Understanding MACRA Quality Payment Program: Using MIPS Scores to Inform Improvement Interventions

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Disclaimer

Information provided in this presentation is based on the latest information made available by the Centers for Medicare & Medicaid Services (CMS) and is subject to change. CMS policies change, so we encourage you to review specific statutes and regulations that may apply to you for interpretation and updates.
Lake Superior Innovation Network (LSQIN)

Three quality improvement organizations:

- MPRO in Michigan
- Stratis Health in Minnesota
- MetaStar in Wisconsin

Collaboration to improve health care for Medicare consumers, share best practices, and maximize efficiencies

Objectives

- Understand your 2017 MIPS score and how your current activities have an impact on your MIPS score
- Learn how to use your MIPS score to identify areas of opportunity for improvement
- Identify interventions and strategies to improve your overall quality and increase your MIPS score
Overview of the Quality Payment Program (QPP)

Polling Question #1

How would you rate your understanding of the Quality Payment Program?

1) Very little understanding
2) Some understanding, still have a lot to learn
3) Moderate degree of understanding
4) Advanced understanding
Quality Payment Program – 2 Tracks for Eligible Clinicians

Advanced Alternative Payment Model

Eligible for 5% *MPBPFS bonus if participating in Advanced APM through Medicare Part B

Merit-based Incentive Payment System

Eligible for *MPBPFS performance adjustment + high performance bonus
* Medicare Part B Physician Fee Schedule

Path 1: Advanced Alternative Payment Models (AAPM)

Promotes quality over volume by moving away from traditional Medicare Fee based services

2017 CMS Advanced APMs
1. Medicare Shared Savings Program (MSSP) Tracks 2 and 3
2. Next Generation ACO Model
3. Comprehensive ESRD Care (CEC) (2-sided risk)
4. Oncology Care Model (OCM) (2-sided risk)
5. Comprehensive Primary Care Plus (CPC+) Model

*A current list of CMS and MIPS APMs is posted at QPP.CMS.GOV

MSSP Track 1 and all of these APMs qualify for higher MIPS APM scoring standard if they do not meet the AAM threshold
Path 2: Merit-Based Incentive Payment System (MIPS)

Replaces PQRs (Physician Quality Reporting System) 60%

New Category 15%

Replaces Meaningful Use (EHR Incentive Program) 25%

Replaces VBM (Value Based Modifier) 0%

Maximum MIPS Composite Score 100

Source: CMS Quality Payment Program – Train-The-Trainer

Advancing Care Information: 25% of MIPS Score in 2017

Replaces “Meaningful Use”

- Maximum score 100 of 155 possible points
- 4 (2014 CEHRT) or 5 (2015 CEHRT) required base measures (50% of score)
- 7 (2014 CEHRT) or 9 (2015 CEHRT) performance measures (50% of score)

- Bonus points:
  - Using CEHRT for Improvement Activities
  - Reporting to additional PH or clinical registries

- No exclusions for individual Objective … whole ACI category exemption
  - similar to hardship exemptions in EHR (MU) Incentive program (submitted annually)
  - Category reweighted to zero, Quality category weight increases
Quality Category: 60% of MIPS Score in 2017

Replaces PQRS: Maximum score 60

- Report six quality measures* from 271 measures - for at least 90 days
  - Specialist may use measures from Specialty set
  - Report via Claims, EHR, Qualified Registry or Qualified Clinical Data Registry (QCDR)
  - QCDR and measures must be approved by CMS
    - 2017 benchmarks not released yet
  - Each reporting method has different benchmark scores
    - 3 to 10 points per measure based on performance against benchmarks
    - Not every measure is available for all reporting methods

- CMS Web Interface
  - 14 quality measures – must report to all
  - Optional for Groups of 25+
  - APMs report quality as a group via web interface

Improvement Activities: 15% of MIPS Score in 2017

New Category: Maximum score 40

- Help participants prepare to transition to APMs and Medical Home Models

- Engage in up to four activities for at least 90 days
  - Medium activity = 10 points
  - High activity = 20 points
    - Double points for small, rural, underserved, and non-patient facing clinicians/groups
    - Full credit for PCMH, MHM (MN model counts)
    - APMs – choose activities based on model criteria
Cost
0% of MIPS Score in 2017

Replaces VBM: No score in 2017

- Category has been set to 0% for 2017 with a reweighting of the other three categories
- Category score will increase from 0 to 30% by 2021 as required by MACRA law, starting in 2018
- No data submission required; Calculated from adjudicated claims

Polling Question #2

Are you planning on participating for 2017 as an:

1. Merit Based Incentive Payment System (MIPS)
2. MIPS APM
3. Advanced Alternative Payment Model (ie: Next Generation ACO)
4. Unsure
MIPS Scoring

Pick Your Pace 2017

Pick your pace in MIPS: If you choose the MIPS track of the Quality Payment Program, you have three options.

1. **-% Don’t Participate**
   - Not participating in the Quality Payment Program: If you don’t send in any 2017 data, then you receive a negative 4% payment adjustment.
   - **NOT RECOMMENDED!**
   
2. **0 Submit Something**
   - Test: If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment.

3. **+% Submit a Partial Year**
   - Partial: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

4. **Submit a Full Year**
   - Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

Engage as a Qualified Participant (QP) in an Advanced APM ... no MIPS requirements!

