CENTER FOR MEDICARE AND MEDICAID SERVICES

Conference Leaders:
Michael Rapp, M.D. (CMS), Bruce Bagley, M.D. (AAFP)
and Michael O'Dell, M.D. (AAFP)

Moderator: Tressa Mundell (CMS)

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2:00 pm ET

Operator: Good afternoon, my name is (Mindy) and I will be your conference facilitator today.

At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum: 2008 Physician Quality Reporting Initiative - Participation by Family Physicians.

All lines have been placed on mute to prevent any background noise.

After the speaker's remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you.

Ms. Tressa, you may begin.

Tressa Mundell: Thank you, (Mindy).

Good afternoon everyone and good morning for those of you who are participating with us from the West Coast.

Thank you for joining us on this special Open Door Forum for the 2008 Physicians Quality Reporting Initiative focusing on family physicians.

CMS together with the American Academy of Family Physicians is hosting this forum to discuss simple steps that family physicians can take to collect and report quality data to be eligible for an incentive payment from CMS.

Here with me in our Baltimore central office is Dr. Michael Rapp, Director of the Quality Measurement and Health Assessment Group in our Office of Clinical Standards and Quality.

I will now turn the call over to him with his opening remarks and introductions.

Michael Rapp: Thank you.

I'm pleased to welcome you all to this open door forum call that we are hosting with the American Academy of Family Physicians. We are quite pleased to have their involvement in this.

We've had a number of calls as we've rolled out the 2008 PQRI. We've had three national provider calls and gone over quite a bit of detail with regard to the program and we're going to have another one coming up in the middle of

July, but one of the things we've noticed about our program is, of course, we have many different types of practitioners and we think it is important to focus on the practitioners that provide primary care, so that's a very important aspect of the PQRI.

And we thought that the best way to be able to provide information on how to participate in PQRI would be to engage the American Academy of Family Physicians to help us since they are much more familiar with aspects of how a office practice works and how you can invest, incorporate into your practices participation in PQRI, so we're very pleased to have with us today on the call and participating and really carrying the ball, Dr. Bruce Bagley who is the American Academy of Family Physicians Medical Director for quality improvement.

I don't think probably any of you require an introduction to Dr. Bagley, but he served previously as President elect, President Board Chair of the American Academy of Family Physicians and has a 28-year practice career as well and many interests involving family medicine.

And Dr. Michael O'Dell is the Chief Quality Officer of the North Mississippi Health Systems, again a very prominent family physician serving in a variety of capacity, particularly in the American Academy of Family Physicians in Mississippi. He's done a lot of work. He's focused on quality improvement and product reviews, so we're very pleased to have these two prominent physicians participating in our open door forum today.

For those of you that have not gotten the slides so far, you can go to the CMS Web site www.cms.hhs.gov/PQRI. That's cms.hhs.gov/PQRI and when you do that, you'll see on the left-hand column CMS sponsor calls and click on

CMS sponsor calls, you'll go to a download that will provide you with - you'll see a download file with slides for today's presentation.

In addition the American Academy of Family Physicians is interested in having you fill out a survey after the call and that can be accessed at www.aafp.org, O-R-G/S-U-R-V6, that's like in survey, surv number 6/PQRI.htm. I'll repeat that www.aafp.org/surv, S-U-R-V, 6/PQRI.htm, so I'm sure they'll give you that at end of the call.

And without any further adieu, I want to thank Dr.'s Bagley and O'Dell for joining us and I'll turn it over to them to discuss gearing up for PQRI participation.

Bruce Bagley: Okay, thank you very much Michael.

Good afternoon, this is Bruce Bagley from the American Academy of Family Physicians and I will assume that most of you will have access to the slides so as we go through we'll try to mention the slide number that we're on so people can kind of follow along.

The first thing I wanted to do is to talk about why we might do PQRI and why it's important for family physicians to become engaged in this kind of activity, so on Slide Number 2 it's labeled "PQRI for the right reasons."

And we wanted to point out that, you know, if really the only thing that you're looking at PQRI for is enhanced Medicare payment and really don't look beyond that then your kind of missing the boat. You're missing the whole point of quality improvement and measurement, so although there is an enhanced reimbursement related to PQRI, the real reason to become involved

in this kind of activity is part of an overall quality improvement strategy and it's because the world of medicine is really changing.

And as we move forward more and more payers including CMS and the private payers will be looking for you to be doing some kind of measurement and improvement and reporting so PQRI is really just one of the first examples or one of the leading examples of this kind of activity which ultimately will be much more common.

And of course the real goal is better patient care and better patient outcome, so let's just try to keep that in mind. Although there is some advance - enhanced payment, it is really about quality improvement so Dr. O'Dell and I will be talking about both PQRI and how to participate in that but also in the context of overall quality improvement.

So on Slide Number 3, Dr. O'Dell do you want to talk a little bit about this?

Michael O'Dell: Sure I'd like to add to what Bruce was saying because I think there are many benefits and consequences in participating in PQRI, and it is a legitimate question to say how does PQRI actually help my practice.

One of the things that I continue to be amazed at is that when people begin to look at the quality of their practice in a systematic way, they gain some very valuable learning about how to provide high quality care to patients. That's really the goal I think all of us seek. And doing the PQRI participation is really a good way to get started down that path of looking at how am I currently doing and can I do better.

It really provides you about some valuable lessons about what it takes to improve quality of care and it gives you a physician and everybody on that

physician's team a great deal of satisfaction in knowing that what your quality of care is and knowing that it is constantly improving, and of, course, the financial rewards are there and are important in undertaking all of this.

So Bruce I think you had some further comments as well.

Bruce Bagley: Yes, on Slide Number 5 I wanted to point out that some people look at this kind of activity as being an additional burden and that it's a lot of extra work to collect these measures and do this kind of work, but if you think about collecting information at the time of service so that as a patient - let's say a patient with diabetes comes through the office, if you're actually collecting the data that you need as the patient comes through the office, there isn't really additional work at that time in the sense that these measures are really about clinical information that you would want to know when your face to face with a patient making clinical decisions about their care.

So if a diabetic comes through, I would want to know what their blood pressure is. I would want to know their last hemoglobin A1c. I would want to know their LDL level. I would want to know if they had a foot exam, if they had a microalbumin, those kind of things.

So it is just really information that you should be gathering anyway, so the additional work is really about reporting these codes for PQRI, it's a relatively low hurdle in the sense that the coding person only has to add three additional codes for a small portion of your Medicare and actually all your patients, so it doesn't turn out to be a huge amount of extra work.

And as we go on through the presentation, I think you'll see that it is relatively easy to accomplish, so there isn't a lot of additional work. Hopefully your MA or nurse is helping you find that information that you need anyway, so it's

really just a question of getting the information about what's been done to the patient and giving that information to the coding person and we're going to talk a little bit more about that.

Now it may be true that the financial incentives are modest at this time, but we anticipate that both Medicare and commercial payers over the next year or two or three are likely to ramp up this form of payment. It's been called "pay for performance." As you probably know, PQRI is really just paper reporting. There is no attempt to meet any particular goals or levels of performance in this year. There may be in the future years, but for now it’s really just enhanced payment for reporting.

Dr. O'Dell, do you want to talk about Slide 6?

Michael O'Dell: Sure, basically PQRI is a fairly simple sort of scheme and one that I think physicians can readily adopt and begin working with because really what you do is you select from a list of measures that you think are important in caring for your/our patients.

So in our practice here in Mississippi, it was pretty clear that we had a lot of patients with diabetes, so it made a great deal of sense to say “are we obtaining hemoglobin A1c levels?

