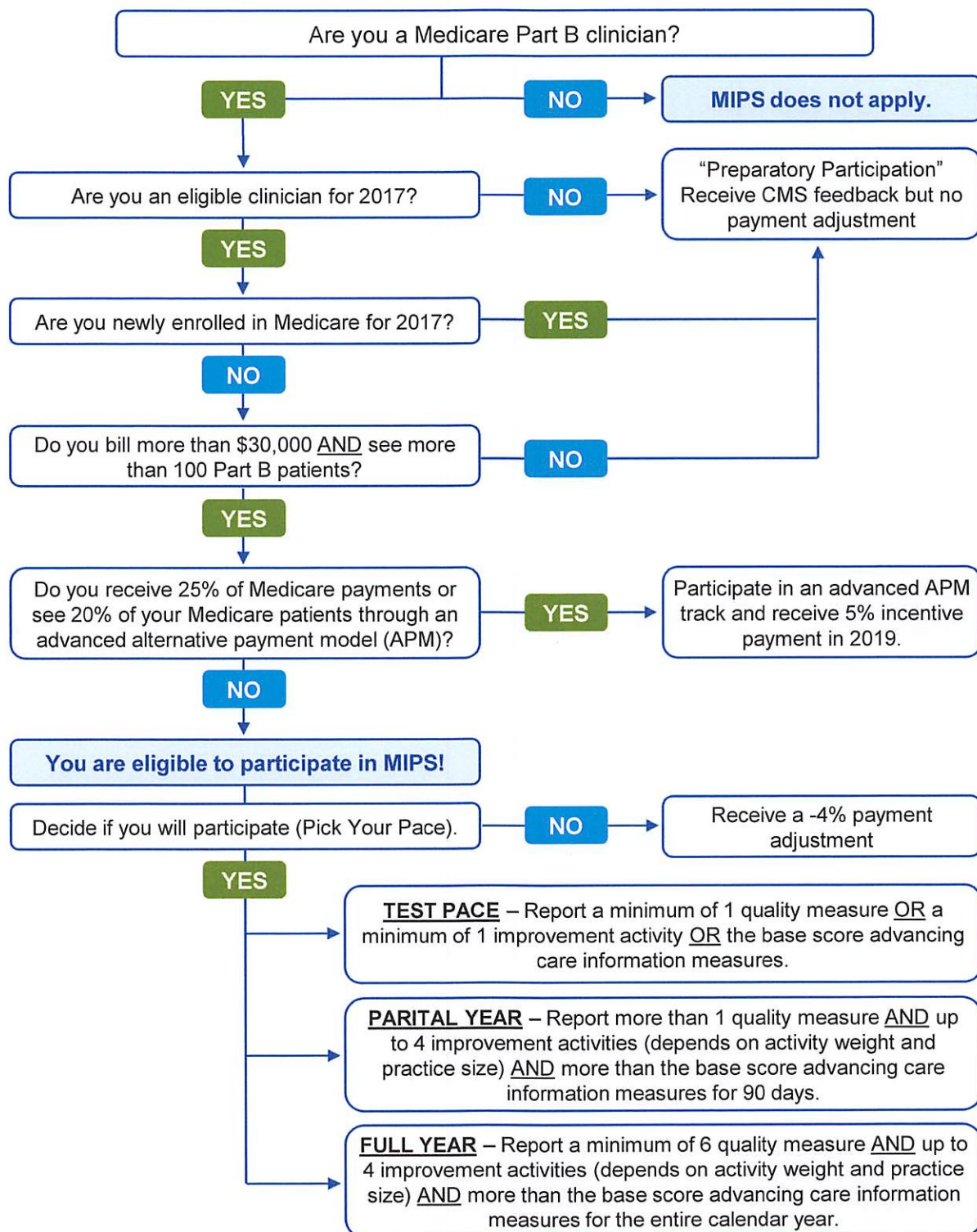


Eligibility & Pick Your Pace: Merit-based Incentive Payment System (MIPS) Transition Year (2017)



APPENDIX A: Advancing Care Information Performance Category Measures and Scores

This chart identifies the full list of Advancing Care Information measures and 2017 Advancing Care Information transition measures. Detailed guidance outlining each element of each Advancing Care Information measure and **2017** Advancing Care Information **transition** measure can be found in the Advancing Care Information Specification Sheets.

