The Quality Payment Program and Diabetes Care

How Diabetes Care can help you meet the 2017 Quality Payment Program Requirements.

This document reflects three of the Quality Payment Program Performance Categories, Quality , Improvement Activities, and Advancing Care Information and how they relate to diabetes care

Quality Measures

Measure Name	Measure Description	Quality ID	NQS Domain	Measure Type	High Priority Measure	Data Submission Method	Specialty
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	1	Effective Clinical Care	Intermediate Outcome	Yes	Claims,CMS Web Interface, EHR,Registry	Internal Medicine, Preventive Medicine, General Practice/Family Medicine
Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	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	18	Effective Clinical Care	Process	No	EHR	Ophthalmology
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	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 mellitus regarding the findings of the macular or fundus exam at least once within 12 months	19	Communication and Care Coordination	Process	Yes	Claims,EHR, Registry	Ophthalmology
Diabetes: Eye Exam	Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period	117	Effective Clinical Care	Process	No	Claims,CMS Web Interface, EHR,Registry	Internal Medicine,Ophthalmology, General Practice/Family Medicine
Diabetes: Medical Attention for Nephropathy	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	119	Effective Clinical Care	Process	No	EHR,Registry	General Practice/Family Medicine
Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy-Neurological Evaluation	Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months	126	Effective Clinical Care	Process	No	Registry	
Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention- Evaluation of Footwear	Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing	127	Effective Clinical Care	Process	No	Registry	
Diabetes: Foot Exam	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year	163	Effective Clinical Care	Process	No	EHR	Internal Medicine, General Practice/Family Medicine

Improvement Activities

Improvement Activity	Activity Description	Activity ID	Sub Category	Activity Weight
Engagement with QIN-QIO to implement self-management training programs	Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs such as diabetes.	IA_BE_3	Beneficiary Engagement	**Medium**
Engagement of patients, family and caregivers in developing a plan of care	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified EHR technology.	IA_BE_15	Beneficiary Engagement	**Medium**
Provide peer-led support for self-management.	Provide peer-led support for self-management.	IA_BE_18	Beneficiary Engagement	**Medium**
Use group visits for common chronic conditions (e.g., diabetes).	Use group visits for common chronic conditions (e.g., diabetes).	IA_BE_19	Beneficiary Engagement	**Medium**
Implementation of condition-specific chronic disease self-management support programs	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.	IA_BE_20	Beneficiary Engagement	**Medium**
Improved practices that disseminate appropriate self-management materials	Provide self-management materials at an appropriate literacy level and in an appropriate language.	IA_BE_21	Beneficiary Engagement	**Medium**
Integration of patient coaching practices between visits	Provide coaching between visits with follow-up on care plan and goals.	IA_BE_23	Beneficiary Engagement	**Medium**
Implementation of use of specialist reports back to referring clinician or group to close referral loop	Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the certified EHR technology.	IA_CC_1	Care Coordination	**Medium**
Practice improvements that engage community resources to support patient health goals	Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following: Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; and/or Provide a guide to available community resources.	IA_CC_14	Care Coordination	**Medium**
Glycemic management services	For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance year, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Is reassessed at least annually. The performance threshold will increase to 75 percent for the second performance year and onward. Clinician would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.	IA_PM_4	Population Management	**HIGH**

Improvement Activities Continued…

Improvement Activity	Activity Description	Activity ID	Sub Category	Activity Weight
Use of toolsets or other resources to close healthcare disparities across communities	Take steps to improve healthcare disparities, such as Population Health Toolkit or other resources identified by CMS, the Learning and Action Network, Quality Innovation Network, or National Coordinating Center. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	IA_PM_6	Population Management	**Medium**
Regular review practices in place on targeted patient population needs	Implementation of regular reviews of targeted patient population needs which includes access to reports that show unique characteristics of eligible professional's patient population, identification of vulnerable patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources.	IA_PM_11	Population Management	**Medium**
Chronic care and preventative care management for empaneled patients	Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning; Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target; Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions; Use panel support tools (registry functionality) to identify services due; Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or Routine medication reconciliation.	IA_PM_13	Population Management	**Medium**
Implementation of formal quality improvement methods, practice changes or other practice improvement processes	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following: Train all staff in quality improvement methods; Integrate practice change/quality improvement into staff duties; Engage all staff in identifying and testing practices changes; Designate regular team meetings to review data and plan improvement cycles; Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.	IA_PSPA_19	Patient Safety & Practice Assessment	**Medium**
Use of certified EHR to capture patient reported outcomes	In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (for example, home blood pressure, blood glucose logs, food diaries, at-risk health factors such as tobacco or alcohol use, etc.) or patient activation measures through use of CEHRT, containing this date in a separate queue for clinician recognition and review	IA_BE_1	Beneficiary Engagement	**Medium**

Activity Weights:
- Medium Weight = 10 Points
- High Weight = 20 Points

Clinicians must choose from 1 of the following combinations:
- 2 high-weighted activities
- 1 high-weighted activity and 2 medium-weighted activities
- At least 4 medium-weighted activities.

Special Consideration Activity Weights:
- Medium Weight = 20 Points
- High Weight = 40 Points

Clinicians must choose from 1 of the following combinations:
- 1 high-weighted activity
- 2 medium-weighted activity

* Special considerations are applied to:

Practices with 15 or fewer clinicians, Clinicians in Rural or geographic HPSA, Non-Patient facing clinicians

Advancing Care Information Measures

Advancing Care Information Performance Category is broken into three sections: Base Score, Performance Score, and Bonus Score. You are REQUIRED to fulfil all of the Base Measures in order to receive any points in this category.

Advancing Care Information Measures and Scores

Required Measures for 50% Base Score

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access*
- Send a Summary of Care*
- Request/Accept Summary Care*

Measures for Performance Score

- Provide Patient Access* ---------- Up to 10%
- Send a Summary of Care* ---------- Up to 10%
- Request/Accept Summary of Care* -- Up to 10%
- **Patient Specific Education ---------- Up to 10%**
- View, Download or Transmit (VDT) ---- Up to 10%
- **Secure Messaging ---------- Up to 10%**
- **Patient-Generated Health Data ------- Up to 10%**
- Clinical Information Reconciliation --- Up to 10%

Requirements for Bonus Score

- Syndromic Surveillance Reporting
- Electronic Case Reporting
- Public Health Registry Reporting
- Clinical Data Registry Reporting

5%

- Report certain Improvement

10%

2017 Advancing Care Information Transition Measures and Scores

Required Measures for 50% Base Score

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access*
- Health Information Exchange*

*Note that these measures are also included as performance score measures and will allow a clinician to earn a score that contributes to the performance score category

Measures for Performance Score

- Provide Patient Access* ---------- Up to 20%
- Health Information Exchange* ---------- Up to 20%
- View, Download, or Transmit (VDT) --------- Up to 10%
- **Patient-Specific Education ---------- Up to 10%**
- **Secure Messaging ---------- Up to 10%**
- Medication Reconciliation ---------- Up to 10%
- Immunization Registry Reporting ----------

These measures for the performance score could be utilized while treating a patient with diabetes .

Requirements for Bonus Score

- Syndromic Surveillance Reporting
- Specialized Registry Reporting

5%

- Report certain Improvement Activities using CEHRT

10%

The following improvement activities that relate to diabetes can count towards your bonus score in the advancing care information performance category:

Activity ID
IA_PM_4
IA_PM_13
IA_CC_1
IA_BE_15

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