Epic EHR workflows for MIPS

Thursday 6/14/2018
12:30 to 1:30 - Presentation & EHR workflows
1:30 to 2:00 – Review of Resources and Q&A

Carl Barton & Anna Smolentzov
Agenda

- Introductions
- Key learning objectives
- High-level overview of Merit-based Incentive Payment System (MIPS) and Comprehensive Primary Care Plus (CPC+)
- Examples of MIPS – Clinical Quality Measures (CQM) and Quality Improvement (QI) with demonstrated Epic EHR workflows
- Resources
Introductions

• Mountain-Pacific Quality Health
  – Carl Barton – Healthcare Transformation Consultant

• Hawaii Pacific Health
  – Anna Smolentzov - Business Systems Analyst

• Hawaii Department of Health (DOH) – Centers for Disease Control and Prevention (CDC) 1305 funding focus
  – Improve control of diabetes and high blood pressure through support for QI, CQM reporting, use of Health Information Technology (HIT), team-based care and referral to community resources
  – Improve identification of potential hypertension, pre-diabetes and diabetes which is not coded
Key Learning Objectives

• Understanding high level MIPS 2018 changes and components that need to be in place to successfully participate in Quality Payment Programs – MIPS
• Navigate the Epic EHR workflows that directly align with MIPS eCQMs and Quality Improvement projects
• Be able to navigate resources available to assist your practice
Polling Question 1

Last year my practice...

• Participated in MIPS
• Did not participate in MIPS
• Not sure
Medicare – Quality Payment Program

- The Quality Payment Program (QPP) offers 2 pathways:
  - The Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APMs)
High-Level Overview of QPP – MIPS

• 2018 who is eligible:
  – Physicians, PAs, NPs, Certified Nurse Specialists, Certified Registered Nurse Anesthetists
  – Low-volume threshold changes for 2018
    ▪ More than $90K a year in Medicare Part B allowed charges AND
    ▪ Providing care for more than 200 Medicare patients per year
  – Check your eligibility: https://qpp.cms.gov/participation-lookup
Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories for Year 2 (2018)

- Quality: 50 points
- Cost: 10 points
- Improvement Activities: 15 points
- Advancing Care Information: 25 points

100 Possible Final Score Points

- Comprised of four performance categories in 2018.
- **So what?** The points from each performance category are added together to give you a MIPS Final Score.
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.
Polling Question 2

This year my practice is...

- Planning on reporting for MIPS
- Not planning on reporting for MIPS
- Participating in CPC+, but will participate in MIPS if necessary
- Uncertain regarding thresholds for MIPS participation in 2018
- Unsure
Components for Quality Improvement

Quality
Population
Utilization
EHR

Resources
Reimbursement
Method
Important Note!

Utilizing the correct workflows of your EHR can ensure you get paid based on the actual quality of the care you are delivering.
Technical Assistance

• Review of resources for Hypertension, Tobacco Use Screening/Cessation and Diabetes
  – Million Hearts resources
  – Mountain-Pacific resources
  – Review and support with community resources
    ▪ Diabetes Education and Prevention programs (DPP & DSME)
    ▪ Lifestyle programs
    ▪ Smoke Cessation programs

• Program Guidance for MIPS
• Assessment of your practice’s approach to team based care and self-management support
• Review methodologies like PDSA and eCQI

Contact Carl Barton at cbarton@mpqhf.org or (808) 440-6015 if you can use additional technical assistance in the next two weeks
## Clinical Quality Measures (CQMs)

<table>
<thead>
<tr>
<th>Measure</th>
<th>CMS/ MIPS ID</th>
<th>Applies to MIPS</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1c Control</td>
<td>122/001</td>
<td>Yes</td>
<td>Outcome</td>
</tr>
<tr>
<td>BP Control</td>
<td>165/236</td>
<td>Yes</td>
<td>Outcome</td>
</tr>
<tr>
<td>BP Improvement</td>
<td>65/373</td>
<td>Yes</td>
<td>Outcome</td>
</tr>
<tr>
<td>Screening for high BP</td>
<td>22/317</td>
<td>Yes</td>
<td>Process</td>
</tr>
<tr>
<td>Nephropathy Screening</td>
<td>134/119</td>
<td>Yes</td>
<td>Process</td>
</tr>
<tr>
<td>DM Eye Exam</td>
<td>131/117</td>
<td>Yes</td>
<td>Process</td>
</tr>
<tr>
<td>DM Foot Exam</td>
<td>123/163</td>
<td>Yes</td>
<td>Process</td>
</tr>
</tbody>
</table>
Polling Question 3