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	% Points
Provide Patient Access*	Up to 10%
Send a Summary of Care*	Up to 10%
Request/Accept Summary Care*	Up to 10%
Patient Specific Education	Up to 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 (see the list below).

Measures for Performance Score	% Points
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%

Quality Payment Program

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%
Immunization Registry Reporting	0 or 10%

Secure Messaging	Up to 10%
Medication Reconciliation	Up to 10%
Immunization Registry Reporting	0 or 10%

Requirements for Bonus Score	% Points
<p>*Report to 1 or more of the following public health and clinical data registries:</p> <ul style="list-style-type: none"> • Syndromic Surveillance Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting 	5%
Report certain improvement Activities using CEHRT	10%

Requirements for Bonus Score	% Points
<p>*Report to 1 or more of the following public health and clinical data registries:</p> <ul style="list-style-type: none"> • Syndromic Surveillance Reporting • Specialized Registry Reporting 	5%
Report certain improvement Activities using CEHRT	10%



The Quality Payment Program

Integrating with the Quality Payment Program: Making Current improvement Activities Work for You

What is MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Sustainable Growth Rate (SGR) formula. MACRA is being implemented through the Quality Payment Program (QPP). This program is designed to improve care for Medicare patients by refocusing the physician payment system to quality of care over quantity of services.

The CMS Quality Payment Program:

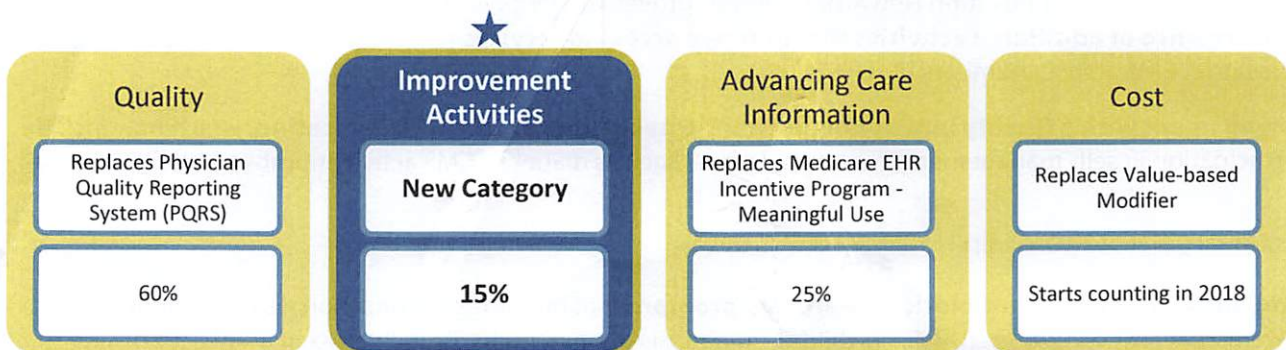
qpp.cms.gov

Quality Payment Program

Merit-based Incentive Payment System

Combines the following existing reporting mechanisms into a single program: Physician Quality Reporting System (PQRS), Value-based Modifier, and Meaningful Use (with EHRs). A new category Improvement Activities (IA) component was also added.

Final score will factor in performance in four weighted categories for transition year:



Improvement Activities

HealthInsight has a limited amount of funding to help practices with QPP technical assistance, but we have funding through other CMS grants to assistance with several improvement activities that can help you reach your QPP goal as well.

Improving Behavioral Health

Depression screening and follow-up plan: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including depression screening and follow-up plan (refer to NQF #0418) for patients with co-occurring conditions of behavioral or mental health conditions. CMS activity number: IA_BMH_4.



The Quality Payment Program

Unhealthy alcohol use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including screening and brief counseling (refer to NQF #2152) for patients with co-occurring conditions of behavioral or mental health conditions. CMS activity number: IA_BMH_3.