The other thing that I think it does encourage you to do is systematically for every applicable patient see if you did indeed provide that service that was being measured and then, of course, you report your performances, but I think we need to talk a little bit more about what might be meant by systematic.

What really happens in many physician offices is that everything in the office resolves around the physician and the physician’s emphasis are lynch pinned

on where all the clinical and patient safety issues fall. Unfortunately the physicians are also usually frequently interrupted because everybody is asking what do I do next and they are unable to carry out a plan for a particular patient in a linear fashion because of that.

Well an odd thing happens when we humans, and physicians are certainly human, are interrupted. We forget what activity we were carrying out and then we also tend to think that we completed the step that we ommitted. You know, that is true of physicians, true of lawyers, true of people at CMS, true of all of us.

And that's why so many physicians get surprised when they actually get their quality data. They honestly thought they had completed the task and so as often as not, when we first see the data, everybody says, well, the data is wrong. And it's not. It’s just the first shock of understanding that the things we thought we were doing maybe we weren't doing as quite as much of as we thought we were.

You know, the physicians thought about the task and because they thought about it, they thought they actually they did it. Unfortunately good intentions are only part of good patient care and the rest of it is the real hard work of providing the care.

Well an office understands how systems work, approaching patient care as a team and serves the needs of the patient. Each member has a defined role and a set of expectations and accountability in that role and the office performs as a well functioning team adapting to the needs of patients in a structured and very systematic matter. The physician is not interrupted as often because everybody knows what is expected of them and the team members are not

waiting for the command of a physician to carry out patient care tasks that are within their scope of practice.

So when you begin collecting the data, I think it actually helps you begin to think about your system and actually think, well, where/how does a patient actually get this done, how does it actually work, how is my office actually structured because your data also has to be collected systematically.

Applicable patients should be defined in advanced and this is something in the lingo of PQRI and other things that we frequently refer to as the "denominator" and the patients who receive the indicated care really are the patients that are the enumerator. It is the number of times I actually did for a patient out of the number of times I had an opportunity to do things for a patient, so the resulting number really speaks for itself and provides you with the opportunity for improvement.

In a team based system that team actually understands that providing care is a system that everybody is contributing to improving, so that's one thing that I think is really exciting about the PQRI process as we begin to really view medicine as a -- I teasingly call it- a team based sport.

Bruce Bagley: You were going to talk about.

Michael O'Dell: Oh, yeah.

Bruce Bagley: The basics of improvement science.

Michael O'Dell: Yeah, let's just move on to that. You know...

Bruce Bagley: Slide 7.

Michael O'Dell: Slide 7, some of the basics are what we are really trying to accomplish, because, like the old saying, “if you don’t know what you’re trying to accomplish, any route will get you there.” So you need to define what you want to accomplish and again in our practice here what we choose is diabetes because we had a large number of diabetics that we care about and want to see the best for.

How will we know that a change is actually an improvement so you need to be able to track that change and have some metric that says, well, the fact the change did work and the change we put in our practice did achieve an outcome and then what change we make that will result in improvement.

A lot of people talk about plan, do, study, act. And I just want to lead you very quickly through this and I apologize because I'll bet a fair number of people on this phone call actually know about plan, do, study, act, but I think it bears, repeating and coming back to.

So on Slide 8 there is a simple plan, do, study, act diagram. You choose a measure. You get your baseline performance data. You plan an intervention to improve. You do the plan intervention. You check the results with that intervention and then you look to see what did the results achieve, did it work or not and then you act on those results and the cycle continuously repeats as you get better and better and better.

On Slide 9 what you see is an example of a PDSA cycle. And an example might be; I bet we can do better with instructing patients to stop smoking. That's probably a common theme in a lot of practices that I bet we can do better with instructing patients to stop smoking. So here the plan might be to involve the nurses, part of our team, in teaching and documenting the smoking

cessation advice, do the planned intervention, check or study the results what was tried and act on those results.

And the next slide acts as an example from my own practice where we did exactly that. We looked at how often we were doing same-day smoking advice and we were a bit humiliated by that and said we weren't doing what we wanted to do so obviously we wanted to improve and so we put in a plan to improve. We bumped up immediately and if we had stop measuring it there, we would have thought well, gee, we fixed this problem.

So like most problems the first try doesn't always work and so you have to continue to try to consolidate your gains and over time with our office, you see, we've learned lessons and moved forward and tried to become a better and better office and discharging this particular accountability for our patients.

Bruce, back to you.

Bruce Bagley: Sure, on Slide 11 I wanted to talk just a little bit about work flow and process improvement. When we've looked out at all of the practices that are trying to do quality improvement and trying to do measurement, certainly it seems that the ones that are more successful will together do some analysis of how their office flow works. In other words, some very simple process analysis about how patients get handed off from one person in the office to the next, how the work actually gets done so they can begin to understand what works better and what caused it not to work so well, instead of just at the end of the day wondering why things didn't work so well, so there is an important step here as we start to look at some of the work flow and process improvement.

Certainly Dr. O'Dell talked about team work and communications and standing orders. There are so many things that we do in the office every day

that really are what amounts to rules base decision making and once the rules have been well established, there is no reason that those things can't become basically standing order so that the physician doesn't have to be an authorization bottleneck for the flow. So look for things like that that can be eliminated.

How do you process messages? Are you batch processing your messages at the end of the morning or at the end of the day or are you trying to work them into the work flow all day long so that they are continuously dealt with? So some of the things like that.

How do you track your lab order and lab review for your patients? I mean, have you examined how that happens or is it happening and nobody is keeping track of it? Look at waits and delays in your office and what might be done about those.

Should you have a lab drawing station in your office or should you try to do all the extra things that patients need in the same room? Those are all considerations that you might want to think about.

On the next slide, this will be Slide Number 12, it shows the importance of a time order graph or what we call a “run chart” and I wanted to use this as an example. When we measure anything, there are four important components that we need to know. The first is what is the level of the measurement and in this case we are measuring cycle time. Cycle time is simply the time a patient enters the office to a time the patient leaves that same door or exits the office. So it is a very simple measure of how long the patient is in the office, and we found in the past that when cycle times are above 60 minutes and we do patient satisfaction surveys, physician satisfaction surveys and staff

satisfaction surveys, none of those three groups are happy when it was over 60 minutes.

If it gets down in the 40, 45 minutes, all those satisfaction surveys start to show a positive result. So there is something to be said in a well organized office versus working in chaos.

So in this run chart we've measured the cycle time and you can see at the beginning it was over 80 minutes and then some change was made in March and it began to reduce and then it stabilized starting about in August to a new level of about a little over 38 or 39 minutes, so this run chart can help you understand how you're doing. This is called trending so you need to know the four things.

The four things are the baseline level, the trend and comparison data, how am I doing compared to other offices that are trying to do this stuff and you should be measuring something important. You can argue that cycle time might not be important, but it's a good overall indicator of office organization.

So let's go on to Slide Number 13 entitled "data collection efficiency." I wanted to mention once again that when we talk about collecting data or if I said the words "chart review," most of us have a collective mental model of a team of nurses headed for the chart room to look at charts from patients with diabetes for the last couple of years and that really is not very efficient. It is costly. It is time consuming and it doesn't get good results because of problems with documentation and definitions so we're not recommending for the most part that you do retrospective chart review for something like the PQRI program.

It works much better if you do prospective data collection or you collect the data that you need as the patient comes through the office so you have a check list or a flow sheet that helps you accomplish that task. It also provides you with the clinical information that you need during the visit and it allows you to have instantaneous quality improvement when you find that something that is on the list that is important that is not available then you make sure it becomes available such as a current hemoglobin A1c.