I have taken a look at my MIPS Dashboard in Epic:

- Yes
- No
- I tried but could not access it (call the Service Desk at 808-522-4343!)
MIPS example # 1

• Project:
  – Improve HTN BP Control: CMS 165 (BP Control) & 65 (BP Improvement)

• Possible Changes/Improvements:
  – Train all staff on correct electronic workflow for CMS 165 & 65
  – Train staff on accurate BP measurements → MH - BP protocol
  – Implement HTN protocol → MH HTN control: change package
  – Make sure HTN is addressed at each patient visit
  – See HTN patients with BP ≥140/90 every six months
  – Implement CDS rules to support protocol
MIPS Example # 1 - Scoring

- Quality Category
  - 1 outcome & 1 additional CQM - outcome measure

- Select Improvement Activities
  - IA-medium – Chronic care and preventative care management for empaneled patients (IA_PM_13)
  - IA-medium – Use of clinical decision support (IA_PSPA_16)

- Earn Bonus Points
  - IA using EHR counts for PI (formerly ACI) 10% bonus
  - 2 bonus points for Quality for submitting extra outcome measure
EPIC EHR WORKFLOWS FOR MIPS
MIPS Example # 1 – Epic Workflows

• Demonstration of Epic workflows for this example
eCQMs in Epic

• How to enter reportable data in Epic
• How to see if a patient is meeting a measure or not
CMS-165: Controlling High Blood Pressure

• What does the measure say?
  – Bulletins on AskIT
CMS-165: 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.”

• How to document:
  – Patients with hypertension
  – Blood pressure
CMS-165: Controlling High Blood Pressure

• Patients with hypertension
  – Problem List & Visit Diagnoses
• Blood Pressure
  – Vitals
CMS-65: Hypertension: Improvement in Blood Pressure

• What does the measure say?
  – Bulletins on AskIT
CMS-65: 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”

• How to document:
  – Patients with hypertension: Problem List & Visit Diagnoses
  – Blood pressure: Vitals
CMS-65: 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”

• Measure timing
  – Patient must be seen in the first six months of the year, then again for a follow up blood pressure.
eCQMs Per Patient

• How do you see how a patient is doing?
• Quality Navigator
  – Shows measures that a patient meets and does not meet
MIPS Example # 2

• Project:
  – Improve performance and required screening for Diabetic patients – CMS 122 (DM A1c Poor Control), CMS 34 (DM nephropathy), CMS 122 (DM Foot Exam) and CMS 131 (DM Eye Exam)

• Project Changes/Improvements
  – Train staff on correct data entry for DM foot, eye, nephropathy and closing the referral loop CQMs
  – Implement chart prep workflow for all DM patients
  – Implement “closing the referral loop” workflow
  – Implement CDS rules to support workflows
  – Implement patient reminder workflow to support requirements
MIPS Example # 2 - Scoring

- Quality Category
  - 1 outcome and 3 process CQMs

- Select Improvement Activities
  - IA-medium – Chronic care and preventative care management for empaneled patients (IA_PM_13)
  - IA-medium – Use of clinical decision support (IA_PSPA_16)

- Earn Bonus Points
  - IA using EHR counts for PI (formerly ACI) 10% bonus
EPIC EHR WORKFLOWS FOR MIPS
MIPS Example # 2 – Epic Workflows

- Demonstration of Epic workflows for this example
eCQMs in Epic

- How to enter reportable data in Epic
- Results Console to enter external results
- How to see if a patient is meeting a measure or not
- How to see how you are doing overall
CMS-122: 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.”

• **Inverse measure: lower score is better!**

• How to document:
  – Patients with diabetes
  – Lab result
CMS-122: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

• Patients with diabetes
  – Problem List & Visit Diagnoses

• Hemoglobin A1c result
  – Lab orders
  – Results console – for external results
CMS-131: Diabetic 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.”