Population management: Proactively manage chronic and preventive care for empaneled patients. CMS activity number: IA_PM_13

Cardiovascular Health and Million Hearts

Participation in CMMI models such as Million Hearts Campaign. CMS activity number: IA_PM_8

Population management: Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: 1) 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; 2) 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; 3) Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions. CMS activity number: IA_PM_13

Reducing Disparities in Diabetes Care

As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, **performance of additional activities that improve access to services** (e.g., investment of on-site diabetes educator). CMS activity numbers IA_EPA_4

Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs such as diabetes. CMS activity number: IA_BE_3

Antimicrobial Stewardship

Implementation of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions (URI Rx in children, diagnosis of pharyngitis, Bronchitis Rx in adults) according to clinical guidelines for diagnostics and therapeutics. CMS activity number: IA_PSPS_15

Care Coordination

Implementation of at least one additional recommended activity from the Quality Innovation Network-Quality Improvement Organization after technical assistance has been provided related to care coordination. CMS activity number: IA_CC_3

Implementation of practices/processes for care transition that include documentation of how a MIPS eligible clinician or group carried out a patient-centered action plan for first 30 days following a discharge (e.g., staff involved, phone calls conducted in support of transition, accompaniments, navigation actions, home visits, patient information access, etc.) CMS activity number: IA_CC_10



The Quality Payment Program

Establish standard operations to manage transitions of care that could include one or more of the following: 1) Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or 2) Partner with community or hospital-based transitional care services. CMS activity number: IA_CC_11

Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: 1) Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; 2) Integrate a pharmacist into the care team; and/or 3) Conduct periodic, structured medication reviews. CMS activity number: IA_PM_16

Participation in the CMS Transforming Clinical Practice Initiative for those participating in a Practice Transformation Network. CMS activity number: IA_CC_4

We Can Help!

HealthInsight can help you get started or continue work on any of the improvement activities listed above. To get assistance contact the project facilitator in your state.

Nevada

Aaron Hubbard
Call: 702-948-0306
Email: ahubbard@healthinsight.org

Oregon

David Smith
Call: 503-382-2962
Email: dsmith@healthinsight.org

New Mexico

Ryan Harmon
Call: 505-998-9752
Email: rharmon@healthinsight.org

Utah

Brock Stoner
Call: 801-892-6602
Email: bstoner@healthinsight.org

Danielle Pickett
Call: 505-998-9768
Email: dpickett@healthinsight.org

For more information about QPP or to get help with other aspects of QPP visit our webpage: <http://healthinsight.org/qpp> or email us at qpp@healthinsight.org.

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



Mountain-Pacific
Quality Health

Mountain-Pacific is able to provide you with MIPS consultation services through grants with the HI State Dept. of Health and CMS. Please complete the Needs Assessment in your packet so that we may serve you best.

Mahalo,
Your Mountain-Pacific Team

MIPS and Me

A guide to prepare for MIPS reporting
Cathy Nelson, RN
James Roberts



Objectives: MIPS and Me: Workshop 1

By the end of this session, you will be able to

- Complete the Mountain-Pacific Needs Assessment
- State a basic overview of MIPS
- Identify your MIPS eligibility, Included or Exempt status, and Special status
- Choose your MIPS reporting goal
- State a plan to achieve your MIPS goal

What is MIPS? (Merit Based Incentive Payment System)

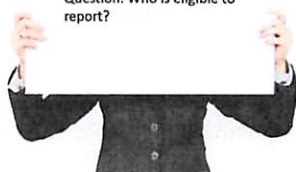
- 1 of 2 tracks in the Quality Payment Program provisioned under MACRA



- CMS Medicare FFS payments will focus on care quality for patients
- MIPS combines and replaces past reporting programs with a single payment system

Who Participates?

Question: Who is eligible to report?



Short answer:
MACRA affects clinicians
who participate in Medicare Part B.

Who Participates in MIPS?

Part B **ELIGIBLE** MIPS providers:

- Physician
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist

You're **INCLUDED** in MIPS if you:

- bill Medicare Part B more than \$30,000 as an individual clinician
AND
- provide care for more than 100 Medicare Part B patients during the determination period

Exempt and Special Status Providers

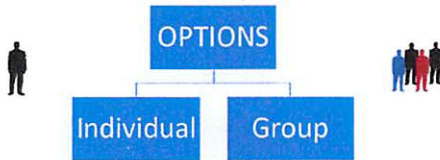
You're **EXEMPT** from MIPS if you:

- are a first year Medicare provider
- Below the low-volume threshold
- Significantly participating in an Advanced APM

SPECIAL STATUS providers have reduced requirements for MIPS reporting:

- Small practices
- Rural
- Health Professional Shortage Area (HPSA)
- Non-Patient Facing
- Hospital based

How Do Clinicians Participate in MIPS?



