Quality Payment Program
Session #2: MIPS Scoring: Quality, Advancing Care Information, and Improvement Activities

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Stratis Health

January 10, 2017
Objectives

- Understand the 4 MIPS categories and how they are scored: Quality, Advancing Care Information, Improvement Activities and Cost
- Discuss how MACRA affects small and rural practices
- Consider how your hospital/clinic can prepare for future Value Based payments by voluntarily participating in MIPS
- Discover how MACRA’s Quality Payment Program affects how your hospital/clinic does business with patients, caregivers, health care partners, and the community
- Learn what steps your hospital/clinic can take to improve patient engagement and care coordination to improve patient outcomes and community wellness
Stratis Health

• Independent, nonprofit, Minnesota-based organization founded in 1971
  – Mission: Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities
  – Working at the intersection of research, policy, and practice

• Part of the Lake Superior Quality Innovation Network serving Michigan, Minnesota, and Wisconsin, under the Centers for Medicare & Medicaid Services Quality Improvement Organization Program.

• Program areas
  – Health disparities
  – Health information technology
  – Rural health
MIPS Overview

- Quality
- Improvement Activities
- Advancing Care Information
- Cost
Quality Payment Program

The Quality Payment Program policy will:
- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

OR

Advanced APMs

Advanced Alternate Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

Source: CMS Quality Payment Program – Train-The-Trainer
MIPS (Merit-Based Incentive Payment System)

Weights assigned to each category based on a 1 to 100 point scale

**Transition Year Weights**

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
</tbody>
</table>

*Note: These are default weights; the weights can be adjusted in certain circumstances*
Individual vs Group Reporting

OPTIONS

1. Individual — under an NPI number and TIN where they reassign benefits

2. As a Group
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

*Clinicians reporting as a group are assessed as a group across all MIPS performance categories

Source: CMS Quality Payment Program – Train-The-Trainer
2017 Transition Year for QPP: APM and MIPS

Participate in an Advanced Alternative Payment Model

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

MIPS

<table>
<thead>
<tr>
<th>Test Pace</th>
<th>Partial Year</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>+ %</td>
<td>+ %</td>
</tr>
</tbody>
</table>

Submit Something
- Submit some data after January 1, 2017
- Neutral or small payment adjustment

Submit a Partial Year
- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Submit a Full Year
- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

Source: CMS Quality Payment Program – Train-The-Trainer
Avoiding a Negative Payment Adjustment Under MIPS is EASY!

- Submit minimum amount of 2017 data to Medicare
- Avoid a downward adjustment

You Have Asked: “What is a minimum amount of data?”

1. Quality Measure

1. Improvement Activity

4 or 5 Required Advancing Care Information Measures

Source: CMS Quality Payment Program – Train-The-Trainer
QPP: Impact on Providers Working in RHCs, FQHCs, and CAHs

• Subject to MIPS Payment Adjustments if provider:
  – Is an “Eligible Clinician (EC)” AND
  – Sees than 100 Medicare patients AND
  – Bills more than $30,000 to Medicare PBPFS in the performance year
  – Including Method II CAH Billing for Professional Services

• Examples of Method II Medicare B Professional Services (* Excludes Facility Charges)
  • ER visits
  • CRNA services
  • Colonoscopy Services
  • Surgical Procedures

LSQIN Webinar: Transitioning from MU / PQRS / VM to the Quality Payment Program, Nov 2016. Haase, Hanson
MIPS: Quality category
MIPS Quality measures = 60% of MIPS Score

<table>
<thead>
<tr>
<th>Quality</th>
<th>Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Groups using the web interface: Report 15 quality measures for a full year.</td>
</tr>
<tr>
<td></td>
<td>Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for MIPS quality.</td>
</tr>
</tbody>
</table>

25% of ACI Score may be reweighted to Quality

Source: CMS Quality Payment Program – Train-The-Trainer
MIPS Scoring

MIPS Scoring for Quality
(60% of Final Score in Transition Year)

Total Quality Performance Category Score

= [Points earned on required 6 quality measures] + [Any bonus points]

Maximum number of points*

Quick Tip: Maximum score cannot exceed 100%
*Maximum number of points = # of required measures x 10
Searching for Quality Measures on QPP.GOV

**Instructions**

1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

**Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model:** Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

**Note:** This tool is only for informational and estimation purposes. You can’t use it to submit or attest to measures or activities.