- How to document:
  - Patients with diabetes: Problem List and Visit Diagnoses
  - Eye exam performed: Results Console
  - Eye exam result (negative): Results Console
CMS-123: 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”

• How to document
  – Patients with diabetes: Problem List & Visit Diagnoses
  – Foot Exam: Results Console
CMS-50: Closing the Referral Loop: Receipt of Specialist Report

“Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred”

How to document:

- Referral order placed
- Report received back
CMS-50: Closing the Referral Loop: Receipt of Specialist Report

- Referral order placed
  - Referral orders (internal or external) in Meds and Orders
- Report received back
  - Internal: received report in InBasket
  - External: scan report into External Referral order with Doc Type Consultation (100046)
eCQM Recap

- CMS-122: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- CMS-131: Diabetic Eye Exam
- CMS-123: Diabetes: Foot Exam
- CMS-50: Closing the Referral Loop: Receipt of Specialist Report
MIPS Dashboard

• How do you see your MIPS scores in Epic?
MIPS Dashboard

Merit-based Incentive Payment System Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Q2 '17</th>
<th>Q3 '17</th>
<th>Q4 '17</th>
<th>Q1 '18</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated MIPS Score - Transition Year</td>
<td>85%</td>
<td>65%</td>
<td>65%</td>
<td>75%</td>
<td>75%</td>
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<tr>
<td>Advancing Care Information - Transition Objectives</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Improvement Activities</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Quality</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
MIPS Dashboard

Advancing Care Information - Transition Objectives

- E-Prescribing: Q2 '17: 67%, Q3 '17: 90%, Q4 '17: 95%, Q1 '18: 96%
- Send Summaries of Care: Q2 '17: 42%, Q3 '17: 22%, Q4 '17: 33%, Q1 '18: 67%
- Patient Education: Q2 '17: 50%, Q3 '17: 50%, Q4 '17: 56%, Q1 '18: 27%
- Medical Reconciliation: Q2 '17: 93%, Q3 '17: 91%, Q4 '17: 87%, Q1 '18: 84%
- Patient Electronic Access: Q2 '17: 69%, Q3 '17: 98%, Q4 '17: 100%, Q1 '18: 96%
- Patients Access Health Information: Q2 '17: 24%, Q3 '17: 31%, Q4 '17: 23%, Q1 '18: 24%
- Secure Messaging: Q2 '17: 11%, Q3 '17: 11%, Q4 '17: 31%, Q1 '18: 23%

Advancing Care Information
MIPS Dashboard
# MIPS Dashboard

## Best Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q2 '17</th>
<th>Q3 '17</th>
<th>Q4 '17</th>
<th>Q1 '18</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 2: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>50%</td>
<td>53%</td>
<td>58%</td>
<td>76%</td>
<td>78%</td>
</tr>
<tr>
<td>CMS 23: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
<td>46%</td>
<td>45%</td>
<td>44%</td>
<td>47%</td>
<td>46%</td>
</tr>
<tr>
<td>CMS 122: Diabetes: Hemoglobin A1c Poor Control</td>
<td>13%</td>
<td>13%</td>
<td>12%</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>CMS 123: Breast Cancer Screening</td>
<td>86%</td>
<td>85%</td>
<td>89%</td>
<td>86%</td>
<td>84%</td>
</tr>
<tr>
<td>CMS 127: Pneumococcal Vaccination Status for Older Adults</td>
<td>93%</td>
<td>92%</td>
<td>90%</td>
<td>90%</td>
<td>93%</td>
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<tr>
<td>CMS 130: Colorectal Cancer Screening</td>
<td>62%</td>
<td>62%</td>
<td>63%</td>
<td>76%</td>
<td>74%</td>
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<tr>
<td>CMS 134: Diabetes: Medical Attention for Nephropathy</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>95%</td>
<td>90%</td>
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## Other Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q2 '17</th>
<th>Q3 '17</th>
<th>Q4 '17</th>
<th>Q1 '18</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 50: Closing the Referral Loop: Receipt of Specialist Report</td>
<td>12%</td>
<td>11%</td>
<td>15%</td>
<td>20%</td>
<td>20%</td>
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<tr>
<td>CMS 65: Hypertension: Improvement in Blood Pressure</td>
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<tr>
<td>CMS 68: Documentation of Current Medications in the Medical Record</td>
<td>95%</td>
<td>90%</td>
<td>87%</td>
<td>83%</td>
<td>80%</td>
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<td>CMS 69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
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<td>30%</td>
<td>30%</td>
<td>34%</td>
<td>33%</td>
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<tr>
<td>CMS 74: Primary Caries Prevention Intervention as Offered by Primary Care Providers, Including Dentists</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Stratification 1 Age 0 to 5</td>
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<tr>
<td>Stratification 2 Age 6 to 12</td>
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<tr>
<td>Stratification 3 Age 13 to 20</td>
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<tr>
<td>All Stratifications</td>
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<td>CMS 75: Children Who Have Dental Decay or Cavities</td>
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<td>CMS 90: Functional Status Assessments for Congestive Heart Failure</td>
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<td>CMS 123: Diabetes: Foot Exam</td>
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<td>CMS 124: Cervical Cancer Screening</td>
<td>21%</td>
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<td>42%</td>
<td>62%</td>
<td>42%</td>
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<td>CMS 128: Antidepressant Medication Management</td>
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<td>42%</td>
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<tr>
<td>On Antidepressants for at Least 12 Weeks</td>
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### MIPS Dashboard