1. **Individual:** under an NPI number & TIN where they reassign benefits
2. **As a Group:**
 - a) Two or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
 - b) As a MIPS APM entity

* If clinicians participate as a group, they are assessed as group across all 4 MIPS performance categories

Group Considerations

- A group can decide to report as individuals or as a group
- There can be a mix of INCLUDED and EXEMPT providers in a group
- If the group decides to report as a group, the EXEMPT provider data is aggregated with the entire group's performance.
- If the group gets a positive payment adjustment, all INCLUDED AND EXEMPT members of the group receive adjustment

Exercise 1: Find your MIPS status

- Go to qpp.cms.gov website
- Type in your individual NPI in the lookup tool
- Answer questions #2, 3, and 4 on your worksheet
 - Are you eligible?
 - Are you included?
 - Are you included as an individual? Are you included as a group?
 - Do you have a special status?

DON'T TAKE THE HIT IN 2017!

EVERYONE INCLUDED IN MIPS SHOULD REPORT AT
LEAST **SOMETHING**

It's easier to avoid future negative Medicare payment adjustments this year than ever before

Performance Categories: <https://qpp.cms.gov>



- Many measures align with those being used by private insurers

Clinicians will be **reimbursed under Medicare Part B** based on this Performance Score

How Are MIPS Performance Categories Weighted?

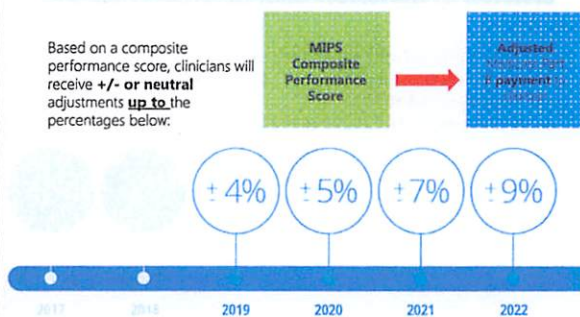
Weights assigned to each category based on a 1 to 100 point scale
Transition Year Weights



NOTE: These are default weights; the weights can adjust in special status circumstances

How much can MIPS adjust payments?

Based on a composite performance score, clinicians will receive +/- or neutral adjustments **up to** the percentages below:



The potential maximum adjustment % will increase each year from 2019 to 2022

Transition Year 2017

Final Score	Payment Adjustment
>70 points	<ul style="list-style-type: none"> • Positive adjustment • Eligible for exceptional performance bonus – minimum of additional 0.5%
4 – 69 points	<ul style="list-style-type: none"> • Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
1 – 2 points	• Negative payment adjustment
0 points	<ul style="list-style-type: none"> • Negative payment adjustment of -4% • 0 points = does not participate

Ways to achieve final score of at least 3 points:

- Advancing care information – Report on 4 required measures
- Improvement activities – Attest to at least 1 improvement activity
- Quality – Submit at least 1 out of at least 6 quality measures; more measures are required for groups who submit using the CMS Web Interface measures

Transition Year 2017 – Pick Your Pace

Participate in an Advanced APM



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

Not participating in the Quality Payment Program for the transition year will result in a **negative 4% payment adjustment**.

MIPS

Test Pace



Submit something

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

Partial Year



Submit a Partial Year

- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year



Submit a Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Choosing to Test for 2017

- If you submit a minimum amount of 2017 data to Medicare, you can avoid a downward adjustment

- Submit 1 quality measure via claims. If you are reporting measures for HMSA on your claims, you can do the same for MIPS. **YOU MUST VERIFY THAT YOU ARE USING THE SAME CODES FIRST**
- Submit 1 improvement activity for 90 days. Check with your Physician Organization to see what activities you might have already done.
- Submit the **base measures** of Advancing Care Information

Partial Participation for 2017



- Submit 90 days of 2017 data to Medicare
 - More than **1** Quality Measure,
 - More than **1** Improvement Activity, or
 - More than the **4** required Advancing Care Information measures
- You may earn a neutral or small positive payment adjustment
- If you're not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017
- Send in performance data by March 31, 2018

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Full Participation for 2017



- Submit a full year of 2017 data to Medicare
 - Report at least **6** Quality Measures, **4** medium weighted or **2** high-weighted improvement activities, and **5** advancing care information measures.
- You may earn a moderate positive payment adjustment
- To earn the largest positive adjustment is to participate fully in the program by submitting information in all the MIPS performance categories.

