of record for the claim so these incentive payments would go to the holder of the TIN. There is no beneficiary notice or co-payment associated with this program.

To participate eligible providers do not enroll or submit letters of intent, but simply must submit quality data codes on benchmarks germane to their practice. To be eligible for the incentive payments Medicare requires that "...when no more than three quality measures are applicable to services provided by an eligible professional, each such measure must be reported in at least 80% of the cases in which the measure is reportable. When four or more measures are applicable to the services provided by an eligible professional, the 80% threshold must be met on at least three of the measures reported."³ The reporting period begins on July 1, 2007, and the program as is currently described will continue until December 31, 2007. For calendar year 2008 proposed benchmarks would be published by August 15th in the Federal Register, and the final set of benchmarks for 2008 would be published by November 15, 2007.

The benchmarks are reported by using Category II CPT4 Codes that are all four numbers long and end in the letter "F". They can be grouped into the seven categories comprising (1) Patient Management, (2) Patient History, (3)

Physical Examination, (4) Diagnostic/Screening Processes or Results, (5) Therapeutic, Preventive or Other Interventions, (6) Follow-up or Other Outcomes, and (7) Patient Safety. Both the short and long descriptor for the codes can be downloaded from the AMA⁴. Appendix H can also be downloaded and this section describes technical aspects such as the rationale for the benchmark, exclusion criteria, definitions of numerators and denominators, applicable CPT4 Procedure and ICD9 Codes, and reporting instructions. On the same web page is a PowerPoint[®] presentation that describes PQRI and gives further information about using the codes.

The quality code would have to be submitted to your fiscal intermediary on the same claim for service that contains the standard CPT4 Procedure payment code and the appropriate ICD9 code. No separate submission would be needed. To calculate the compliance rate for a given indicator, the numerator would be the number of claims submitted with the Quality Code, and the denominator the total number of claims submitted for the indicator either with or without the quality code. The paper-based 1500 form or electronic claims can be used.

DISCUSSION

The primary reason for PQRI is to reward providers using patient care algorithms that lead to better results, and the assumption is that the standards are valid proxies to measure good outcomes. Many of the core measure standards are included in PQRI and several recent articles have questioned the value of the core measure standards to substantively measure differences in patient outcomes. A comparison between outcomes for patients with congestive heart failure and five performance measures germane to these patients did not show any statistically significant difference for combined mortality/readmission at 30 or 90 days except for the benchmark calling for the use of an ACE Inhibitor or blocker.⁵ The authors concluded that additional and better measures may be needed to measure outcomes for these patients. Another recent article also in *JAMA*⁶ compared

the difference in risk adjusted mortality at 30 days and one year between the highest quartile and lowest quartile hospitals with respect to their scores in the ten core measures that hospitals are required to report to receive their full Medicare reimbursement. The differences between the highest and lowest performing groups of hospitals and mortality was statistically significant; nevertheless the authors concluded that based on their results, the ability of the ten CMS core measures to detect clinically meaningful differences in quality across hospitals is questionable. The authors surmised that one of the reasons for this is that the ten core measures tend to focus on a small albeit important portion of the patient's care, yet it is the totality of the care that determines outcomes. The article calls for the development of benchmarks that may be better tied to desirable end results. A correction to the statistical method used in the original article was published;⁷ however in this errata the authors did not modify their original, overall conclusions.

Some of the PQRI benchmarks move away from just one narrow focus on a particular benchmark and so possibly these new standards will prove better proxies for desirable outcomes. PQRI has benchmarks applicable not only to the generalist, but to specialists including the gastroenterologist, ophthalmologist, oncologist, and psychiatrist. Some measures cross disciplines: in the management of a diabetic the generalist, endocrinologist, ophthalmologist, dietician, and podiatrist could all be involved as they all may be needed for the optimal care of a complex diabetic patient. In long-standing diabetics having fundus exams is essential in itself; however the communication of this finding to the practitioner who is managing the patient's diabetes adds another dimension to patient care and PQRI metrics capture this communication process. Medication reconciliation is another benchmark in the PQRI group of measures. Effective and accurate medication reconciliation often requires communication between the patient, physician, nurse and neighborhood pharmacist, and no individual can expeditiously do it alone.

Two recent articles emphasize the importance of communication and demonstrate how

often it is lacking. Kripalani⁸ analyzed the availability of discharge summaries and found that they were available only 12 percent to 34 percent of the time at the first post discharge visit. The author states that in 25 percent of the patients quality of care was affected and this led to primary care physician dissatisfaction. Stille⁹ found that in a pediatric setting, specialists reported communication from referring primary care physicians for only 50 percent of initial referrals, whereas primary care physicians reported communication from specialists after 84 percent of initial consultations. The author concludes that for optimal patient care, communication is important but it is frequently absent. The Joint Commission finds that communication issues are one of the primary weaknesses at many complex healthcare institutions (Personal observation).

Some of the PQRI benchmarks such as those requiring the development of care plans, medication reconciliation, and communication between providers, endeavors to overcome shortcomings in health care alluded to by the authors of the previous two articles. Time will tell if providers and organizations that do well in these benchmarks will have significantly better patient outcomes compared to those that do not. It may be that the best outcomes occur when patients are taken care of by providers who consistently meet clinical benchmarks shown to increase the probability of a good outcome, and also communicate effectively with each other and their patients.

CONCLUSIONS

The financial incentive for participating in PQRI is modest; however the costs for reporting PQRI codes should be quite manageable for either a paper-based practice or one with electronic records. One would simply have to remember, when applicable, to add the quality code to your claim, and submit the completed bill to your fiscal intermediary as you currently do. The final analysis in deciding if you should participate in PQRI should be based upon whether or not you believe participation will improve pa-

tient care for your practice. I believe that for the vast majority of us it will either do just that, or simply validate our already good practices. So why not try it for both patient care and the bottom line?

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