**Select Measures**

[Image of search and filter options]

Website: https://qpp.cms.gov/measures/quality
## ER Quality Measure Set

<table>
<thead>
<tr>
<th>MEASURE NAME</th>
<th>MEASURE TYPE</th>
<th>HIGH PRIORITY MEASURE</th>
<th>DATA SUBMISSION METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Use and Help with Quitting Among Adolescents</td>
<td>Process</td>
<td>No</td>
<td>Registry</td>
</tr>
<tr>
<td>Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
<td>Process</td>
<td>No</td>
<td>Registry</td>
</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Process</td>
<td>No</td>
<td>Claims,CMS Web Interface,EHR,Registry</td>
</tr>
<tr>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
<td>Process</td>
<td>No</td>
<td>Claims,EHR,Registry</td>
</tr>
<tr>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Process</td>
<td>Yes</td>
<td>Claims,EHR,Registry</td>
</tr>
<tr>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
<td>Process</td>
<td>Yes</td>
<td>EHR</td>
</tr>
<tr>
<td>Care Plan</td>
<td>Process</td>
<td>Yes</td>
<td>Claims,Registry</td>
</tr>
<tr>
<td>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</td>
<td>Process</td>
<td>Yes</td>
<td>Registry</td>
</tr>
<tr>
<td>Appropriate Testing for Children with Pharyngitis</td>
<td>Process</td>
<td>Yes</td>
<td>EHR,Registry</td>
</tr>
<tr>
<td>Acute Otitis Externa (AOE): Topical Therapy</td>
<td>Process</td>
<td>Yes</td>
<td>Claims,Registry</td>
</tr>
<tr>
<td>Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use</td>
<td>Process</td>
<td>Yes</td>
<td>Claims,Registry</td>
</tr>
</tbody>
</table>

Website: https://qpp.cms.gov/measures/quality
MIPS Quality Scoring

- **MIPS Individual Eligible Clinician**
  - Choose Six individual measures OR specialty measure set
  - up to three population-based measures calculated from administrative claims data
  - Small groups less than 10:
    - All-cause hospital readmissions measure would not be applicable
    - Only two population-based measures from claims data

- **Eligible groups reporting via CMS Web Interface**
  - 15 measures × 10 points
  - 3 population-based measures × 10 points
  - subject to CMS Web Interface reporting criteria

- Report for a minimum of 90 days up to full year
  - Easier for a clinician that participates for longer period to meet case volume criteria needed to score > 3 points

- Bonus Points available for reporting additional outcome, pt. experience, high priority measure or using CEHRT for reporting

- 3 to 10 points per measure based on performance against benchmarks

- The 2017 Quality Benchmarks are available on the [website](#)
MIPS Reporting Quality Measures

MIPS Performance Category: Quality – Reporting

Individual clinicians may report through:
- Qualified Registry
- Electronic Health Record (EHR)
- Qualified Clinical Data Registry (QCDR)
- Claims

Groups may report measures through:
- Qualified Registry
- EHR
- QCDR
- CMS Web Interface (groups of 25 or more)
- CAHPS for MIPS Survey
  - Counts as 1 patient experience measure
  - Must submit 5 other measures through a different mechanism above

Source: CMS Quality Payment Program – Train-The-Trainer
MIPS: Improvement Activities (IA) category
## Improvement Activities

**Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days.

**Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days.

Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.

Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

Participants in any other APM: You will automatically earn half credit and may report additional activities to increase your score.
MIPS Scoring

MIPS Scoring for Improvement Activities
(15% of Final Score in Transition Year)

Total points = 40

<table>
<thead>
<tr>
<th>Activity Weights</th>
<th>Alternate Activity Weights*</th>
<th>Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Medium = 10 points</td>
<td>- Medium = 20 points</td>
<td>*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups</td>
</tr>
</tbody>
</table>
MIPS IA Sample From QPP

Select Improvement Activities

Search All by keyword

Filter by:

- Additional improvements in access as a result of QIN/QIO TA
- Administration of the AHRQ Survey of Patient Safety Culture
- Annual registration in the Prescription Drug Monitoring Program
- Anticoagulant management improvements
- Care coordination agreements that promote improvements in patient tracking across settings
- Care transition documentation practice improvements