Key Takeaway:

Payment adjustments are based on the performance data submitted, not the amount of information or length of time submitted.

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PICK YOUR PACE Considerations

- Does your PYP option make sense financially given today's date?
- Is your EHR able to create QRDA 3 reports for you?
- What Quality category measures can your EHR report?
- What if you don't have an EHR, can you still report?
- What if I'm a specialist? Do I have to report specialist measures?
- What if I'm in CPC+? Do I have to report MIPS?

Exercise 2: Decide Your Reporting Goal and Plan

- Answer Worksheet questions #5, 6, 7
 - Do you plan to report MIPS?
 - What is your Pick Your Pace Goal?
 - Describe your initial thoughts on how you will achieve your goal?

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MIPS Review

- Know your reporting status
- If included in MIPS, REPORT SOMETHING. Don't take the 4% HIT!
- The last quarter of reporting is quickly approaching – Oct 2
- Plan your MIPS reporting goal this week
- Refer to resource list for assistance

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Invitation to Next Workshops

Session 2 Tuesday, August 15, 2017
12:30 – 2:00 p.m.

- Create your EIDM account
- Consider your Pick Your Pace option and reporting period
- Select mechanism of reporting for individuals and groups – claims, EHR, registry reporting
- Choose Quality Category Measures – from gpp.cms.gov website

Session 3 Tuesday, August 22, 2017
12:30 – 2:00 p.m.

- Choose Advancing Care Information measures – from gpp.cms.gov website
- Choose Improvement Activities – from gpp.cms.gov website
- Tracking and Monitoring throughout 2017
- Data Submission

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Questions?



mahalo iā 'oe

This information is brought to you by Mountain-Pacific Quality Health, with funding from the Hawaii Health Department and the Centers for Medicare & Medicaid Services. Mountain-Pacific is the Medicare Quality Improvement Network-Quality Improvement Organization (QIN-QIO) for Montana, Wyoming, Alaska, Hawaii and the U.S. Pacific Territories of Guam and American Samoa and the Commonwealth of the Northern Mariana Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contents presented do not necessarily reflect CMS policy. 11/2016 AMPQH-AS-20-07-10

PART A: General Practice and Provider Information

Name and title: _____

Position: _____

Email: _____

Phone: _____

1. How many practice sites does this form represent? _____
2. Practice name(s): _____
3. Practice zip code(s): _____
4. Does your practice belong to one or more Physician Network Organizations (PO) or Accountable Care Organizations (ACO)?
☐ Yes ☐ No
If yes, which one(s): _____
5. How many **physicians (MDs/DOs)** do(es) your practice(s) employ *(altogether, if multiple practices)?*
☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6-9 ☐ 10-49 ☐ 50+
6. Please provide the names of all MDs and/or DOs in your practice:

7. How many FTE of non-physician clinical providers does your practice employ? (e.g. 2 full time and 1 part-time = 2.5 FTE [full time equivalent])
Nurse Practitioner: _____
Physician Assistants: _____
Medical Assistants: _____
Other Team-based Care (Pharmacists, Community Health Workers, etc.): _____
Other Allied Health Professional (Psychologists, Social Workers, etc.): _____
8. Approximately how many patients were in your panel(s) in 2016? *Please answer this question based on how you defined your practice for this survey, considering whether this answer represents the panel size across a single site or multiple sites, and whether it represents multiple providers' panels.*
☐ 1-400 ☐ 401-750 ☐ 751-1,500 ☐ 1,501-2,500
☐ 2,501-4,000 ☐ 4,001-6,000 ☐ 6,001-8,000 ☐ 8,001-10,000 ☐ 10,000+

PART B: ELECTRONIC HEALTH RECORD (EHR) FUNCTIONAL CAPACITY

9. Which Electronic Health Record (EHR) system does your practice utilize? *Please do not include billing record systems.*
☐ EHR: _____
☐ We do not have an EHR but we are trying to acquire or implement one. List product if you have a specific one in mind: **(skip to Q13)**