#### Best Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q2 ’17</th>
<th>Q3 ’17</th>
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<th>Q1 ’18</th>
<th>YTD</th>
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<tbody>
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<td>75%</td>
<td>78%</td>
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<tr>
<td>CMS 22: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
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<td>45%</td>
<td>44%</td>
<td>47%</td>
<td>46%</td>
</tr>
<tr>
<td>CMS 122: Diabetes: Hemoglobin A1c Poor Control</td>
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<td>13%</td>
<td>12%</td>
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<td></td>
</tr>
<tr>
<td>CMS 125: Breast Cancer Screening</td>
<td>86%</td>
<td>85%</td>
<td>89%</td>
<td></td>
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</tr>
<tr>
<td>CMS 127: Pneumococcal Vaccination Status for Older Adults</td>
<td>93%</td>
<td>92%</td>
<td>90%</td>
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<td></td>
</tr>
<tr>
<td>CMS 130: Colorectal Cancer Screening</td>
<td>82%</td>
<td>82%</td>
<td>83%</td>
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</tr>
<tr>
<td>CMS 134: Diabetes: Medical Attention for Nephropathy</td>
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<td>96%</td>
<td>97%</td>
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<td>CMS 160: Depression Utilization of the PHQ-9 Tool</td>
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<tr>
<td>Last Four Months of the Year</td>
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<td>13%</td>
<td>19%</td>
</tr>
<tr>
<td>Middle Four Months of the Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>First Four Months of the Year</td>
<td></td>
<td></td>
<td></td>
<td>20%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Value: 46% (131/286)

**Thresholds:**
- ≥31.7%
- ≥28.84%
- ≥0%
# MIPS Dashboard: Drilldown Reports

## Best Quality Measures

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Q2 '17</th>
<th>Q3 '17</th>
<th>Q4 '17</th>
<th>Q1 '18</th>
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<td>83%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>CMS 160: Depression Utilization of the PHQ-9 Tool</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
</tr>
</tbody>
</table>

- Last Four Months of the Year
- Middle Four Months of the Year
- First Four Months of the Year

- View Quarter
- See Patients
- View Graph

- 13%  
- 19%  
- 20%  
- 23%
### Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

#### Measure Description

##### Outcomes

<table>
<thead>
<tr>
<th>Outcome from the last run (6/11/2018):</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected outcome for the next run:</td>
<td>Not Met</td>
</tr>
</tbody>
</table>
MIPS Dashboard: Drilldown Reports

**Population Criteria**

**Outcome: Not Met**

All patients aged 18 years and older at the start of the measurement period with at least one eligible encounter during the measurement period who were not screened for high blood pressure OR do not have a recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive.

- **Initial Population / Denominator**
  All patients aged 18 years and older before the start of the measurement period with at least one eligible encounter during the measurement period.

- **Denominator Exclusions**
  Patient has an active diagnosis of hypertension.

- **Numerator**
  Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive.

