How to Succeed in MIPS for 2019

What is New for Quality Measures
Session’s Topics

• What are the 2019 Measures
• How to Successfully Meet Measures
• Review and Rate Your Practice
• Next Steps
What are the 2019 Measures?
In 2018, 31 Measures

In 2019, 23 Measures

2019 ACO Quality Measures
2019 ACO Quality Measures by Domain & Submission Type
23 Measures

Better Health for Populations

AT RISK – 25%
- DM HbA1c Poor Control
- Hypertension Control
- Depression Remission

PREVENTION – 25%
- Breast Cancer Screen
- Colon Cancer Screen
- Flu Vaccine
- Tobacco Use & Follow Up
- Depression Screen & Follow Up
- Statin Therapy for CVD

Better Care for Individuals

PT/CAREGIVER EXPERIENCE – 25%
ACO-CAHPS Survey
- Timely Care
- Doctor Communication
- Patient’s Rating of Provider
- Access to Specialists
- Health Promotion and Education
- Shared Decision Making
- Health Status/Functional Status
- Stewardship of Pt. Resources
- Courteous and Helpful Office Staff
- Care Coordination

CARE COORD. & PT SAFETY – 25%
- Fall Screen

Claims Based
- All conditions Readmissions
- Admissions - Chronic Conditions
- Admissions - Prevention Quality Indicator – Acute composite

Clinical Data from EHR

RED = 10 ACO Web Interface (WI) Measures. Must be reported using Clinical data NOT Claims.

Vendor Administered Survey

CMS Claims Analysis
### ACO Quality Measures Used in MIPS Quality Category

<table>
<thead>
<tr>
<th>2019 ACO Web Interface Measures</th>
<th>MIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Screen and Cessation Intervention</td>
<td>✓</td>
</tr>
<tr>
<td>Hypertension Control</td>
<td>✓</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>✓</td>
</tr>
<tr>
<td>Breast Cancer Screen</td>
<td>✓</td>
</tr>
<tr>
<td>Colorectal Cancer Screen</td>
<td>✓</td>
</tr>
<tr>
<td>Diabetes A1c Control</td>
<td>✓</td>
</tr>
<tr>
<td>Fall Risk Screen</td>
<td>✓</td>
</tr>
<tr>
<td>Depression Screen</td>
<td>✓</td>
</tr>
<tr>
<td>Statin Therapy for CVD</td>
<td>✓</td>
</tr>
<tr>
<td>*Deception Remission at 12 months</td>
<td>NA</td>
</tr>
<tr>
<td>ACO-CAHPS (all measures)</td>
<td>✓</td>
</tr>
</tbody>
</table>

* Measure does not have a benchmark set so not included in MIPS APM scoring.

### TCPI 2019 Quality Measures

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>NQF #</th>
<th>Quality Measure Name</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0059</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</td>
<td>Intermediate Outcome</td>
</tr>
<tr>
<td>130</td>
<td>0419</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Process</td>
</tr>
<tr>
<td>110</td>
<td>0041</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>Process</td>
</tr>
<tr>
<td>111</td>
<td>0043</td>
<td>Pneumococcal Vaccination Status for Older Adults</td>
<td>Process</td>
</tr>
<tr>
<td>113</td>
<td>0034</td>
<td>Colorectal Cancer Screening</td>
<td>Process</td>
</tr>
<tr>
<td>134</td>
<td>418</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>Process</td>
</tr>
<tr>
<td>226</td>
<td>0028</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Process</td>
</tr>
<tr>
<td>236</td>
<td>0018</td>
<td>Controlling High Blood Pressure</td>
<td>Intermediate Outcome</td>
</tr>
<tr>
<td>318</td>
<td>0101</td>
<td>Falls: Screening for Future Fall Risk</td>
<td>Process</td>
</tr>
<tr>
<td>No longer a MIPS Measure</td>
<td>0052</td>
<td>Use of Imaging for Low Back Pain</td>
<td>Process</td>
</tr>
</tbody>
</table>
### CPC+ Quality Measures

