



White Paper

How the new PQRI will affect
emergency department
provider documentation

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How the new PQRI will affect emergency department provider documentation

The Change

The Physician Quality Reporting Initiative (PQRI) program instituted by the Centers for Medicaid and Medicare Services (CMS) has received changes for the 2008 calendar year. The PQRI program replaces the Physician Voluntary Reporting Program (PVRP) and involves all emergency care providers (i.e., physician assistants and nurse practitioners), not just physicians. CMS began collecting the PQRI data on July 1, 2007. Data reporting utilizes the CMS coding and billing infrastructure through the use of CPT® Category II codes or in some instances G-codes.

Revisions have been made to both The T System® paper templates and The T SystemEV®, our electronic ED information system, to make it easier for providers to document and coders to capture all relevant PQRI data. Currently, PQRI incorporates 119 quality measures into the program. These measures are endorsed by the various quality improvement organizations, including the American Quality Alliance (AQA), National Quality Forum (NQF) and National Committee for Quality Assurance (NCQA). Eight of these measures relate directly to the practice of emergency medicine and were developed with input from ACEP and other emergency medicine professional organizations. The eight emergency medicine-related PQRI measures are:

- > Aspirin on arrival for AMI
- > ECG performed for non-traumatic chest pain
- > ECG performed for syncope
- > Vital signs for CAP
- > Assessment of oxygen saturation for CAP
- > Assessment of mental status for CAP
- > Appropriate empiric antibiotic for CAP
- > t-PA considered for ischemic stroke

Note: Additionally, maximum sterile technique for central line insertion and deep vein thrombosis prophylaxis for ischemic stroke or intracranial hemorrhage can also be applied to the ED setting, although not developed specifically for use in the ED.

PQRI vs. Core and Outpatient Quality Measures

A few of the emergency medicine-specific PQRI measures overlap with current hospital-based quality measures sponsored and/or supported by the Hospital Quality Alliance (HQA), The Joint Commission (formerly JCAHO), Agency for Healthcare Research Quality (AHRQ), National Quality Forum (NQF), CMS and other organizations involved in hospital quality oversight. The hospital-based measures that relate to inpatient care are collectively referred to as “core measures”. New in 2008 are the hospital-based outpatient quality measures. The core and outpatient quality measures will be used in the Hospital Quality Initiative (HQI) program for comparison among hospitals in the Hospital Compare program and as standards in the Joint Commission's accreditation process. Three measures common to the PQRI and core and outpatient quality measures programs are:

- › Aspirin on arrival for AMI
- › Assessment of oxygen saturation for CAP
- › Appropriate empiric antibiotic(s) for CAP

Other core and outpatient quality measures involve the ED and require data collection from the ED record, but are not currently part of the emergency medicine portion of the PQRI program. These measures include:

- › Time to ECG for chest pain of suspected cardiac origin
- › Aspirin on arrival for chest pain of suspected cardiac origin
- › Initial ECG interpretation documented for AMI
- › Beta-Blocker on arrival for AMI
- › Time to thrombolytics for AMI (30 minutes)
- › Time to PCI for AMI (90 minutes)
- › Blood culture prior to antibiotics for CAP
- › Time to initial antibiotics for CAP
- › CXR/CT findings documented for CAP
- › Pneumonia pathogen identified for CAP
- › Transfer to and from another facility documented for chest pain of suspected cardiac origin, AMI and CAP
- › Relievers (bronchodilators) administered for pediatric asthma
- › Systemic corticosteroids administered for pediatric asthma

Note: Examples of other core measures that are better addressed during the patient's hospital stay but sometimes initiated in the ED include smoking cessation advice for AMI, CAP and CHF, pneumococcal vaccine assessment/administration for CAP, and influenza vaccine assessment/administration for CAP.

The PQRI program will likely continue to expand in the coming years.

All efforts should be made to keep new changes simple and least intrusive as possible.

Why the Change?

PQRI and the PVRP program that it replaced are the first provider-focused programs instituted by CMS whose goal is to induce physicians to practice quality, evidence-based medicine in the hope that it will lead to improved patient outcomes. The PQRI program will likely continue to expand in the coming years adding new measures as they are identified and endorsed by the various quality care organizations, and possibly imposing financial penalties on providers/groups that render suboptimal care and/or fail to adequately report the required data. Emergency physicians must continue to work with CMS and other quality improvement agencies to develop measures that truly reflect the quality of care in emergency medicine and have proven beneficial effects on patient outcomes. High quality, safe, efficient and cost-effective patient care in the ED are goals of all who practice emergency medicine. The purpose of the PQRI program is to positively impact efforts in achieving this goal.

How to Participate?

Participation in the PQRI program remains voluntary in 2008, but it does offer a monetary incentive for participating providers who successfully report data per CMS guidelines. While this incentive does not alleviate the coming Physician Fee Schedule cuts, it may help offset some of the impending losses. CMS is strongly urging providers to take advantage of the voluntary period to gain understanding and experience in using and reporting with the new PQRI program. Participating providers/groups must choose at least three PQRI measures to report to CMS using appropriate CPT® Category II codes or G-codes. Providers/groups able to report data on at least 80 percent of qualified patients for each of three measures during the January 1 through December 31, 2008 reporting period will receive a financial bonus from CMS. Therefore, it would be prudent for providers/groups to report more than three measures (perhaps four or five) in the event they fall short of the 80 percent threshold on one or more of their selected measures. In determining bonus eligibility, CMS will accept the three highest compliance percentages on the measures reported.

What Should You Expect from Your Documentation Provider?

Ideally, your documentation provider should work with CMS and other organizations to better understand the documentation and reporting requirements of the PQRI program. Paper and electronic templates should be revised to make it easier for providers to document and coders to capture all relevant PQRI data. All efforts should be made to keep new changes simple and least intrusive as possible for the facility to be compliant and successful with this new quality initiative.

A T-System Approach to the PQRI Program

T-System has made appropriate modifications to each documentation solution. On The T System paper templates, a bullet now appears in front of all of the diagnoses in which PQRI and, in some cases core, and outpatient quality measures should be addressed in the Clinical Impression section. If one of these diagnoses is present, it should be circled as usual. In the Progress section of the templates that contain quality measures, T-System has added a section summarizing the quality measures that could be addressed on that particular template preceded by a bullet corresponding to the bullets found in the Clinical Impression. The quality measures that were addressed can be circled, and in the space provided the reason(s) for exclusion can be documented. By utilizing this section, providers will help data extractors/coders gather pertinent quality reporting information. Additionally, a new Quality Reporting Addendum has been updated with a comprehensive list of the new emergency medicine-related PQRI measures, core measures, and the new hospital outpatient quality measures. This addendum includes in some cases the accepted reasons why a patient was not eligible to receive a recommended test or therapy, and sufficient space to document the reasons for exclusion or delays in treatment. This sheet can be completed by the provider or posted in/near the provider work area for quick reference. Clients using The T SystemEV will receive prompts or reminders when certain quality/compliance measures exist and must be addressed.

Summary

Facilities and physician groups are well-advised to familiarize themselves with the PQRI program, including its 2008 modifications, and take the necessary steps toward participating as early as possible. This includes consulting with your documentation provider to assess their modification intentions as to the PQRI program and make sure their goals regarding the initiative align with yours.

For questions regarding this white paper or the PQRI program, please e-mail T-System at PQRI@tssystem.com. Additionally, for detailed information about the PQRI program and its measures, you can also visit the CMS website at www.cms.hhs.gov/PQRI/.