The Quality Payment Program and Cardiac Health:

• How our Cardiac Health Initiative Can Help You Meet QPP Requirements •

Learn how you can be successful with reporting to the Merit-based Incentive Payment System (MIPS) by reviewing two key Performance Categories on which eligible clinicians (ECs) will be scored: **Quality** and **Improvement Activities** and how they relate to Cardiac Health.

For more information, visit the Centers for Medicare & Medicaid Services (CMS) website: *https://qpp.cms.gov/.*

Quality (60% of Final MIPS Score)

As part of MIPS, ECs will need to report six quality measures, including an outcome measure. Here are a few measures from the 271 total Quality Measures.

Community / Population Health Measures

Quality ID 402: Tobacco Use and Help with Quitting Among Adolescents

Quality ID 317: Screening for High Blood Pressure and Follow-Up Documented

Quality ID 226: Tobacco Use - Screening and Cessation Intervention

Patient Safety Measures

Quality ID 130: Documentation of Current Medications in the Medical Record

Communication and Care Coordination Measures

Quality ID 047: Care Plan

Quality ID 374: Closing the Referral Loop: Receipt of Specialist Report

Effective Clinical Care Measures

Quality ID 204: Ischemic Vascular Disease (IVD): Use of Asprin or Another Antiplatelet

Quality ID 236: Controlling High Blood Pressure

Quality ID 441: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)

Quality ID 373: Hypertension: Improvement in Blood Pressure

Improvement Activities (15% of Final MIPS Score)

As part of MIPS, ECs will need to attest to four (most participants) or 2 (small, rural practices) Improvement Activities for a minimum of 90 days. There are over 90 Improvement Activities from which to choose; below are the ones that align with New England Cardiac Health Initiative.

Improve Health Status of Communities (Weight: Medium)

Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist MIPS eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.

Improve Healthcare Disparities (Weight: Medium)

Take steps to improve healthcare disparities, such as Population Health Toolkit or other resources identified by CMS, the Learning and Action Network, Quality Innovation Network, or National Coordinating Center. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.

Participate in CMMI Models (Weight: Medium)

Participation in CMMI models such as Million Hearts initiative.

Manage Chronic and Preventive Care for Empaneled Patients (Weight: Medium)

Proactively manage chronic and preventive care for impaneled patients that could include one or more of the following:

- Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning
- 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
- Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions
- Use panel support tools (registry functionality) to identify services due
- Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or routine medication reconciliation

Implementation of Condition-Specific Chronic Disease Self-Management Support Programs (Weight: Medium)

Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.

Implementation of Improvements that Contribute to More Timely Communication of Test Results (Weight: Medium)

Timely communication of test results - defined as timely identification of abnormal test results with timely follow-up.

Tobacco Use (Weight: Medium)

Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.

Best Practices:

1. Implement protocol
2. Use **Self-Measured Blood Pressure (SMBP) monitoring** with hypertensive patients
3. Follow the **M.A.P. Framework**

M.A.P. Framework:

MEASURE	blood pressure accurately, every time it's measured
ACT	rapidly to address high blood pressure readings
PARTNER	with patients, families & communities to promote self-management

Source: American Medical Association and The Johns Hopkins University

For more information, visit these Resources:

Million Hearts: https://millionhearts.hhs.gov/index.html

American Medical Association's Target:BP Program: http://targetbp.org/

American Heart Association: http://www.heart.org/HEARTORG/

CMS Quality Payment Program: https://qpp.cms.gov

New England Quality Payment Program Support Center: https://neqpp.org

New England QIN-QIO: http://www.healthcarefornewengland.org/initiatives/cardiac-health/

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