Source: QPP.CMS.GOV
Reporting Improvement Activities

MIPS Performance Category: Improvement Activities – Reporting

- Must perform selected activities for 90 consecutive days
- Must attest each activity performed for 90-day period by selecting “Yes” during reporting
- May report activities through:
  - Qualified Registry
  - Electronic Health Record (EHR)
  - Qualified Clinical Data Registry (QCDR)
  - CMS Web Interface (for groups of 25 clinicians or more)

10% bonus under ACI for completing 1 or more Improvement Activities using Certified EHR Technology; 18 available IA use CEHRT

Source: CMS Quality Payment Program – Train-The-Trainer
MIPS: Advancing Care Information (ACI) category
Advancing Care Information = 25% MIPS Score

- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
- Greater flexibility in choosing measures
- In 2017, there are 2 measure sets for reporting based on EHR edition:
  - Advancing Care Information Objectives and Measures
  - 2017 Advancing Care Information Transition Objectives and Measures

Source: CMS Quality Payment Program – Train-The-Trainer
## ACI Objectives/Measures

<table>
<thead>
<tr>
<th>Advancing Care Information</th>
<th>Fulfill the required measures for a minimum of 90 days:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓ Security Risk Analysis</td>
</tr>
<tr>
<td></td>
<td>✓ e-Prescribing</td>
</tr>
<tr>
<td></td>
<td>✓ Provide Patient Access</td>
</tr>
<tr>
<td></td>
<td>✓ Send Summary of Care</td>
</tr>
<tr>
<td></td>
<td>✓ Request/Accept Summary of Care</td>
</tr>
</tbody>
</table>

Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

OR

You may not need to submit Advancing Care Information if these measures do not apply to you.

Source: CMS Quality Payment Program – Train-The-Trainer
Reporting ACI Requires CEHRT

- In 2017, there are 2 measure sets for reporting based on EHR edition:
  - MU Stage 3 Objectives (*2018 req’d)
  - Advancing Care Information Objectives and Measures
  - 2017 Advancing Care Information Transition Objectives and Measures
  - MU Modified Stage 2 Objectives

- Clinicians must use certified EHR technology to report

For those using EHR Certified to the 2015 Edition:

- Option 1: Advancing Care Information Objectives and Measures
- Option 2: Combination of the two measure sets

For those using 2014 Certified EHR Technology:

- Option 1: 2017 Advancing Care Information Transition Objectives and Measures
- Option 2: Combination of the two measure sets

LSQIN Webinar: Transitioning from MU / PQRS / VM to the Quality Payment Program, Nov 2016. Haase, Hanson
Modified from: CMS Quality Payment Program – Train-The-Trainer
# ACI Category: Base Measures

## 2015 CEHRT

### Advancing Care Information Objectives and Measures:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>e-Prescribing</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Send a Summary of Care</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Request/Accept a Summary of Care</td>
</tr>
</tbody>
</table>

## 2014 CEHRT

### 2017 Advancing Care Information Transition Objectives and Measures:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>e-Prescribing</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Health Information Exchange</td>
</tr>
</tbody>
</table>

Source: CMS Quality Payment Program – Train-The-Trainer
## ACI Category: Performance Measures

### 2015 CEHRT

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access*</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Patient-Specific Education</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>View, Download and Transmit (VDT)</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>Secure Messaging</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>Patient-Generated Health Data</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Send a Summary of Care*</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Request/Accept a Summary of Care*</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Clinical Information Reconciliation</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Immunization Registry Reporting</td>
</tr>
</tbody>
</table>

### 2014 CEHRT

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
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</thead>
<tbody>
<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access*</td>
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<tr>
<td>Patient Electronic Access</td>
<td>View, Download and Transmit (VDT)</td>
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<tr>
<td>Patient-Specific Education</td>
<td>Patient-Specific Education</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Secure Messaging</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Health Information Exchange*</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Medication Reconciliation</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>Immunization Registry Reporting</td>
</tr>
</tbody>
</table>

Source: CMS Quality Payment Program – Train-The-Trainer
ACI Score = 25% of MIPS Score

- Earn up to 155% maximum score, which will be capped at 100%

Advancing Care Information category score includes:

- 50% Required Base score (50%)
- 90% Performance score (up to 90%)
- 15% Bonus score (up to 15%)