So we're hoping to get you to think about this data as a byproduct of the process of care and not collecting data as a separate activity.

The next Slide 14 kind of reiterates some of this, but if you build these measures into the process of care so that they become part of how you do the work, then it doesn't amount to an additional burden. It is actually a more efficient way to get the work done that you're getting done now and as a result you also collect measurement information.

The other thing I wanted to say about this slide is that whenever we talk about data collection or quality improvement, physicians have a tendency to think that all the work is going to fall on their shoulders and we really need to begin to think team as Dr. O'Dell said earlier on that all of the team members should have a role in this data collection and reporting and the physician's role is likely to be actually minimal in this particular activity of PQRI because their work is just really to see the patients and use the information that they get from their MA or nurse to do better jobs seeing the patients and then the coder will take up the rest of the work. We'll talk about that in a minute.

Mike, did you want to talk about Slide 15?

Michael O'Dell: Sure, one of the things that I am really again excited about is there are nice templates and other things out there that offices that are new to this activity can build upon. Actually the American Medical Association has been very involved in developing some of the measures and some of the standards that CMS is now using to measure our practices and they've actually done a lot of the work in trying to develop templates that physicians out in their office can use

So on Slide 15 I've got an example of one of those templates and the things that I think are useful about what the MA's provide. They provide a readable and easy means to see what the measures actually are so you can go through reams of reading and other things, or actually you can go to the AMA Web site and look up the their Physician Consortium Practice Improvement site and pull up one of the templates and it will list the things that are being measured at CMS plus some other measures that you might find useful.

They are also in a format that you can use to setup your chart notes, so if you've got a favorite chart, you can look at this format and say, well, what things do I need to collect in my notes and what things can I put on this prospective data collection pull up sheet that AMA developed for me. They provide an example of how to collect data over time on patients. Most of the PCPI forms are actually set up with columns so you could enter a date at the top of the column and over time they'll track that patient and actually add new sheets that need data to continue to track the patient.

They can be used with a paper chart. You can use it to build a paper base registry system if you'd like. Although frankly I think you'll find it's a lot more work, but we'll get into registries later.

And if you are purchasing an electronic medical record, they can actually guide you in discussions with your vendors to put these sheets in front of them and say at a minimum this is the type of data that I need to get out readily. This is the type of data that you need to provide me in report as you begin to negotiate with that vendor for electronic health record so the consortiums are really quite useful. The AMA forms, I think, are a good place to start if you are brand new to this activity.

Bruce, back to you.

Bruce Bagley: Great, Mike, and they are available in PDF format. So you can just download them and print them out for free. I don't even think you need to be an AMA member to get them. They are available on the public side of the Web site and they have these prospective data collection sheets for virtually all of the sets of measures that they have developed.

On Slide 16 I wanted to spend just a very brief period of time talking about some of the typical barriers that we hear from physicians about measurement and when we look at a measure for instance, if we had a measure, hemoglobin A1c less than 7, you know, physicians immediately say, well, I don't want to be measured on that because, you know, my patients are sicker and I really don't have control over the patient to get them all under 7 and those kind of responses are fairly typical so there are few common concerns that I'd like to address right at the outset.

The first one is my patients are sicker. Most physicians when they say that really don't have any quantitative evidence for that. In other words, most have not measured to know whether that is actually true or not. It’s just sort of a defensive statement so if they are actually measuring and have comparison

data to other practices that might be a true statement but most people that say that don't know that.

The next one is whenever we talk about a measure, let's stick with the hemoglobin A1c less than 7, physicians tend to focus on their most difficult management patient, the one that doesn't follow directions, doesn't take the pills, can't afford the pills, doesn't exercise, you know, all that kind of stuff, when, in fact, if you have enough patients, for instance, with diabetes, the likelihood is that some of them are going to do just fine without your help.

Some of them are not going to do well no matter who is taking care of them and then there is the bell-shape curve in the middle that you have some effect on by the things that you do, so if you think about almost any patient population that's large enough, it should be a bell-shape curve. They all won't look like your worse management nightmare.

The next one is that the right answer for measurement should be 100%. You know, we're are all good test takers and testing and measurement in the past has always been about, well, how do I get 100% or how do I get the highest possible grade.

But there are measures like the hemoglobin A1c less than 7 where the right answer is probably not 100%, more likely somewhere around 50, 60% of patients with diabetes could probably be managed to that level safely and it probably shouldn't be 100%, so we don't want to make measurements so easy that everybody can get the right answer at 100% because then the measure wouldn't be helpful, so try to appreciate the fact that we're measuring to try to understand what's happening in the patient population not for individual patient.

Physicians like to have lots of exclusion criteria so that everyone can score well on the measures and it is similar to the idea of 100% is not the right answer. We really don't have to exclude a lot of people if we can understand what causes some to do well and what causes others not to do well.

Let's move on to Slide 17.

Michael O'Dell: Okay, now one of the things that helps your team and you as well drive toward improvement is goal setting. I think most of us understand goals but I think the problem that many of us have is we set a grand hill as the goal which is good. You need some things that will definitely stretch you to improve your performance.

Goals should certainly support that big picture, but you've got to have enough focus to accomplish those goals, so it's real important to have the goals fairly well defined and that's another thing that I think PQRI as well as the physician consortium on practice improvement have done. They hope you have a very targeted measure that you're going to use and then once you get your baseline data you can set up some very targeted goals to focus on and your goals should be doable.

They shouldn't be doable by just doing the same thing you've always been doing because you can - here all of us want to improve and frankly most of us have plenty of room to do that - so you really want to have a goal that is bit of a stretch but is one you can accomplish, nonetheless.

It is helpful to create a dashboard of those measures and how you're progressing. One of the tricks I think or it is not only a trick, it is human nature, is that we all like to see how we're progressing down whatever road we're driving down. I don't care if that's in your car, in your life, or how

you're taking care of patients. You want to say well I'm progressing towards something that I really do want to accomplish.

We use run charts and story boards in my practice. These are posted monthly on our diabetes data. People look forward to seeing those. We celebrate them when we see that we've improved and we get very busy when we see something we haven't improved in and we want to improve in so that public posting, public and sense of your staff although you may certainly want to share it with your patients as well.

Our patients like to see that we're actually driving down this path and we're delivering high-quality care so that might be a bit of a stretch for some people right now but at least it's at your office. Go ahead and share that data widely. Let people know where you are on this path. Story board and frequent communications really help.

Bruce Bagley: I'll talk about Slide 18 it says - kind of the first step in PQRI or actually in any improvement activity is to choose your measures wisely. If you focus on the PQRI program, you really are only required to submit three measures and for family physicians, it would make sense if all three of those measures applied to the same denominator.

So the only condition that has three measures for the same condition is diabetes in the current PQRI program. If you select those three measures, you could then have a relatively limited, relatively small denominator that is easy to manage. So even though you might have 2,000 or 2500 patients in your practice, sometimes even more, a relatively small number of those patients will be Medicare patients with diabetes. It might be 50, 60, 70. It is probably not going to be 300.

So keep in mind that you're selecting these measures for a defined denominator; that is, all patients with diabetes who have Medicare insurance.

Ideally these measures should help you do the care, so it’s not additional work. We mentioned that before and they should be the kind of things you'd want to know anywhere - anyway and the data can be collected prospectively as we've said before with flow sheets.