- **Most recent: Occurrence A of Encounter, Performed: BP Screening Encounter Codes satisfies all**
  - overlaps Physical Exam, Performed: Diastolic Blood Pressure (result)
  - overlaps Physical Exam, Performed: Systolic Blood Pressure (result)

- **AND**
  - All of
    - Physical Exam, Performed: Systolic Blood Pressure satisfies all
      - BP sys
    - Most recent: during Occurrence A of Encounter, Performed: BP Screening Encounter Codes
      - (result < 120 mmHg)
    - AND Physical Exam, Performed: Diastolic Blood Pressure satisfies all
      - BP diast
    - Most recent: during Occurrence A of Encounter, Performed: BP Screening Encounter Codes
      - (result < 80 mmHg)

- **OR**
  - Any of
    - All of
      - Physical Exam, Performed: Systolic Blood Pressure satisfies all
        - BP sys
      - Most recent: during Occurrence A of Encounter, Performed: BP Screening Encounter Codes
        - (result > 120 mmHg)
      - (result < 140 mmHg)
    - AND Physical Exam, Performed: Diastolic Blood Pressure satisfies all
MIPS Dashboard: Drilldown Reports

Advancing Care Information - Transition Objectives

- E-Prescribing: Q2 '17 - 97%, Q3 '17 - 96%, Q4 '17 - 96%, Q1 '18 - 95%, QTD - 96%
- Send Summaries of Care: Q2 '17 - 43%, Q3 '17 - 28%, Q4 '17 - 33%, Q1 '18 - 98%, QTD - 98%
- Patient Education: Q2 '17 - 58%, Q3 '17 - 98%, Q4 '17 - 98%, Q1 '18 - 98%, QTD - 98%
- Medical Reconciliation: Q2 '17 - 93%, Q3 '17 - 91%, Q4 '17 - 87%, Q1 '18 - 98%, QTD - 98%
- Patient Electronic Access: Q2 '17 - 59%, Q3 '17 - 98%, Q4 '17 - 98%, Q1 '18 - 24%, QTD - 24%
- Patients Access Health Information: Q2 '17 - 24%, Q3 '17 - 23%, Q4 '17 - 25%, Q1 '18 - 23%, QTD - 24%
- Secure Messaging: Q2 '17 - 11%, Q3 '17 - 11%, Q4 '17 - 31%, Q1 '18 - 29%, QTD - 30%

Eski, Paul T, MD
Where can you get help?

Contact Information

HealthAdvantage CONNECT
An Exciting New Venture from PacificCare Health Systems

Phone Support: 522-4343
Live Support: Monday – Friday 7:30am – 5:30pm
Email: ServiceDesk@HealthAdvantageConnect.com
Extra Resources
CMS-134: Diabetes: Medical Attention for Nephropathy

• “The percentage of patients 18-75 with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.”

• How to document:
  – Patients with diabetes
  – Patients with evidence of nephropathy
  – A nephropathy screening test performed
CMS-134: Diabetes: Medical Attention for Nephropathy

• Patients with diabetes
  – Problem List & Visit Diagnoses

• Patients with evidence of nephropathy
  – Nephropathy-related diagnosis: Problem List & Visit Diagnoses
  – Taking an ACE inhibitor or ARB: Medication List

• A nephropathy screening test performed
  – Lab orders
  – Results Console – for external lab results
RESOURCES
MIPS Resources

• https://qpp.cms.gov/
• QPP help desk – 866-288-8292
• Mountain-Pacific QPP tools & resources
• Mountain-Pacific calls
• Contact Mountain Pacific
  – Carl Barton – cbarton@mpqhf.org – 440-6015
  – Cathy Nelson – cnelson@mpqhf.org – 440-6007
Million Hearts Resources

- **Hypertension Control: Change Package for Clinicians**
- **Hypertension Control: Action Steps for Clinicians**
- **Template - Protocol for Controlling Hypertension in Adults**
- **Tobacco Cessation Protocol**
- **Cholesterol Management Protocols**
Diabetes and Smoking Cessation Resources

- Hawaii Department of Health - Patient Resources
- American Association of Diabetes Educators
  - ADA-recognized and AADE-accredited DSMES Program Sites
  - Algorithm of Care
  - Algorithm Action Steps
- Hawai‘i Tobacco Quitline
  - Healthcare Providers
  - Community Programs
  - Community Resources
Mountain-Pacific Resources

- **Diabetes Tools and Resources**
  - Fitness and Blood Sugar Trackers Handout
  - Exercise Prescription and Maintenance article

- **eClinical Quality Improvement (eCQI) Quality Methodology**
  - eCQI Resources