☐ We do not have an EHR. Please explain: **(skip to Q13)**

10. What version EHR do you have? *(If you are unsure, please say "Don't Know")*

11. Did your current EHR system meet Meaningful Use criteria in 2016, as defined by the Centers for Medicare and Medicaid Services (CMS)?
☐ Stage 1 ☐ Stage 2 or higher ☐ No ☐ Not Sure
12. Is your EHR certified to the 2014 or 2015 edition or a combination of both?
☐ 2014 ☐ 2015 ☐ Combination ☐ No ☐ Not Sure

PART C: REPORTING OF CLINICAL QUALITY MEASURES

13. Who is in charge of reporting clinical quality measures for your practice(s)? *Please write in the name and title/position of the assigned individual(s.) If not applicable, please write N/A.*
Name: _____
Title: _____
14. Did your practice submit 2016 Physician Quality Reporting System (PQRS) measures to Center for Medicare and Medicaid Services (CMS)?
☐ Yes ☐ No **(skip to Q17)** ☐ Not Sure **(skip to Q17)**
15. Was/Were your 2016 PQRS submission(s) to CMS successful? Please respond based on 2015 data if you do not yet know the results of your 2016 data submission.
☐ Yes, all ☐ Yes, some ☐ No ☐ Not Sure
☐ We did not submit 2015 data and do not know the results of our 2016 submission
16. What reporting mechanism(s) did you use for reporting PQRS measures in 2016?
☐ Certified EHR ☐ Qualified registry ☐ Clinical data registry
☐ Group Practice Reporting Option Web Interface ☐ Claims Submission
☐ Other: _____ ☐ Not Sure
17. Does your practice qualify for the Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program?
☐ Yes, my practice qualifies ☐ Yes, I am affiliated with a practice that qualifies
☐ No, my practice does not qualify **(skip to Q20)** ☐ Not Sure
18. Do you plan to participate in MACRA's Quality Payment Program?
☐ Yes, we plan to submit 2017 Merit-based Incentive Payment System (MIPS) measures
☐ Yes, as part of CPC+
☐ No, but we are evaluating the feasibility of participating in future years **(skip to Q20)**
☐ No, we do not intend to participate in this program **(skip to Q20)**
☐ Not Sure **(skip to Q20)**
19. How does your practice plan to submit 2017 clinical quality measures (CQMs) to CMS?
☐ Certified EHR - Name: _____
☐ Qualified Registry - Name: _____
☐ Clinical Data Registry - Name: _____
☐ Group Practice Reporting Option Web Interface
☐ Claims Submission
☐ We are still identifying the best method to submit MIPS measures
☐ Not Sure
☐ Other: _____

20. Has your practice recently reported, or does your practice plan to report, on any of the following CQMs to any health plan in the following chronic disease areas?

Clinical Quality Measure and brief summary	Previously Reported	Plan to report	Did not report	Not sure	Undecided Not/Sure
<i>Hypertension Screening and Control</i>					
<u>PQRS 317/Quality ID 317:</u> Percentage of patients aged who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure reading as indicated.					
<u>PQRS 236/Quality ID 236:</u> Percentage of patients who had a diagnosis of hypertension and whose blood pressure was adequately controlled					
<u>PQRS 373/Quality ID 373:</u> Percentage of patients with a diagnosis of hypertension whose blood pressure improved during the measurement period.					
<i>Diabetes Control and Management</i>					
<u>PQRS 001/Quality ID 001:</u> Percentage of patients with diabetes who had hemoglobin A1c > 9.0%					
<i>Cancer Screening and Follow Up</i>					
<u>PQRS 309/Quality ID 309:</u> Percentage of women who received one or more Pap tests to screen for cervical cancer					
<u>PQRS 112: Quality ID 112:</u> Percentage of women who had a mammogram to screen for breast cancer					
<u>PQRS 113/Quality ID 113:</u> Percentage of patients who had appropriate screening for colorectal cancer					
<i>Tobacco Use Screening and Cessation Support</i>					
<u>PQRS 226/Quality ID 226:</u> Percentage of patients who were screened for tobacco use one or more times AND who received cessation counseling intervention if identified as a tobacco user.					
<i>Asthma Management</i>					
<u>PQRS 398/Quality ID 398:</u> Patients whose asthma is well-controlled as demonstrated by one of three age-appropriate patient reported outcome tools					
<u>Quality ID 444:</u> Percentage of patients who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period					
<i>Patient Safety</i>					
<u>PQRS 130/Quality ID 130:</u> Percentage of visits for patients for which the eligible professional attests to documenting a list of all current medications on the date of the encounter, including medication names, dosages, frequencies, and routes of administration					
<i>BMI Screening and Counseling</i>					
<u>PQRS 128/Quality ID 128:</u> Percentage of patients with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter					