The next slide, Slide Number 19, we're going to get into some of the new options now for the PQRI program, so there are a number of ways to report the PQRI measures. The original one is the 80% of claims for a condition are accompanied by a quality code so this would be the way the program was structured initially in 2007 and 2008 up until the recent changes so that if you had 100% patient with diabetes that you billed for - billed Medicare within a given year that 80% of those patients would have three measures reported as being accomplished. That's basically what that means.

There are a couple of new features of PQRI that start today, July 1, and one is that you can have 15 consecutive patients with a particular condition that you report on. The 30 consecutive patients has to do with the 12-month reporting period, 15 consecutive patients with a 6-month reporting period.

This year for the first time you can have two possible reporting periods, one would be for the full year of 2008 from January 1 to December 31 or you can begin July 1 and finish up December 31. Obviously if you did 6 months only then the 1.5% would be on physician's fee schedule billings for the second half of the year only not for the entire year.

Some people have a registry option available to you so if you have been working with a large group or an organization or a disease registry like for

instance, DocSite, or one of those that actually has collected the information that's required to report CMS measures, then you may be able to retrospectively report that through the registry for the entire year of 2008 assuming that you were participating in the registry from the beginning of the year. We will talk a little bit more about that in the minute.

On Slide 20 I just wanted to review. Most of you I'm sure at least know what a registry is. But a registry is simply a list of all the patients with a particular condition so back to our example of diabetes.

So a registry for diabetes would have on it a list of all of the patients in your practice who have diabetes and you can establish this list fairly easily using your billing system to get you started and then you and your office staff can add anybody that comes through the office with a diagnosis of diabetes that is not currently on the registry.

You don't have to have 100% of the names right from the opening gun but you can build this registry and the registry also has all the things on it that a diabetic patient should have. So if you think about a spreadsheet, it would have the names of the patient down the left side and each column would be whether they had, for instance, hemoglobin A1c done, what was the level of that, hemoglobin A1c, when was it actually tested, LDL level, foot exam, eye exam, are they on an ACE inhibitor, are they on an aspirin, have they had a Microalbumin, all that kind of stuff so that the result is that once you begin to fill out this spreadsheet or this chart, you can see where the gaps in care are.

So the only things that are on that registry are things that are evidence based indicated for patients with diabetes, so if there is something on the chart that's not been done, you can begin to proactively to make sure that those things are done either at the time of a visit or actually in between visits as well.

So that's really what a registry is. It allows you to keep track of individual patients and the population of patients and make sure that all the people on the list get the evidence base indicated care.

Registries can be a number of different types. Certainly there are handwritten registries, but this is a little bit cumbersome, especially if you get a much larger population of patients.

Spreadsheets as I mentioned can be used and certainly there are a lot of electronic registries available.

I think on Slide Number 22 we have a Web link to the California Health Care Foundation which has a wonderful section on their Web site about registries in general and also a catalog of available registries.

Mike, did you want to mention something about the COMMAND registry that you've used and how that's helped you out.

Michael O'Dell: There is actually a couple of registries that are free that I'm aware of and I think the California Health Care Foundation Web site is a wonderful one to look further, but there are two.

There is (T-downs) which is a registry I believe originated up in Washington in the State of Washington and then Command which is actually a registry that originated here. Both of these were actually funded by Center for Medicare and Medicare Services and our wonderful tools that are available for free.

So, you know, if go to the Web site and just download the tool, it is something you can get for free and you can start getting experienced with the Web site or with the registry. They're very useful.

A word of caution on both - if you're already engaged with electronic health record, obviously you would like to be able to pull data over from your electronic health record. That might take some extra programming and other things to get that accomplished.

If you are using electronic health records, obviously the best thing to do is see if you can get a registry that is actually built into your electronic health record before you buy it.

I know the academy is doing a lot of work trying to make certain that all the major vendors have that option

Bruce Bagley: Good point, Mike.

And we're trying to get everybody to embed these kind of quality measures in the EMR products as they build them.

Let's move on to Slide Number 23. We're going to get down to some very specific recommendations about PQRI and 2008 because there have been a few very important changes.

The first thing we'd like to point out is that you can report for an entire year a single measure for some patients. In other words, some of the measures are designed to be so that the reporting requirement is only once per year and an example might be that they had a flu vaccine or a Pneumovax or a fall risk assessment.

Those are a couple of examples. When I went through the list I found 31 measures that could be reported once a year that would be typical for family physicians to be seeing in their practice so theoretically you could go back through possibly using your billing system to determine which patients were in and make sure that those patients had a report for instance that they had a flu vaccine or Pneumovax or those type of things.

I don't believe that CMS has posted a separate list of measures that only need reporting once a year, but we can ask Dr. Michael Rapp that at the end when we have the question-and-answer period.

You need a systematic way to identify those patients when they come in so you can report them. Unfortunately the system does not allow you to report retrospectively. In other words, if you saw a Medicaid patient - I'm sorry Medicare patient back in February and you want to go back and report that you did fall risk assessment and that patient doesn't come in for the rest of the year, that won't be one that will qualify.

The next slide, Slide Number 24 talks about measure groups. Another new feature of the PQRI program is that there are groups of measures. Initially we just had groups for diabetes and cardiovascular disease, but I believe that as CMS moves forward, the proposed rule for next year will be to include a number of other disease related groups that may be helpful in term of reporting these measures.

Slide Number 25 is sort of a reporting options overview. I mentioned before there are two reporting periods either the 12 month or 6 month and there are 9 different ways to report PQRI measures and we’re going to try to go through those.

There are three claims based ways to report the measures and there are 6 registry based ways. Now this information was covered on the CMS calls about the PQRI program and so I'm going to go through this fairly briefly and for more details those of you who have seen or listened to the CMS calls will recognize these slides because they're borrowed from that and we might use them during the question-and-answer period to help illustrate some of the different reporting options.

So on Slide Number 26, if you choose the claim base reporting option you can follow this algorithm down. This talks about if you have less than three measures that apply and for family physicians that's probably not an option because for most of us there are plenty of measures for family practice or primary care.

So you're probably in the three or more measures that apply. You choose the 6 or 12 month period and you report on 80% of those patients for the 12-month period and you would have really had to start back in January or February to accomplish that or by selecting measures that only require a single report once a year, you might be able to accomplish that depending on your patient mix.

The other option is to report for 6 months and you can report on 80% of eligible patients from today forward to the end of the year. You obviously would have to get started and get going probably before the end of this month otherwise you wouldn't be able to be reporting 80% just mathematically it gets difficult to do.

The other way is to do 100% of 15 consecutive eligible patients anytime within the next 6 months and that leaves you an option if you don't get started until later in the year.

The next slide, Slide Number 27 talks about registry based options and I'm not certain how many family physicians are already participating in a registry but this clearly is an option if you're in a large group, if you're already been using registry as we mentioned earlier or if you have been reporting to some state agency or some other group that's been helping with diabetes improvement.

So the options are to once again submit data on 80% of eligible patients on three measures very similar to the claims based reporting and this information would just come out of the registry.

The advantage of this method is that they don't have to be submitted at the exact same time at the claim which is a limitation of the claim base reporting so this registry option allows you to submit the data separate from the claims which is a nice feature.

The next - the other option is to chose the measures groups that we talked about and the 30 consecutive eligible patients within 12 months and, of course, if you had enough patients coming through with a specific diagnosis you could do that some time within the next 6 months even though you’re starting late so another opportunity to participate in a way that we couldn't participate before.

And you could also use 15 consecutive patients but then you'll be qualifying for only the last half of the year for the 1.5% bonus.

Let's move on to Slide 28. This is kind of the same information just divided up into the 6 and 12 month reporting period. I don't think I'll go through this one in detail unless we want to use it to illustrate some answers to questions later, but this is for your information.