**Benchmark Results for the Quality and Utilization Measures in CPC+**

<table>
<thead>
<tr>
<th>CMS ID#</th>
<th>MIPS ID#</th>
<th>Measure Title</th>
<th>Benchmarks</th>
<th>Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHPS</td>
<td></td>
<td>CAHPS Summary Score</td>
<td>78.77%</td>
<td>82.44%</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>Controlling High Blood Pressure</td>
<td>56.52%</td>
<td>70.94%</td>
</tr>
<tr>
<td>eCQMs</td>
<td>CMS165v6</td>
<td>236</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>67.95%</td>
</tr>
<tr>
<td>CMS122v6</td>
<td>001</td>
<td>Inpatient hospital utilization&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.17</td>
<td>0.89</td>
</tr>
<tr>
<td>Utilization</td>
<td></td>
<td></td>
<td>P50</td>
<td>P80</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>Emergency department utilization&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.42</td>
<td>1.07</td>
</tr>
</tbody>
</table>

<sup>a</sup>This measure is reverse-scored.

*Source: CPC+ Implementation Guide*
How To Successfully Meet Measures
Guiding Principles for Success in Meeting Measures

Making it easy to do the right thing and hard to do the wrong thing.
Guiding Principles for Success in Meeting Measures

1. **Understanding** the Measure Specifications:
   - Which **patients qualify**?
   - **Who** can perform the measure?
   - In **what setting** (inpatient/office setting)?
   - **When** measure should be performed?
   - Documentation **required**?
   - Denominator **exceptions/exclusions**?
Guiding Principles for Success in Meeting Measures

2. Pair clinical and IT staff
3. Bake into technology – use existing dashboards and/or build templates in EHR to control variability
   • Work with IT or EHR Vendor
4. Train providers and staff on measures
5. Track and share performance reports

Close Care Gaps as part of AWV and CCM visits
Tips for Successful Quality Measure Documentation

• Use HRA and Care Team
• Ensure evidence is documented
• Enter documentation into discrete, abstractable fields
• Adopt standardized documentation processes among providers
• Establish communication channels with outside providers to receive results and reports back on attributed patients.
**Tips for Successful Quality Measure Documentation**

- Enable variance in documentation and lack of standardization
- Rely on narrative notations or dictation to capture quality actions
- Scan in results reports in PDF format
- Rely on old measure specifications or those from other payers

**DON’Ts**
Review and Rate Your Practice
### Caravan Health ACO Low-Performing Quality Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>2016 Caravan Health Measure Rate</th>
<th>2017 Caravan Health Measure Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reflects YR1 ACOs</td>
<td>Reflects YR2 ACOs</td>
</tr>
<tr>
<td>Depression Remission</td>
<td>4.74%</td>
<td>7.27%</td>
</tr>
<tr>
<td>Depression Screen</td>
<td>33.81%</td>
<td>58.63%</td>
</tr>
<tr>
<td>Colorectal Cancer Screen</td>
<td>60.62%</td>
<td>65.69%</td>
</tr>
<tr>
<td>Breast Cancer Screen</td>
<td>63.61%</td>
<td>68.67%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>68.86%</td>
<td>67.28%</td>
</tr>
</tbody>
</table>

Fall Screen – was at 53.70% measure rate in 2016. Jumped to 76.25% in 2017. No longer considered low performing measure at CH level. May be for individual YR1 communities.

Goal is to move the needle
Format of Activity

**Goal**: Leave with a plan on additional/new workflow ideas to improve quality measures discussed.

**Part 1: Review measures specs & basic workflow for:**
- Depression Screen
- Breast & Colorectal Cancer Screening
- Hypertension Control

**Part 2: Share Best Practices & Struggles**
- Activity to identify how well think your facility is currently doing on each measure.
- Share best practices, dialogue and learn from one another.
PREV-12: Depression Screening & Follow-Up Plan

How to Meet the Measure

**What**: Complete depression screen on patients 12+ using an age appropriate standardized depression screening tool PHQ-2 or PHQ-9 (PHQ-9 recommended at point of care)
  
  • If positive, document a follow-up plan on date of positive screen.

**When**: During measurement period
  
  (January 1–December 31, 2019)

**Who**: A qualified healthcare professional must interpret the screening tool.
**Denominator Exclusions**: Active diagnosis of depression or bipolar disorder.