- **Cardiac Health Tools and Resources**
  - Cardiac Toolkit
  - Blood Pressure Zone Tool
  - Blood Pressure Poster
  - Blood Pressure Measurement Tips and Tricks
  - Smoking Cessation Butt Out
Hawaii Pacific Health Resources

• HealthAdvantage Connect Service Desk
  - Phone: 808-522-4343
  - Email (non-urgent issues): ServiceDesk@HealthAdvantageConnect.com

• More information about CQM
  – Bulletins on AskIT
How to choose QI projects and get started using PDSA
Plan-Do-Study-Act (PDSA)

- The PDSA quality improvement methodology is an iterative, four-stage problem-solving model used for improving a process
- PDSA is a simple, yet powerful, tool for accelerating change
- Quality improvement is an ongoing cycle with a strong emphasis of the use of data for decision making and to verify performance
PDSA, cont.

Links

Mountain-Pacific eCQI PDSA Worksheet template

Institute for Healthcare Improvement Plan-Do-Study-Act (PDSA) Worksheet
Choose a QI Project

1. Choose your condition/QI focus
2. Identify the evaluation measures (CQMs) that apply
3. Run the clinical quality measures (CQM) (or other evaluation measure) reports (min. 90-day period) to establish current performance
4. Compare current performance on measures to benchmarks or goals
5. Prioritize list of improvement projects and identify your first QI project
6. Establish project goals or evaluation metrics/targets

For example: MIPS:

1. Run CQMs chosen for quality category
2. Run Advancing Care Information reports, both base and performance measures
3. Compare to benchmark/goals
4. Choose first measure to work on and establish a target goal
Identify Possible Improvements

• Answer this question: “What changes can we make that will result in an improvement to the project goal selected?”

• Brainstorm ideas for possible changes that will ultimately improve the project goal/outcome measure
Identify Possible Changes

• Identify possible EHR functionality changes
  – How can EHR support best practices/protocols?
  – Review staff use and workflows (based on clinical best practices for QI topic)
    ▪ Computer provider order entry (CPOE)
    ▪ Care coordination and transition of care
  – Determine available options, decide on applicability (based on clinical best practices for QI Topic)
    ▪ Clinical Decision Support (CDS)
    ▪ Patient Portal/eSecure messaging
    ▪ Patient Education materials
    ▪ Interfaces
    ▪ Etc.
Identify Possible Changes (cont.)

Review your workflows:

• What is the EHR vendor’s recommended workflow for correct population of the CQM? (ASK YOUR VENDOR!)

• What process do you need to analyze further that will have the biggest impact on the measure outcome?

• Is it electronic, physical or a data flow?
  – Physical - Includes environmental layout of patient room, equipment, devices, supplies, etc.
  – Electronic - How is the work documented? What screens and fields are used?
  – Data -
    ▪ Where does the information documented go?
    ▪ Why does it go there (triggers or reports)?
    ▪ How does it get there (interfaces, uploads, etc.)?
Identify the first PDSA (improvement)

• Prioritize your change backlog and choose your first PDSA cycle from the list of possible changes
• Identify a measurable goal for the PDSA cycle
  – Use standard data measures, easily accessible and repeatable
• Establish baseline data, if one is not already available (make step one of plan if needed)
• Determine a target goal for improvement
• Tasks to keep in mind for PDSA plan:
  – Reviewing electronic, data entry and physical workflows, audit reports
  – Leveraging EHR functionality whenever possible
  – Implementing clinical best practices/protocols to support improvement
First QI PDSA Cycle Recommendation

• If data in CQM report is not “accurate,” make your first PDSA cycle about determining accurate electronic workflow, training staff on accurate workflow and validating that data

• That will be your immediate “improvement” and allow all the other functionality in the EHR to work correctly with the structured data
Acronyms

• QPP – Quality Payment Program
• MIPS – Merit-based Incentive Payment System
• APM – Alternative Payment Model
• EHR – Electronic Health Record
• CEHRT – Certified Electronic Health Record Technology
• QI – Quality Improvement
• CQM/eCQM – Clinical Quality Measure / electronic Clinical Quality Measure
• PDSA – Plan-Do-Study-Act (iterative, four-stage problem-solving model)
• CDS – Clinical Decision Support
• CPOE – Computerized Provider Order Entry
• HIE – Health Information Exchange
• eCQI - [link to eClinical Quality Improvement Quality Methodology]

[eCQI Resources]