On Slide 29 the - it is just a reiteration of the three claim base option, January 1 through December 31 the full year and the half year that we mentioned before.

So Slide Number 30, we thought it would be important just to reiterate what some of the steps would be for PQRI success and we'll finish up very shortly and so we can have a good amount of time for question and answer.

Step 1 would be to select the measure option that you want to use and at the same time select the proper measures that will make that work well for you.

The second step is to use some kind of a data collection flow sheet or if you are in an EHR environment then you may want to prepare or modify a template to make sure that it has the correct data on it to be used for data extraction.

Step 3 would be to somehow attach a copy of the flow sheet or the quality data to the super bill if you're in a paper environment or make sure that the template in the EHR is easily accessible to the coder when he or she is putting those codes in.

Step 4 is probably the most important and that is that the coders must be alerted to the condition that you're working on, so if it is diabetes they should know that they need to have a code - a CPT II Code accompany every single claim that they turn in for diabetes with an ICD9 of 250 so it's something that

they can do right at their time of entry that they can be constantly looking for the quality codes to go along with the conditions you've selected or the measures you've selected.

Step 5 would be sure that you include the unique initial patient identifier number, the NPI for each provider. The PQRI program from its inception has always required that the data comes back on physician's specific information or provider's specific information. The bonus payments go back to the Tax ID but the quality data are reported by the NPI so it has to be part of the claim.

Step 6 and I'll talk a little more about this later, is to have someone in your office analyze the data so that as the coder puts in the data, they should be somehow reporting or saving that information so that it could be looked at collectively and we'll talk a little bit more about that in a minute.

And the other one that a lot of people forget about and that is to look for - Step 7, look for other opportunities in your community and your market that might provide bonus payments for the same kind of work so if there is a health plan or some other activity that is going on that recognizes quality improvement work make sure that you use the same work that you're doing to participate in that.

And also for family physicians, this can be combined with our metric program at the academy to help with maintenance of certification Part 4 especially if you combine this activity under the condition of diabetes with a metric diabetes module, great opportunity to synergize this improvement work.

Slide Number 31 reiterates the coder as the key link in the chain so if the coder knows exactly what you're doing, they can be alert to look for the

quality data when ever the diagnosis code comes through and to keep that log of the quality improvement information.

Slide 32 points out a very important point. If you're engaging in quality improvement work, you don't want to wait for Medicare to send you a report before you act on that. It’s just going to be way too for in the future for it to have any meaningful feedback, so there ought to be some way to look at your data and to sort of see how you’re doing with time so you can begin to look at improvements.

As Dr. O'Dell said it is just really a question of interventions and trying to see if it gets you better results or not and you can't tell that if you don't have the feedback.

Medicare will send a report out for the 2008 program halfway through the year in 2009 so you're going to be a whole another half year in the reporting and not know how you're doing unless you analyze some of your own data, so put systems in place that help your practice succeed and do better.

Finally on Slide 33 once again just to reiterate make sure you enlist the entire office team so that everybody has part of this. I mentioned earlier that this is paper reporting not paper performance. In the future I suspect and Dr. Rapp could probably comment when and will it turn to paper performance in the sense of expecting certain targets level of performance, but right now it’s paper reporting.

Make sure that specific roles and responsibilities are assigned to the team members and use the tools that Dr. O'Dell talked about fo a systematic approach. By having a standardized flow sheet, data collection tools and an expectation that we are always going to use these when people with a chronic

illness come through, can certainly increase your chances of doing the right thing for the right patient at the right time every time.

Monitoring your progress through measurement is the only way to know how you are doing. I just don't think you can tell how you're doing unless you are measuring something, so we are just trying to get you to use this program and peak your eye to begin a much wider range of measurement activity.

Submit the quality CPT II Codes at the same time as the billing per patient. That's absolutely essential. CMS will not accept a bill that has been sent in after the time of service has been billed. In other words, if you send in a bill for payment and then send in a separate bill two months later with just the CPT Code on it, that cannot be accepted for this program.

On Slide Number 34 we've already talk about some useful tools, just a reminder to keep a positive attitude about measurement improvement.

We really would like to have this in the context of better patient care and not just an additional burden. We really think it will provide better care.

On Slide Number 35 is an example of a couple - this is one article that appeared in family practice management. This one's actually July and August of 2006 about the overall idea of measuring your practice. You might find that to be very helpful.

And the next slide, an article it was actually written last year for the PQRI program but for the most part still applies. It gives some tools in there for data collection, some ideas for office flow and team work that we talked about today.

So Slide Number 37 just kinds of reiterates some of our conclusions that PQRI is not just a stand-alone program. It's really a sign that the medical care and the payment environment is really going to change for physicians in this direction so that we will be required to submit quality data probably more as a sign that we're doing quality improvement work rather than just a requirement to show we're doing a good job. I think it is a whole different mindset and having a positive attitude about quality improvement is absolutely required.

I really think that we're going to begin to see employers and health plans using their administrative data to do some of this work in addition to requiring in the future some reporting from the clinical record either directly as in PQRI or through electronic medical records, so PQRI participation is an easy way to get started.

So I think that's really our theme today and try to use your energy and resources to install processes and systems that really help you do a better job and use them on all your patients not just your Medicare patients.

So I think with that we'll go to some questions, but before I do that I want to reiterate. We have developed a survey about your PQRI participation and that can be found at www.aafp.org/surv6/PQRI.htm and if you'll try to access that survey during the question and answer, that would be great so that if anybody is having any trouble, we can help you to get on to that survey.

So before we open up the questions, Dr. Rapp, did you have any particular additional things you would like to add or comments you would like to make.

Michael Rapp: Well not particularly, Dr. Bagley.

I think, first of all, I want to thank you for going through this information. As I mentioned at the beginning, the participation of family physicians is very important to us and I congratulate you on going through a very nice presentation and hopefully bringing it home to the family physicians.

First of all, you mentioned the purpose for PQRI which is, of course, associated with incentive, financial incentive for participation, but the basic thrust of this whole program both from your perspective and our perspective is about quality improvement and assessing the care that is provided to Medicare beneficiaries.

So I think what we'll do as we go through the questions if there is some details and some specifics and some technicalities about how the reporting works in the program, we will weigh in there, but thank you.

Bruce Bagley: Make sure you keep us honest too.

You know, if we said anything that didn't sound right make sure you hold us - you hold our feet to the fire.

Michael Rapp: Well, sometimes the program can be a little complicated but I want to say you definitely have it down so you understand it very well.

Bruce Bagley: Okay, let's open it up for questions.

Tressa Mundell: Great, (Mindy), we're now ready to go into our Q&A session.

If you could please remind the participants on how to enter the queue to ask their questions and as for the participants once you get online if you could

please state your name and the organization or association that you are representing for.

(Mindy).

Operator: At this time I would like to remind everyone, if you would like to ask a question, press star then the number 1 on your telephone keypad.

Your first question comes from (Melanie Hayes). Your line is open.

(Melanie Hayes): Yes, I have a question about the 15 consecutive patients for the July 1 through December 31 timeframe versus 30 consecutive patients.

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If we are just now ready to start doing that submission, can we submit 30 consecutive patients and be eligible for reimbursement for the entire year or is it just...

Man: I'm going to...

(Melanie Hayes): past July 1.

Bruce Bagley: I'll take a crack at that and if Mike Rapp doesn't agree he'll chime in, but if you have a way to make sure that you get the 30 consecutive patients and you have at least 30 patients let's say with diabetes coming in between now and the end of the year which shouldn't be too hard and you get them consecutively on a systematic way to make sure that happens then you should be able to get the reimbursement, the enhanced payment for the entire year.