*Keep in mind:* You need to fulfill the Base score or you will get a zero in the Advancing Care Information Performance Category

Source: CMS Quality Payment Program – Train-The-Trainer
MIPS ACI Scoring and Choices

MIPS Performance Category: Advancing Care Information

1. Clinicians recognized as participating in a MIPS-APM entity will automatically receive a 50% score in the category
   - Clinicians need to earn the remaining 50% to receive full credit in the category

2. If objectives and measures are not applicable to a clinician, CMS will reweight the category to zero and assign the 25% to the other performance categories to offset difference in the MIPS final score
   - If clinicians face a significant hardship and are unable to report advancing care information measures, they can apply to have their performance category score weighted to zero
   - Hospital-based MIPS eligible clinicians may choose to report under the Advancing Care Information Performance Category

Source: CMS Quality Payment Program – Train-The-Trainer
2 Ways to Earn ACI Bonus Points

1. Earn a 5% bonus for reporting to additional Public Health and Clinical Data Registry Reporting measures (aside from the Immunization Registry Reporting measure)

2. Earn a 10% bonus for using CEHRT to complete certain activities within the Improvement Activities performance category

Source: CMS Quality Payment Program – Train-The-Trainer
MIPS: Cost category
Cost: (Cancelled for 2017)

<table>
<thead>
<tr>
<th>Cost</th>
<th>No data submission required. Calculated from adjudicated claims.</th>
<th>Counted starting in 2018.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replaces Value-Based Modifier.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cost: (Cancelled for 2017)

• The Cost category has been set to 0% for 2017
• 10 episode measures being finalized
• As of 2018, performance feedback will be available annually
• Category score will increase from 0 to 30% by 2021 (required by MACRA law)
• Clinicians will not select Cost measures
• Measures will be based on services delivered
• Based on TIN and NPI combination (previously only TIN in Value Based Measure method in 2016 and prior)
MIPS: Cost category
Calculating the Final MIPS Score

60% Clinician Quality performance category score x actual Quality performance category weight

0% Clinician Cost performance category score x actual Cost performance category weight

15% Clinician Improvement Activities performance category score x actual Improvement Activities performance category weight

25% Clinician Advancing Care Information performance category score x actual Advancing Care Information performance category weight

= 100

Quality score X .6
Cost score NA
IA score X .15
ACI score X .25

Adapted from: CMS Quality Payment Program – Train-The-Trainer
How the Quality Payment Program Impacts Health Care Delivery in Small and Rural Setting
Transforming Health Care

• Organizations not affected by QPP, are affected by Value-based care and other CMS initiatives impacted by QPP

• Clinicians you coordinate care with are directly affected by QPP and are seeking ways to work collaboratively to improve outcomes for individual patients and populations
  – Team based care requires assessment, planning and workflow redesign
  – **Involve patients and clinicians early and often**
  – Education and culture change

• The health care system is collaborating to improve care, engage patients and decrease costs
  – QPP: MIPS and APMs
  – State Medicaid Agencies
  – Third Party Insurers
  – All Payer Claims Data Base Initiatives
  – Physician Compare
  – Hospital Compare
  – Transforming Clinical Practice Initiative
Small, Rural Practices Can Succeed in the QPP

• Advanced APMs are more available to small Practices
  – Transforming Clinical Practices Initiative

• Easier for clinicians practicing in RHC, FQHC, CAH to qualify as a Qualifying APM participant
CMS Committed to Helping Small, Rural, HPSA

- Reduce time and cost to participate
- More clinicians in small, rural settings excluded from MIPS by raising low volume threshold
- Ineligible clinicians can voluntarily report
- Allow practices to pick their pace in 2017
- Higher scores in some MIPS categories
First Steps to Value-based Care

• Determine Eligible Clinicians MIPS/APM
  – Determine billings for Medicare Part B Prof services in all settings, including CAH Method II Billing, outpatient services
    • ER, SDS, observation, procedures, surgeries

• Plan to report to MIPS if close to low volume threshold (100 beneficiaries, $30,000)

• Consider voluntary reporting to become familiar with reporting
# MIPS 2017 Transition Year Scoring (0-100 Points)