**Denominator Exceptions**:
Patient Reason(s): Patient refuses to participate; Medical reasons: functional capacity, etc.
Follow-up plan must contain one or more of the following:

- Additional evaluation for depression.
- Suicide risk assessment.
- Referral to a practitioner who is qualified to diagnose and treat depression.
- Pharmacological interventions.
- Other interventions or follow-up for the diagnosis or treatment of depression.
Depression Screen & Follow-Up Plan - Workflow

Pre-Visit*

Send blank copy of HRA & depression screen to patient when AWV scheduled either via portal (PIO win!) or via mail and instruct to bring completed form with them to visit.

Front desk to verify completion of HRA & depression screen at check-in, place in chart or hand patient copy to begin completing in waiting area.

*Care team member responsible for pre-visit/post-visit activities TBD by practice based on process and resources available.
**Depression Screen & Follow-Up Plan - Workflow**

1. **Nursing Visit (LPN/MA or RN)**
   - AM Huddle with team

2. **Room Patient and Review**
   - PHQ-2/PHQ-9 with patient as part of the standard AWV workflow*

3. **Hand off to provider with flag when provider action needed for pertinent positives**

4. **Flag Positive Results and add to provider Schedule if not a dual visit**

5. **Document results in the medical record via AWV template**

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*If pt has diagnosis of depression make sure to screen with PHQ-9 for remission to meet MH-1 quality measure*
On same date of positive screening, document date and time of f/u plan specific to intervention for depression.

F/U plan in med record includes one or more of following: additional depression eval., suicide risk assessment, referral to appropriate provider, pharmacological or other pertinent interventions.

Provider

Review/verify scored results of PHQ-9
How Well is Your Facility Doing – Depression Screen

Rate your facility on scale of 1- 10
1 = Needs lots of work
10 = Doing well – incorporating all elements

2017 Caravan ACO Measure Rate
DS = 58.63%
PREV-5: Breast Cancer Screening

How to Meet the Measure

**What:** Verify screen current or refer women 50 - 74 years of age for a mammogram

**When:** October 1, 2017 – December 31, 2019 - during measurement period OR 15 months prior. 27 month window.

**Who:** Any qualified healthcare professional may perform the mammogram.
**Denominator Exclusions:** 1) A bilateral mastectomy or evidence of two unilateral mastectomies, 2) patients 65 or older in Institutional Special Needs Plans (SNP) or residing in a long-term care facility

**Denominator Exceptions:** None
How to Meet the Measure

**Documentation Requirements:**

• Date the mammogram was performed and results.

☆ Documentation of “abnormal” or “normal” results sufficient.

☆ **Patient report acceptable to meet the measure.** Requirement – Date, type of test and results/findings.

☆ Documentation can be collected over the phone.
**What:** Verify screening current or refer adults 50 - 75 for a colorectal cancer screen.

**When:** During measurement period or according to screening type:
- FOBT - Measurement period (2019)
- Flex Sig - 2015-2019 (4 yrs. prior to measurement period)
- Colonoscopy - 2010-2019 (9 yrs. prior)
- CT Colonography - 2015-2019 (4 yrs. prior)
- FIT-DNA - 2017-2019 (2 yrs. prior)
  - Per CMS Cologuard is a FIT-DNA & meets measure.
Denominator Exclusions:
1) Patients with diagnosis or history of total colectomy or colorectal cancer, 2) patients 65 or older in Institutional Special Needs Plans (SNP) or residing in a long-term care facility.

Denominator Exceptions: None
Who: Any qualified healthcare professional may perform screening.

Documentation Requirements:
- Type of test/procedure administered
- Date performed & Result
- Documentation of “abnormal” or “normal” results sufficient.
- Patient report acceptable to meet the measure.
- Requirement – Year, type of test & results
- Documentation can be collected over the phone.
Mammogram/Colorectal Cancer Screen - Workflow

Pre-Visit*

Identify patients due for screening

Flag charts with previous mammogram and colorectal screening documents/dates

Assist with retrieving documents from other providers and ensure documents are entered into the EHR

Request report using Direct to build numerator in Promoting Interoperability HIE Measures