If you only do 15 consecutive patients in the last half of the year then it would be for half of the year.

Is that correct, Mike?

Michael Rapp: I'm going to let Dr. (Daniel Green) add to this but you're correct if one uses registries, but for the claims based submission of consecutive patients for measures groups, there is only - the only reporting period available is the second half of the year which is starting as you say today.

So for the measures groups reporting using the claim base process, the requirement is to report 15 consecutive patients or 80% of all of the patients for that 6 months. If a family physician is interested in reporting measures groups at that - the incentive payment for the entire year would be applicable then the only way that that could be done for 2008 would be using a registry.

And the reason for this is not just a technical difference, but we have implemented the measure groups for 2008 based on statutory requirement that was passed in December, so it wasn't feasible and practical really to implement any other way than just half of the year and in particular because on the claims base process, it requires the notice to start the 15 consecutive patients with the G Code and that wasn't available until July, so we didn't have a practical way to implement more than 15 - more than half of the year using the claim base process.

We did recently publish yesterday the proposed rule for 2009 and for 2009 one would be able to do it for the whole year using claims because, of course, the mechanics are available.

Bruce Bagley: Good, thanks for that clarification.

By the way, those of you who are viewing the slides on the PowerPoint if you have the PowerPoint open you can just push 26 on the numbers and enter and it will take you to Slide 26 which is a nice diagram of how this work.

Let's take the next question.

Operator: Your next question comes from (Theresa Minkon).

Your line is open.

(Theresa Minkon): Hi, thank you, yes, this is (Theresa Minkon) from Northwest Hospital in Seattle and my question was actually pretty much the same as the last one.

I just want to verify. I have a group that is starting the measures group reporting today and I want to let them know their incentives payment will be based only on those themes from today through the end of the year, correct

Bruce Bagley: That's correct.

(Theresa Minkon): Okay, that's just what I wanted to let them know. Thank you so much

Bruce Bagley: And you're going to try to do the 80% between now and the end of the year

(Theresa Minkon): I think they're going to shoot for the 15 and then since they only have that one, they will continue doing it through the end of the year just to make sure they get 80.

Bruce Bagley: Great, good strategy because if you miss one of the patients in the consecutive list, you're out.

(Theresa Minkon): Yeah, yeah, so I'm just going to advise them to keep going.

Bruce Bagley: Just because it’s the right thing to do.

(Theresa Minkon): Yes, exactly thank you so much.

Bruce Bagley: Okay, all right.

Bruce Bagley: That really goes back to some comments about systematic as well even though this is designed for Medicare patients, it is applicable to all of our patients so personally I think it's been true for most people who implemented this who feel that you’re going to do it for your Medicare patients, you really ought to do it for all of your patients. That helps you from a variety of ways. Number 1 you aren't running two systems.

Anytime you run two systems you end up with errors being made, but Number 2 it enhances the quality of all of your practice

Michael O’Dell: Right, and, of course, you wouldn't have to report - that part of it wouldn't be required for your non-Medicare patients.

Bruce Bagley: That's true. That's true. You actually wouldn't report a non-Medicare patient.

Bruce Bagley: Okay, next question, please.

Operator: Our next question comes from (Barbara Maystrak). The line is open.

Woman: Hi, this is Dr. (Stacy Yasmin) and (Lee Lamberg) from Holy Cross Medical Group in Fort Lauderdale.

We had a question in regards to the three measures that we're to be recording. Now does this three measures have to be under the same diagnosis code diabetes or cardiovascular disease or osteoporosis?

Dan Green: No, they actually do not have to be under the same diagnosis...

Woman: I'm sorry can you repeat that again? I need to put you back on the speaker phone.

Dan Green: That's fine.

They actually do not have to be under the same diagnosis. That does make it easier, but it can be - you can have a measure on heart failure. You can have a measure on diabetes and you can have a measure on hypertension so it just makes it a little bit harder to keep track of but you certainly can do that.

For people that are just starting this, we would not necessarily recommend that you do measures that require the entire Medicare population because the reporting burden is a little bit higher.

In other words I wouldn't necessarily start with fall risk assessment because you immediately have to add these codes to every single Medicare patient that you bill for. So although if you have a systematic way to do that, it is not very hard, but it is a whole lot larger denominator than a measure like diabetes, hemoglobin A1c, but certainly you can collect measures from any one of the 117 available measures.

Woman: If we choose osteoporosis do we have to report it every single time the patient comes in or once a year?

Dan Green: That one is for once a year.

Woman: How do we know which one is once a year?

Dan Green: Well, by looking at the measure specifications, that is usually pretty easy to tell so it will say within the last year has the patient had osteoporosis screening.

Woman: Oh, okay.

Man: So it will be pretty obvious from how the measure is spelled out.

Woman: So how do - when do we get paid for like 2007 because I know I was doing it really religiously for osteoporosis and diabetes in 2007 and then kind of just lately I went a little bit more relaxed about it, but when are we going to here a feedback for 2007?

Bruce Bagley: Well, two parts to that answer. The first is that Medicare expects to have checks coming out within this month or later in July and Mike may have better information, but I think it is supposed to be by the end of the month and along with that will come information on your performance.

Now as I mentioned during the talk, I think it is extremely important that you have some way to monitor how you're doing that is separate from waiting for your Medicare report.

Because if you're kind of fallen off on your performance because you're not paying as much attention as you were, then by the time it comes time for the performance report from Medicare it might be too late to do something about it so it kind of has to be internal quality improvement with external reporting.

Let's take the next question.

Operator: Your next question comes from (Ann Cook). The line is open.

(Janice Lee): Hi, this is (Janice Lee) from Bethlehem Family Practice in upstate New York. I actually have three questions and after this last question, I have a fourth question.

Tressa Mundell: (Janice), we cannot hear you.

Can you speak up?

(Janice Lee): This is (Janice) from Bethlehem Family Practice in upstate New York and I actually have three questions, but I want to ask something about the last question that was asked.

Bruce Bagley: Okay, go ahead.

(Janice Lee): Okay. When you are talking about the three measures, that's back in 2007.

If we are starting July 4 and we are using a measure group, we have to - don't we have to report everything that is within the group?

Bruce Bagley: Well there...

(Janice Lee): Diabetes mellitus and my providers have to report hemoglobin, cholesterol, blood pressure, eye exam and Micro albumin, right?

Bruce Bagley: That's if they choose to submit the data in the measures group.

Now that would be - if you go to Slide 27 that would be a registry based report.

(Janice Lee): That's not how I understood it. I thought that that was.

Bruce Bagley: Well...

(Janice Lee): If we're not doing registry base then our providers have to do just the individual measures?

Bruce Bagley: That's right.

(Janice Lee): And not to a group.

Bruce Bagley: The three - and I'll ask Mike to make sure that we're on the right track here - but for the claims based reporting options that would be Slide Number 26.

(Janice Lee): Yes.

Bruce Bagley: And you have three or more measures that apply and you are in the 6 month group. There are only two ways to do it. One is it the 80% of the eligible patients for the rest of the year or the 15 consecutive eligible patients.

(Janice Lee): Upon three individual measures?

Bruce Bagley: Correct.

(Janice Lee): Okay, I misunderstood that.

Bruce Bagley: Let's go over the diagram.

This - I'm going to ask Dr. (Green) to go over it, the algorithm.

Michale O'Dell: And is this pertaining to Slide 26 so people can focus?

(Daniel Green): Yes, Slide 26.

First of all, (Janice), you bring up a good point.

