The Quality Payment Program and Cardiac Health

How Cardiac Care can help you meet the 2018 Quality Payment Program Requirements

This document reflects three of the Quality Payment Program Performance Categories,:Quality Improvement Activities Promoting Interoperability and how they relate to Cardiac Care.

(This is not an exhaustive list of quality measures or improvement activities that are involved in cardiac care.)

Quality Measures

Measure Name	Measure Description	Quality ID	NQS Domain	Measure Type	High Priority Measure	Data Submission Method	Specialty
Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	130	Patient Safety	Process	Yes	Claims, EHR, Registry	Allergy/Immunology, Internal Medicine, Cardiology, Dermatology, Emergency Medicine, Gastroenterology, General Surgery, General Oncology, Hospitalists, Neurology, Obstetrics/Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology Physical Medicine, Preventive medicine, Rheumatology, Thoracic Surgery, Urology, Vascular Surgery, Mental Behavioral Health, Plastic Surgery, General Practice/Family Medicine
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period.	204	Effective Clinical Care	Process	No	Claims, CMS Web Interface, EHR, Registry	Internal Medicine, Cardiology, General Practice/Family Medicine
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	226	Community/ Population Health	Process	No	Claims, CMS Web Interface, EHR, Registry	Allergy/Immunology, Internal Medicine, Cardiology, Dermatology, Emergency Medicine, Gastroenterology, General Surgery, General Oncology, Hospitalists, Neurology, Obstetrics/Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology Physical Medicine, Preventive medicine, Rheumatology, Thoracic Surgery, Urology, Vascular Surgery, Mental Behavioral Health, Plastic Surgery, General Practice/Family Medicine
Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period	236	Effective Clinical Care	Intermediate Outcome	Yes	Claims, CMS Web Interface, EHR, Registry	Internal Medicine, Cardiology, Obstetrics/Gynecology, Preventive Medicine, Thoracic Surgery, Vascular Surgery, General Practice/Family medicine

Quality Measures Continued…

Measure Name	Measure Description	Quality ID	NQS Domain	Measure Type	High Priority Measure	Data Submission Method	Specialty
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure reading as indicated	317	Community/ Population Health	Process	No	Claims, EHR, Registry	Allergy/Immunology, Internal Medicine, Cardiology, Dermatology, Emergency Medicine, Gastroenterology, General Surgery, General Oncology, Hospitalists, Neurology, Obstetrics/Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology Physical Medicine, Preventive medicine, Rheumatology, Thoracic Surgery, Urology, Vascular Surgery, Mental Behavioral Health, Plastic Surgery, General Practice/Family Medicine, Pediatrics
Hypertension: Improvement in Blood Pressure	Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period	373	Effective clinical care	Intermediate Outcome	Yes	EHR	N/A
Tobacco Use and Help with Quitting Among Adolescents	The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	402	Community/ Population Health	Process	No	Registry	Allergy/Immunology, Internal Medicine, Anesthesiology, Cardiology, Dermatology, Emergency Medicine, Gastroenterology, General Surgery, General Oncology, Hospitalists, Neurology, Obstetrics/Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology Physical Medicine, Preventive medicine, Rheumatology, Thoracic Surgery, Urology, Vascular Surgery, Mental Behavioral Health, Plastic Surgery, General Practice/Family Medicine
Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)	The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control)- Using the IVD denominator optimal results include: Most recent blood pressure (BP) measurement is less than 140/90 mm HG-- And most recent tobacco status is Tobacco Free -- And Daily Aspirin or Other Antiplatelet Unless Contraindicated -- And Statin Use	441	Effective Clinical Care	Intermediate Outcome	Yes	Registry	N/A

Improvement Activities

Improvement Activity	Activity Description	Activity ID	Sub Category	Activity Weight
Use of certified EHR to capture patient reported l outcomesl	In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (e.g., 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 certified EHR technology, containing this data in a separate queue for clinician recognition and review.	IA_BE_1l	Beneficiary Engagementl	Medium
Engagement with QIN-QIO to implement self-l management training programsl	Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs, such as diabetes.	IA_BE_3l	Beneficiary Engagementl	Medium
Engagement of patients, family and caregivers in l developing a plan of carel	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_15l	Beneficiary Engagementl	Medium
Implementation of condition-specific chronic l disease self-management support programsl	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.	IA_BE_20l	Beneficiary Engagementl	Medium
Improved practices that disseminate appropriate l self-management materialsl	Provide self-management materials at an appropriate literacy level and in an appropriate language.	IA_BE_21l	Beneficiary Engagementl	Medium
Practice improvements that engage community l resources to support patient health goalsl	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 provide a guide to available community resources. • Including through the use of tools that facilitate electronic communication between settings; • Screen patients for health-harming legal needs; • Screen and assess patients for social needs using tools that are preferably health IT enabled and that include to any extent standards-based, coded question/field for the capture of data as is feasible and available as part of such tool; and/or • Provide a guide to available community resources.	IA_CC_14l	Care Coordinationl	Medium
Engagement of community for health status l mprovementl	Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. 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 MIPS eligible clinicians and groups with quality improvement and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	IA_PM_5l	Population Managementl	Medium
Use of toolsets or other resources to close l healthcare disparities across communitiesl	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_6l	Population Managementl	Medium

Improvement Activities Continued…

Improvement Activity	Activity Description	Activity ID	Sub Category	Activity Weight
Chronic care and preventative care management I for empaneled patientsI	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; and plan of care for chronic conditions; • 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; such as a CDC-recognized diabetes prevention program; • 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 predictive analytical models to predict risk, onset and progression of chronic diseases; or • 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_13I	Population ManagementI	Medium
Use of patient safety toolsI	Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of a surgical risk calculator, evidence based protocols such as Enhanced Recovery After Surgery (ERAS) protocols, the CDC Guide for Infection Prevention for Outpatient Settings, (https://www.cdc.gov/hai/settings/outpatient/outpatient-care-guidelines.html), predictive algorithms, or other such tools.	IA_PSPA_8I	Patient Safety & Practice I AssessmentI	Medium
Use of decision support and standardized I reatment protocolsI	Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	IA_PSPA_16	Patient Safety & Practice I AssessmentI	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

Promoting Interoperability Measures

Promoting Interoperability Performance Category is broken up into three sections: Base Score, Performance Score and Bonus Score. You are REQUIRED to fulfill all of the Base Measures in order to receive any points in this category.

*The version of your EHR will guide you to which Measure sets you should follow:

Promoting Interoperability 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

* Report to 1 more of the following public health agencies or clinical data registries not reported for the performance score:

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

} 5%

- Report certain Improvement Activities using CEHRT

} 10%

2018 Promoting Interoperability Transition Measures and Scores

Required Measures for 50% Base Score

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

*Note: 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 for cardiac health

Requirements for Bonus Score

* Report to 1 more of the following public health agencies or clinical data registries not reported for the performance score:

- Immunization REgistry Reporting
- Syndromic Surveillance Reporting
- Specialized Registry Reporting

} 5%

- Report certain Improvement Activities using CEHRT

} 10%

The following improvement activities that relate to cardiac health can count towards your bonus score in the promoting Interability performance category:

Activity ID
IA_BE_1
IA_PM_13
IA_PSPA_16

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains Quality Innovation Network

This material was prepared by the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for l Kansas, Nebraska, North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an l agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11S0W-l GPQIN-NE-D1-143/0618l