The Quality Payment Program and Diabetes Care:

• How our Diabetes Care 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 Diabetes Care.

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.

Effective Clinical Care Measures

Quality ID 001: Diabetes: Hemoglobin A1c Poor Control

Quality ID 009: Anti-Depressant Medication Management

Quality ID 117: Diabetes: Eye Exam

Quality ID 119: Diabetes: Medical Attention for Nephropathy

Quality ID 126: Diabetes Mellitus: Peripheral Neuropathy, Diabetic Foot and Ankle Care

Quality ID 127: Diabetes Mellitus: Ulcer Prevention, Diabetic Foot and Ankle Care

Quality ID 163: Diabetes: Foot Exam

Quality ID 236: Controlling High Blood Pressure

Quality ID 373: Hypertension: Improvement in Blood Pressure

Quality ID 438 – Statin Therapy for Prevention and Treatment of Cardiovascular Disease

Communication and Care Coordination Measures

Quality ID 019: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Community / Population Health Measures

Quality ID 134: Preventive Care and Screening: Screening for Clinical Depression and Follow Up Plan

Quality ID 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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

Improvement Activities (15% of Final MIPS Score)

As part of MIPS, ECs will need to attest to four (most participants) or two (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 Diabetes Care Initiative.

Glycemic Management Services (Weight: Medium)

For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance year, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Is reassessed at least annually. The performance threshold will increase to 75 percent for the second performance year and onward. Clinician would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.

Additional Improvements in Access as a Result of QIN-QIO TA (Weight: Medium)

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).

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

Proactively manage chronic and preventive care for 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

Diabetes Screening (Weight: Medium)

Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.

Use Group Visits (Weight: Medium)

Use group visits for common chronic conditions (e.g., diabetes).

Engagement with QIN-QIO to Implement Self-Management Training Programs (Weight: Medium)

Engagement with a QIN-QIO (Quality Innovation Network-Quality Improvement Organization), which may include referring patients to DSME (Diabetes Self-Management Education) programs, having the opportunity to host a DSME class in your practice or training your staff to lead DSME classes for your patients.

The New England QIN-QIO uses the **Diabetes Self-Management Program (DSMP)** in all six New England states. As part of this program, participants will learn about diabetes, its risks. Additionally, participants will learn about the importance of:

- Diet and exercise
- Keeping regular physician exams
- Receiving annual foot and eye exams
- Managing medications and more

DSMP is an evidence-based program that teaches participants self-management skills for a healthier life. Our trained leaders teach classes as well as provide peer training so organizations can lead their own DSME programs.

Read more: DSMP - http://patienteducation.stanford.edu/programs/diabeteseng.html

Everyone with Diabetes Counts Foot Care Campaign: http://qioprogram.org/edc-foot-care-campaign

For more information, visit these Resources:

American Association of Diabetes Educators: https://www.diabeteseducator.org/

American Diabetes Association: http://www.diabetes.org/

CDC Prediabetes Screening Test: https://www.cdc.gov/diabetes/prevention/pdf/prediabetestest.pdf

QIO Program: http://qioprogram.org/diabetes-prediabetes-and-cardiovascular-preventive-services

2017 ADA® Standards of Medical Care in Diabetes: http://professional.diabetes.org/content/clinical-practice-recommendations

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

New England QIN-QIO: http://healthcarefornewengland.org/initiatives/diabetes-care/

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