On several of the national provider call we've had questions. There seems to be some confusion. For practices that are currently participating using claims, in other words like they participated in 2007, they don't need to do anything else except to continue to report on the three measures they were originally reporting. I wanted to make that point because some folks think they need to now change because we've added different options that people can choose to report.

These are additional options, but you don't have to choose one of these if you are already reporting using the three measures through claims again as you did in 2007.

However, if you want to start reporting now using claims in 2008 but you have not yet begun, so in other words, you're looking at the July 1 through the December 31 reporting period and again using claims, on Slides 26, you can see that three or more measures apply which would be true for most family practitioners so you can choose to report a measures group for 6 months. Do you see the box down there that says 7-1-08 through 12-1-38 - through 12-31-08, excuse me.

So you can either report 15 consecutive patients from a measures group like the diabetes or preventive care or you can report on 80% of the patients that would fall within that measure's group.

So in other words 80% of your diabetic's patient will have the appropriate CPT and ICD9 Code, so again, you are correct. You'd have to report and in the example you gave there are 5 measures so you would have to report all of the applicable measure for that particular patient and the age range for that is 18 to 75 so basically if one measure applies in that group, all five measures are going to apply for that group.

It is different in the preventive group where you see that some patients - I'm sorry, some measures only apply to men and others apply - I'm sorry, let me re-focus. All of the measures apply to woman, but only some apply to men. In other words you certainly wouldn't have to do a mammography on a man.

(Janice Lee): Okay.

Dan Green: I got tongue-tied there, sorry.

Bruce Bagley: So just to reemphasize that this Slide 26 is about claims base reporting so it shows that basically there are two reporting periods. The entire year 12 months which is the two left-hand sets of options and then there is the 6-month reporting option, so as I previously indicated for the 6-month reporting option that only applies to July through December 31, the only way you can report on claims for that 6 months reporting option is measures groups and those measures groups would be reported on 15 consecutive patients or 80% of patients for that measures group.

(Janice Lee): Okay.

Bruce Bagley: Now for the entire year program for those people as Dr. (Green) indicated that started in the beginning of the year that can report three measures for the entire year; that is, individual measure, they don't have to be part of the measure group and if one is reporting that way, there is no particular reason - and there is really no reason to switch to the measures group.

As a matter of fact, if you switch to the measures group and then you reported 15 measures, 15 consecutive patients and stopped, and you might qualify for that second half of the year, you would qualify for the second half of the year, but you would have given up on the work that occurred in the first half of the year because now you probably won't get 80% for the whole year.

So it is better if one is doing something already to stick with it, but really the new option is very attractive for those who, well, they haven't been participating in PQRI but they would like to start with only reporting 15 consecutive patients, they would be able to get the 1 and 1/2% incentive for the second half of the year, but again it has to be on measures group which is more than three measures. It is five in general.

Dan Green: And if you look at Slide 28 that will break it down by reporting period so again if you haven't been reporting for the 12 months and you want to start reporting today basically or in the 6-month reporting period, you could see your options that are spelled out for you that way.

(Janice Lee): Thanks.

My next question was about the consecutiveness of our billing and we wondered about how - how Medicare was going to determine whether those -

the claims were consecutive or not if say you had to hold a claim before, you know, posting it just for audit purposes or completion purposes.

Will it still be considered consecutive if it comes in after, you know, another consecutive claim? Do you know what I'm saying? We're having questions about the billing date whether it's...

Dan Green: The consecutive date -I'm sorry, the consecutive sequence is determined by the date of service for the patient.

(Janice Lee): Okay.

Dan Green: So even if you hold it for 6 months, but the date of service for that patient fell on the 15 consecutive time period, you'd be okay again as long as all claims are submitted by February 28 of 2009

(Janice Lee): Okay, that's what I wanted to know.

And Question Number 3 is, you know, in the definitions of all of these measures, they talk about reporting the measures in the reporting period.

And if we're starting on July 1, 2008, what is that reporting period?

Is it 6 - is it 12 months or is it 6 months or is it like - if I tell my providers that they need to report hemoglobin A1c, if the patient comes in tomorrow and there was a hemoglobin done in March, is that an acceptable hemoglobin to report?

Dan Green: It is because the patient was seen within the reporting period so the patient qualifies based on that and I believe the measure says that within the past 12 months the hemoglobin A1c was whatever it was.

(Janice Lee): Okay, so the reporting period still remains the 12-month period of time.

Dan Green: No, no, no. The reporting period is the 6-month time period for which the patient was actually seen. That particular measure that you gave us an example that is to say that the hemoglobin A1c was done within the past 12 months that really doesn't have to do anything with the reporting period.

Bruce Bagley: And keep in mind - this is Bruce again - keep in mind that if you did not do the hemoglobin A1c within the last 12 months and you just submit the code that said it wasn't done and you've turned in a quality code even though you didn't do it and you - that gets you credit.

(Janice Lee): Okay, yeah.

Dan Green: Yeah.

(Janice Lee): And the other question my provider asked today is can you count one patient more than once in your 15 consecutive visits?

You know, if a patient is uncontrolled diabetic and they come in tomorrow and then the doctor asks them to come back in two or three weeks and they are still - they haven't met their 15 consecutive patients, can you report that patient again?

Dan Green: You can continue to report on that particular patient but it would not count.

(Janice Lee): Okay.

Dan Green: As an additional patient.

(Janice Lee): All right, great, thank you very much.

Dan Green: Thank you.

Operator: Our next question comes from (Lisa Arbanski). Your line is open.

(Lisa Arbanski): Hello, my name is (Lisa) and I'm calling from Dr.'s (Coster), (Meyer), (Chung) and (Garcia) in Dallas, Texas and my question is regarding, for example, measure number 1 and...

Bruce Bagley: What's measure number 1 for everybody's...

(Lisa Arbanski): Okay, it is hemoglobin A1c.

Bruce Bagley: Okay.

(Lisa Arbanski): And we're doing the single measures and I know that this one falls within a group, but it is required to be reported once.

Is that okay to do?

Bruce Bagley: Well, have you been doing it since the beginning of the year?

(Lisa Arbanski): I have since '07.

Bruce Bagley: Yes, right, then you can keep going. What are your other two measures?

(Lisa Arbanski): Orally I have one doctor that is doing four and one that is it doing seven.

We are doing the fall, the number 39 which is screening for osteoporosis and we're also doing number, I'm sorry, I'm going through my book, number 3 which is high blood pressure control in Type I and Type II diabetes.

And we're doing Number 41 osteoporosis for a pharmacologic therapy and then I have another doctor that is doing number 111, pneumonia vaccination.

Bruce Bagley: That's great. It sounds like you guys are really into measurement.

It does bring up a point though. Some people think that if they were doing 10 measures that their chances of getting to 80% on any one measure is greater than if they are only doing three and I would say that's probably a dangerous idea in the sense that to do the three measures but do them systematically so that they get done every single time is more likely that you get the 80% level.

So even if you are doing 10 measures, you need to have some kind of systematic strategy to make sure those happen every time and not just try harder to work on all 10 of those things.

(Lisa Arbanski): And we do. We do have a system.

Bruce Bagley: Perfect.

(Lisa Arbanski): What I don't understand is the reporting when the patient does not qualify. For instance on measure number 1, what if I have a patient that is on Medicare but does not have diabetes.

Bruce Bagley: Well then you wouldn't report the diabetes measure, but you might report the osteoporosis screening measure on that patient.

(Lisa Arbanski): Okay, so that part I'm doing right.

Bruce Bagley: Right, for instance if any patient comes in with - for osteoporosis screening, now I believe that that's all female Medicare patients up until what age, Mike?