<table>
<thead>
<tr>
<th>Points Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;70 points</td>
<td>Eligible for positive payment adjustment and exceptional performance bonus</td>
</tr>
<tr>
<td>4-69 points</td>
<td>Positive payment adjustment. No exceptional performance payment. No negative</td>
</tr>
<tr>
<td>3 points</td>
<td>Neutral payment adjustment</td>
</tr>
<tr>
<td>1-2 points</td>
<td>Negative payment adjustment</td>
</tr>
<tr>
<td>Do nothing – 0 points</td>
<td>-4% payment adjustment</td>
</tr>
</tbody>
</table>

Modified from: CMS Quality Payment Program – Train-The-Trainer
Score 3 points – It’s a breeze!

- **Score at least 3 points** to avoid a 4% negative payment adjustment in 2019

- **Report to ACI (25%)**
  - 5 required base objectives (50 points x .25 = 12.5 MIPS points)
    OR

- **Report Quality Measures (60%)**
  - Individuals: 1 quality measure (3 MIPS points for reporting)
  - Groups: 15 quality measures for groups doing CMS web interface
    OR

- **Report Improvement Activities (15%)**
  - APM, PCMH or MHM (20 pts): 1 high or 2 medium IA (20 points x .15= 3 MIPS points)
    OR
  - practices over 12 - 2 medium or 1 high (20 points x .15=3)
  - small, rural, non-patient facing clinicians - 1 medium or 1 high (20-40 points x .15 =3-6)

Modified from LSQIN Webinar: Transitioning from MU / PQRS / VM to the Quality Payment Program, Nov 2016. Haase, Hanson
Steps to improve Patient Engagement, Care Coordination and Outcomes
Team-Based Care = Care Coordination

• Focus shifting from provider-based care to care teams and Medical Home Models
  – Cost-effective
  – Enhances care coordination and safety

• Rural settings more challenged in resources
  – financial resources, human resources and technology resources
  – Employees wear multiple hats and have limited time and training opportunities
  – Geographical challenges affect Health Information Exchange (HIE) and care coordination and access to care, and care options
Team-Based Care = Care Coordination

• **Actions:**
  – Become PCMH or Medical Home Model
  – **Involve clinical staff and patients early and often**
  – Use employees to problem solve workflows
  – Put processes in place that allow clinicians to work at the tops of their licenses
  – Engage with QIN/QIO and other support available through CMS funding for Small, Underserved and Rural Practices - to be announce by CMS very soon!
  – Join TCPI (Transforming Clinical Practice Initiative)
Person and Caregiver Engagement

• Assess policies and practices in person-centered care
  – Ex: patient advisory panels, patient reported outcomes, shared decision making, patient feedback, patient access to records, education and provider

• Increase patient involvement in organizational planning, including quality improvement

• Educate staff and patients on benefits of increased patient engagement:
  – improved outcomes, empowering patients in self-care, increased access to medical records, improved education, better communication with provider, better understanding of health issues, and most importantly
  – Patient satisfaction and safety
Quality Improvement and Quality Reporting

- Assess organization’s current Quality Improvement goals
- Utilize data analytics to identify patients and populations at risk and set targets for improvement
  - Impacts cost and outcomes
- Assess current Quality reporting metrics, methodologies and vendors for 3 MIPS Categories: Quality, ACI, IA
- Align QI activities across multiple reporting requirements (UDS, Hedis, ACO, PTN, state programs, etc.)
- Make your efforts meaningful
  - Match goals to your community’s needs, not just the measures. Choose your measures wisely!
  - Involve clinicians and patients early and often
Do you Plan to report to MIPS in 2017? * Enter only one response

1- No, no eligible clinicians, don’t plan to report
2- No, have eligible clinicians, don’t plan to report
3- Yes, no eligible clinicians, plan to report voluntarily
4- Yes, have eligible clinicians, plan to report
5- Don’t know if clinicians are eligible yet
6- Don’t know if plan to report yet
QPP Website and Help Desk

**CMS Website**
- Quality Paymehttps://qpp.cms.gov/nt Program Help Desk
- (866) 288-8292
- 8am – 8pm EST / 7am – 7pm EST
- Email: [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov)
References and Resources

• Agency for Healthcare Research and Quality: Defining the PCMH

• Centers for Medicare and Medicaid Quality Payment Program
Questions?

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Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.