21. Do you need more information from us (i.e. MPQH) on the financial implications of the MACRA Quality Payment Program for your practice?
☐ Yes ☐ No ☐ Not Sure
22. Are you fully informed about your EHR vendor's role in assisting you with reporting your quality measure to CMS?
☐ Yes ☐ No ☐ Not Sure
23. Would you like additional support from MPQH in facilitating conversations with your EHR vendor to enhance your ability to report CQMs to CMS?
☐ Yes ☐ No ☐ Not Sure

PART D: QUALITY IMPROVEMENT ACTIVITIES

24. Does your practice have access to and utilize a population health management tool?
☐ Yes - Name: _____
☐ No (skip to Q26) ☐ Not Sure (skip to Q26)

25. Have you ever used (or are you currently planning to use) your population health management tool to identify action items and conduct quality improvement across your patient panel (e.g. identify patients overdue for checkups; flag patients with poor chronic disease management for follow-up actions; set up reminders to refer patients meeting certain criteria to additional services, etc)?
☐ Yes ☐ No ☐ Not Sure

26. Please list any quality improvement activity projects your practice is currently working on, or plans to implement. If not applicable, please write N/A. MACRA requires every practice to engage in at least one quality improvement activity, in addition to reporting clinical quality measures.

Previously worked on the following activities:

Currently planning/working on the following activities:

27. If you have implemented an **innovative strategy** in your practice related to improving chronic disease screening and diagnosis, risk stratification, self-monitoring, self-management education, lifestyle change, or team-based care (using pharmacists, community health workers, or care coordinators/patient navigators, especially), or anything else **you think may be useful for your peers to consider adopting**, please share it with us. Also, please indicate if you may be interested in sharing your successes with peers in upcoming quality improvement learning collaborative and other conferences focused on providers.

Would you be willing to present on this strategy to your peers at one or more events over the next year?

☐ Yes absolutely ☐ Yes, tentative, I'll decide on a case by case basis ☐ No, I'm not ready at this time ☐ No, absolutely not

28. Do you currently electronically identify patients who meet any of the criteria below (either using your EHR or your population health management tool)? Please check all that apply

Identification of Undiagnosed Chronic Diseases	We currently <u>have and use</u> this functionality	We currently <u>have</u> , but do not use this functionality	We currently <u>do not have/do not know if we have</u> this functionality
Patients with 2-3 elevated blood pressure readings without a diagnosis of hypertension			
Patients with hypertension with blood pressure > 140/90 mmHg			
Patients with elevated blood sugar/HbA1c without a corresponding diagnosis of diabetes			
Patients with elevated blood sugar/HbA1c without a corresponding diagnosis of pre-diabetes			
Patients with diabetes with A1c > 9.0%			
Patients due for a blood sugar check/HbA1c test without a diagnosis of pre-diabetes/diabetes			
Patients due for cervical cancer screening			
Patients due for colorectal cancer screening			
Patients due for breast cancer screening			
Patients due for HPV vaccination			
Patients who smoke who also have a chronic condition			

29. Is your health system interested in participating in any of the following improvement activities with the assistance and support of MPQH? Please check all that apply. *These improvement activities will fulfill the MIPS Improvement Activities requirements for 2017 reporting.*

Quality Improvement Activity	Interested	Not interested
Improving coding the highest specificity (enhancing documentation of patient acuity and diagnosis of undiagnosed conditions)		
Engaging pharmacists in patient medication reconciliation to improve medication adherence and reduce preventable hospitalizations		
Enhancing care coordination for high acuity patients through the support and engagement of community health workers		
Promoting self-management and self-monitoring of chronic conditions through patient empowerment and use of support staff		
Other:		
Other:		

PART E: TECHNICAL ASSISTANCE

Please respond to the following questions as you consider the types of assistance that would be most helpful to you and your practice at this time.