Follow-up in 4 weeks to obtain reports as needed

*Care team member responsible for pre-visit/post-visit activities TBD by practice based on process and resources available.
Mammogram/Colorectal Cancer Screen - **Workflow**

**Nursing Visit (LPN/MA or RN)**

- AM Huddle with team

**Room**

- Patient and identify if patient's screen is current

**YES: Document date (year) and results in the medical record**

**Hand off to provider**
Mammogram/Colorectal Cancer Screen - Workflow

Provider

Review; verify patient meets criteria for screening

YES: Order screening and discuss with patient
How Well is Your Facility Doing – Breast Cancer Screen & Colorectal Cancer Screen

Rate your facility on scale of 1- 10
1 = Needs lots of work
10 = Doing well – incorporating all elements

2017 Caravan ACO Measure Rate
BCS = 68.67%
Colorectal = 65.69%
Getting a Proper BP Technique

• With new guidelines around HTN it is important to be sure all staff take this vital sign correctly.
  • Make sure patient is relaxed and seated:
    • Arm without clothing and supported by desk at heart level
    • Inquire about caffeine or nicotine use in 30 mins prior
    • Legs should be uncrossed with feet on floor
    • Back should be supported
    • Patient should be relaxed for 5 mins before reading
    • Bladder should be emptied
    • Patient should not speak during measurement
  • Use appropriate cuff size such that bladder covers 80% of arm.
  • Place cuff in middle of upper arm.
  • Make sure BP device is regularly calibrated.
  • Take average of >2 readings if in hypertensive range.
HTN-2: Hypertension Control

How to Meet the Measure

**What:** Performance of a blood pressure reading and document result for all hypertensive patients 18-85.

- Adequately controlled = systolic reading of *less than* 140 mmHg and diastolic reading *less than* 90 mmHg.

**When:** During measurement period (January 1 – December 31, 2019)

**Who:** Any qualified healthcare professional may take the patient’s blood pressure.
Denominator Exclusions:
1) Patients with evidence of ESRD, dialysis or renal transplant before or during 2019, 2) pregnant patients, 3) patients 65 or older in Institutional Special Needs Plans (SNP) or residing in a long-term care facility.

Denominator Exceptions: None
**Documentation Requirements:**

- A diagnosis of essential hypertension within the first 6 months of 2019 or any time prior to 2019.
- Date and value of most recent BP reading.

☆ If there is more than one BP reading:
  - Use the most recent
  - If multiple on same day – use lowest systolic and lowest diastolic for reporting.

☆ Only BP readings performed in the **provider office** are acceptable for measure. No patient reported BP readings from home.
Hypertension Control - Workflow

*Care team member responsible for pre-visit/post-visit activities TBD by practice based on process and resources available.
Nursing Visit (LPN/MA or RN)

Running patient, take vital signs including Blood Pressure; document in EHR

If B/P above 140/90, repeat before provider visit and then flag note for provider in chart

Perform a med list review; if pt. taking meds for HTN, have the patient explain how and when they take this medication. Make note to provider if deviation to prescribed regimen identified. Document note of any new meds disclosed by patient since last visit.
Hypertension Control - Workflow

Provider

Consider recheck of B/P to verify if any changes since beginning of visit.

Review HTN med regimen, plan of care, and why important to overall health.

Document follow up plan component(s) in EHR on date of encounter.

Items to consider for plan of care include one or more of the following as indicated: weight reduction, dietary adjustments, increased physical activity, and/or medication adjustment.

**NOTE:** The JNC 7 report is what CMS uses for quality measure recommendations and lifestyle modifications.
How Well is Your Facility Doing – Hypertension Control

Rate your facility on scale of 1 - 10
1 = Needs lots of work
10 = Doing well – incorporating all elements

2017 Caravan ACO Measure Rate
HTN = 67.28%
Next Steps

Access 2019 Quality Resources:
• Quality Tab/Folder on ACO Resource page & Portal
• Measure Specifications from CMS

Monthly Webinars and Checkpoints:
• Attend Monthly Quality Webinars
• Work through measure improvements on monthly Roadmap calls
  • Assess performance from PY2018 reporting
  • Target low-performing measures for improvement
  • Chart review of documentation and PDSA process
Thank You

bringing population health to life

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