Dan Green: Oh, I'm blocking right now, 75.

(Lisa Arbanski): It is just a single patient say 65 older.

Bruce Bagley: So once you send in a quality code, every single woman who was Medicare insurance becomes a denominator.

(Lisa Arbanski): Right.

Bruce Bagley: As soon as you send in the first one.

(Lisa Arbanski): Okay.

Bruce Bagley: Does that make sense?

(Lisa Arbanski): Yes, so I am doing it right.

Bruce Bagley: Yes.

(Lisa Arbanski): However, we - like on measure number 1 which is hemoglobin we do have patients that return and they already - I've already reported.

Do I need to do anything the second time?

Bruce Bagley: You don't have to report the second time, but the trouble with that is that you may not have a way to remember whether you report it or not.

(Lisa Arbanski): Oh, we do. We're keeping track.

Bruce Bagley: All right, so you know you reported and the patient comes in again and you've already reported on a measure that only requires one report for year then you don't need to report a second time but that requires that you know whether you reported or not.

(Lisa Arbanski): Yes, okay, so I feel like we're doing it correctly.

Bruce Bagley: It sounds like you are doing great. I hope everybody else is listening to your story. This is great.

(Lisa Arbanski): The only other question I have is the doctors are asking about feedback for 2007 and I did hear you say that we should get a response by the end of July?

Bruce Bagley: Yeah, Mike do you want to just clarify that because we're running out of time why don't you just tell what you expect to happen, Mike Rapp that is, in terms of the payment in the reports and before I turn over to Mike, I just want to reiterate you really need to be looking at your own data.

(Lisa Arbanski): Yes.

Dan Green: To get it back in a timely basis. Medicare is just not - as currently structured able to get it back to you in a very short period of time.

(Lisa Arbanski): Yes.

Tressa Mundell: Dr. Rapp had to step away but Dr. (Green) is here.

Man: Perfect, thanks.

(Daniel Green): Thank you.

Well we hope to have the payments in the mail starting around July 15. I hope to have all of them out by the end of the month, certainly no later than the first weekend in August.

With respect to the feedback reports, providers will be able to - they will need to actually register it is call an IACS account on the Web and they will need to access their feedback reports that way. There will be more detailed instructions on how they can obtain IACS access, pardon me, repetition there.

But in any case that will be posted on our Web site. We expect that providers wills be able to get access for these instructions as well as the access to the feedback report should also be available later in July. We believe some time after July 10 but we are working through that currently.

Bruce Bagley: Yeah, this is Bruce Bagley again.

I'd like to at this point of the call, call the call to a close, but I want to again mention the CMS Web site. There is a wonderful area Web site under PQRI with frequently asked questions and that's been a great way to get some of the straightforward typical questions answered.

So if you have not had a chance to look at that and you have a question, I'd start there first.

Any other comments?

Back to you, Tressa.

Tressa Mundell: Okay, (Mindy) are there any more questions?

Operator: We do have quite a few questions.

Tressa Mundell: We are near the close of our session. We will take two more questions and we will end it there.

Operator: Okay, your next question comes from (Rose Hild). Your line is open.

(Rose Hild): Thanks for taking my call. I'm calling from a medical group practice in Milwaukee, Wisconsin, and my question is when the checks are sent, will they be indicated in anyway to know that it is your PQRI bonus check?

Bruce Bagley: Dr. (Green), do you have an answer for that one?

Dan Green: When the checks are - I am not sure.

Bruce Bagley: How are they going to know it has to do with the PQRI program versus just a plain old Medicare check?

Daniel Green: That's a good question.

They will be linked to your feedback report and the feedback report will be online prior to the checks being disseminated. Feedback reports will up on line after you register for IACS account on July 10 and I know reports will have the Tax ID number and the carrier who processes the bills and the amount of the refund is for each carrier if you use more than one carrier.

So you link your check back to the information that is on the feedback report which will be out five days prior to the checks going in the mail.

Checks plan to go out July 15 through the 31.

(Rose Hild): Okay, we are registered with IACS. The key will be to look at the IACS report and know what the dollar amount is and then link that up to check; is that right?

Michael O'Dell: That sounds right.

Daniel Green: That's correct.

(Rose Hild): Thank you.

Michael O'Dell: You're welcome.

(Rose Hild): And can I ask one more quick question.

In the registry reporting it says that you can include some non-Medicare patients and I just don't understand that.

Does it mean that that if you happen to include in non-Medicare patient in your registry reporting that it wouldn't disqualify you?

Bruce Bagley: Dr. (Green), do you want to answer that one?

(Daniel Green): I'm sorry could you repeat the question, please.

(Rose Hild): In the registering reporting information, it indicates that the provider can include some non-Medicare patients and I'm just not clear on what that means.

Does it mean if you have them in your registry reporting to include some non-Medicare patients that you are not disqualified?

(Daniel Green): I'm sorry. So if you're reporting using the 15 or 30 consecutive patients option, we are accepting patients for the reporting groups that do meet the rest of the group requirements. In other words, for the diabetics, the age qualification is 18 to 75 so you could report on patients in their 20s; however, at least 2 of those 15 or 30 consecutive patients must be Medicare Part B for service patient.

So only under the registry option are we allowing patients to be reported to the registry that are non-Medicare patients. Again two of them have to be Medicare Part B for service patient.

And you might say, well, gees, what if we get 15 patients that are in their 20s, 30s and 40s before we have a Medicare patient then you would need to continue to collect patients until you at least have two Medicare B per service patients.

(Rose Hild): Okay

Bruce Bagley: You need to continue to submit that to the registry.

(Rose Hild): Okay, all right, thank you.

Bruce Bagley: Thank you.

Tressa Mundell: Thank you, that concludes the end of our Q&A session.

Now we will go to Dr. Bagley and Dr. O'Dell for their closing remarks.

Bruce Bagley: Yes, thank you very much.

And I just wanted one more reminder about the survey. It really would be very helpful to the academy and to CMS to help you complete that survey. It should only really take you 3 to 5 minutes, probably closer to 3 to give us some feedback; not so much about this particular program, but about the PQRI program in general and how your office is dealing it.

I think that's really going to be helpful to using as we begin tools to help you out and programs to make sure that this helps you do quality improvement work.

Dr. O'Dell, did you have any closing comments

Michael O'Dell: I would just like to go back to the beginning of the conference and actually say it is really about improving care for patient. This is really all about patients as it should be and second it is about the team that supports that care.

PQRI hopes it will be a good catalyst in moving forward in patient centered care and improving how we work in teams in delivering that care.

Daniel Green: Very good, thank you very much.

Tressa Mundell: On behalf of Dr. Rapp… Dr. Green?

Daniel Green: Yes, thank you Drs. Bagley and O'Dell.

We really appreciate you leading this call today and for all of your hard work with respect to PQRI. We would also like to extend our thanks to the Academy of Family Physicians for your interest in PQRI.

The questions that were asked on today's call were very good questions and important questions and we obviously noted you all are committed and we look forward to continue working with you.

So with that thank you for your interest and your help and support.

Bruce Bagley: You're welcome.

Michael O'Dell: Thank you.

Tressa Mundell: This is a reminder. There will be an audio replay of this Special Open Door forum posted to the CMS open door Web site, that's www.cms.hhs.gov/opendoorforums and you can click on the Special Open Door Forum link to access the replay of the audio.

The audio should be available July 8.

Thank you all for participating.

(Mindy), could you tell us how many joined us on the call today?

Operator: Three hundred and eighty-two.

Tressa Mundell: Thank you.

Operator: This concludes today's conference call. You may now disconnect.

END