30. Of the following EHR concerns, please choose **one** that represents your greatest challenge at this time:
- ☐ Using an/my EHR system
 - ☐ Meeting criteria for Advancing Care Information (formerly Meaningful Use)
 - ☐ Figuring out how to report MIPS measures (I need to establish a mechanism by which to report to CMS)
 - ☐ Figuring out how to report MIPS measures (I have a mechanism in place, but I need assistance in learning how to use it)
 - ☐ Selecting the best MIPS measures to report
 - ☐ Documenting patient health data within my EHR in a way that maximizes my MIPS measures values
 - ☐ Having access to clinical community support and shared learning opportunities that help me participate in the most useful/successful quality improvement initiatives

- ☐ EHR to support to build automated processes to support my quality improvement initiatives
- ☐ Realigning workflows/protocols within my practice(s) to streamline our efforts in quality improvement
- ☐ Other:

31. How concerned are you about your ability to address your greatest challenge you selected in the previous question without assistance?

- ☐ Extremely concerned
- ☐ Very concerned
- ☐ A bit concerned
- ☐ Not too concerned
- ☐ Not at all concerned

32. From the list below, select up to **3** types of support that would be most helpful to you:

- ☐ Assistance with acquiring/implementing an EHR
- ☐ Assistance with identifying the best MIPS measures to report
- ☐ Assistance with extracting/submitting MIPS data
- ☐ Resolving documentation issues in my EHR to maximize my MIPS measures values
- ☐ Learning from other community providers on successful quality improvement strategies
- ☐ Implementing clinical decision supports and other alerts/reminders within my EHR to support my quality improvement activity
- ☐ Evaluating and reconfiguring workflows/protocols within my practice to support our efforts in quality improvement
- ☐ Other:

33. Do you have any other topics you are interested in learning about, or what resources, if any, do you wish you were able to provide your patients to better manage their chronic conditions? *Please especially consider challenges with case finding, team-based care, and management that could benefit from learning collaboratives with peers. You might also list challenges with using your EHR effectively.*

34. Please provide us with the name of the best person in your practice to follow up with on the responses you provided. We will contact you about the next steps for the provision of technical assistance, if we are able to help you with the support you need at this time. Thank you for your time completing this important survey.

Name: _____

Title: _____

Company Name: _____

Address: _____

Phone: _____

Email: _____

MIPS WORKSHEET

Please keep this as a plan for MIPS reporting.

Name _____

Practice Name _____

Individual NPI _____

1. Do you feel you have a basic understanding of MIPS? ☐ YES ☐ NO

2. Are you eligible for MIPS? ☐ YES ☐ NO

3. Are you INCLUDED in MIPS? ☐ YES ☐ NO

IF YES, are you included as an ☐ Individual ☐ Group

Do you have a MIPS Special Status? ☐ YES ☐ NO

4. My special status is _____

5. Do you plan to report MIPS? ☐ YES ☐ NO

What is your Pick Your Pace Goal? ☐ TEST ☐ PARTIAL ☐ FULL

Please describe your initial thoughts on how you will achieve this goal.

Resources to prepare you for MIPS Reporting

1. Where do I go to learn more about MIPS?

The CMS QPP website and bookmark/favorite

<https://qpp.cms.gov/>

The Mountain-Pacific website and bookmark/favorite

<http://mpqhf.com/QIO/qpp-tools-resources/>

Subscribe to the Mountain-Pacific blog

<http://mpqhf.com/blog/macra/>

2. Do you want to know if you are eligible and included in MIPS? Enter your NPI in CMS QPP look-up tool

<https://qpp.cms.gov/>

3. Complete the Mountain-Pacific Needs Assessment so that we can serve you best

<http://www.surveygizmo.com/s3/3530273/GetMACRA>

Here is the password: HealthIT

4. Link to online tool to complete the Security Risk Analysis

https://www.healthit.gov/sites/default/files/attachmenta-security_risk_assessment_tool_user_guide_v6.pdf

5. Total 2015 Medicare FFS payments for your practice

<https://data.cms.gov/Medicare-Physician-Supplier/Medicare-Physician-and-Other-Supplier-National-Pro/p3uv-6dv4/data>