Source: CMS Quality Payment Program – Train-The-Trainer
MIPS 2017 Transition Year
Scoring (0-100 Points)

<table>
<thead>
<tr>
<th>Points</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>≥70 points</td>
<td>Eligible for positive payment adjustment and exceptional performance bonus payment</td>
</tr>
<tr>
<td>4-69 points</td>
<td>Positive payment adjustment. No exceptional performance bonus payment. No negative payment adjustment</td>
</tr>
<tr>
<td>3 points</td>
<td>Neutral payment adjustment</td>
</tr>
<tr>
<td>Do nothing – 0 points</td>
<td>-4% payment adjustment</td>
</tr>
</tbody>
</table>

Avoiding a Negative Payment Adjustment in 2017 Transition Year

*Report at least one category for at least 90 days*

**ADVANCING CARE INFORMATION**
- 4 (2014 CEHRT) or 5 (2015 CEHRT) required base objectives

**QUALITY** (271 MIPS-approved measures)
- Individuals or groups: 1 quality measure:
- Groups using GPRO web interface: 14 quality measures
- Specialty quality measures – see list

**IMPROVEMENT ACTIVITIES** (choose from 92 care-related activities; medium (10 points) or high (20 points))
- **Double points**: Small, rural, underserved, non-patient facing clinicians: 1 medium or 1 high activity
- Practices >15 clinicians: 2 medium or 1 high activity
- Automatically receive full credit if you are in MIPS APM or CMS approved Medical Home Model
Preview of Stratis Health MIPS Estimator On-Line Version

Home Page
1. Practice / Provider Information

Instructions:
- Please answer all questions to the best of your knowledge.
- If you do not know the answer to a question, select "Don’t Know".

Practice / Provider Information

1. Practice Name:
- MIPS Health Organization Name:

2. How are you entering your MIPS data for this MIPS estimation?
- Individual / Group

3. Individual provider name:
- Last name:
- First name:
- Middle initial:
- NPI Number:
- Provider specialty:
- AOR specialty:
- Medicaid:
- Medicare:
- Other:
- Yes / No

4. Does this provider qualify for an Advanced Alternative Payment Method (AAPM), or a Direct Ordering Provider (DOP), or any other Alternative Payment Method (APM)?
- Yes / No

5. Does this provider qualify for an Advanced Alternative Payment Method (AAPM), or a Direct Ordering Provider (DOP), or any other Alternative Payment Method (APM), or any other Coordinated Care Program (CCP)?
- Yes / No

3. For 2017, will you report AGI using 2014 CESHR or 2014 Transmittal Paper or 2015 CESHR?
- Yes / No

4. What setting are you reporting from?
- Hospital / Office
- Not Hospital / Office

5. Are you a Primary Care Medical Home (PCMH) or certified PCMH status by CMS for 2017?
- Yes / No

6. How do you plan to report quality measures for 2017?
- Electronic
- Paper

7. Is this the first time you are using this MIPS Estimator?
- Yes / No
### Objective & Measures

#### Lisa Gall

<table>
<thead>
<tr>
<th>Objective Name</th>
<th>Performance Impact</th>
<th>Total QC Category Score</th>
<th>Score</th>
<th>Measure Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Electronic Prescribing</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>3. Health Information Exchange</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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</table>

#### Quality Measures

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Result</th>
<th>Measure Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Choose Quality Measure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Yes</td>
<td>Yes</td>
<td>100</td>
<td>100</td>
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<tr>
<td>Medical Record Access</td>
<td>Yes</td>
<td>Yes</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

**Your current reporting method:**

**A Note:** All measures are certified for all measures. Verify what measures your vendor is certified to report.

Quality Measure instructions that are highlighted yellow mean that they are not used to measure your score for this reporting method.

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2. Choose Quality Measure: 100 - Electronic Prescribing: Medication Prescription

**Measure Score:**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Result</th>
<th>Measure Score</th>
</tr>
</thead>
</table>

**22**
Improvement Activities

1. Choose Activity
   VA_02: Use of certified EMR to capture patient reported outcomes
   VA_03: Use of certified EMR to capture patient reported outcomes
   VA_04: Use of certified EMR to capture patient reported outcomes

   Description:
   Improves patient access, performing additional activities that enable capture of patient-reported outcomes (e.g., home telemonitoring, virtual visits, remote monitoring, self-assessment tools, etc.) in patient-centered care models through use of certified EMR technology, capturing this data in a separate domain for clinical decision support.

   Notes: Use of certified EMR to enhance EMR adoption.

   Checklist:
   Are you using certified EMR to complete this activity?
   Yes: Yes
   No: No

2. Choose Activity
   VA_11: Use of care coordination agreements that promote improvements in patient outcomes in patient-centered care models
   VA_12: Use of care coordination agreements that promote improvements in patient outcomes in patient-centered care models

   Description:
   Establishes effective care coordination and active clinical management that ensure delivery of care across the care continuum. Establishes care coordination agreements and frequently used consults to share information of care delivered and sets expectations for outcomes/ therapies of patients and other stakeholders in environments such as group operations, integrated settings, or patients and their family members. Such expectations are reviewed in conjunction with the care coordination agreements.

   Checklist:
   Are you using care coordination agreements that promote improvements in patient outcomes in patient-centered care models?
   Yes: Yes
   No: No

Scoring Results Mockup

EHR Selected Reporting Method

82.00

MIPS Category MIPS Category Weight

<table>
<thead>
<tr>
<th>MIPS Category</th>
<th>MIPS Category Weight</th>
<th>Total Possible Score</th>
<th>Category Base Score</th>
<th>Status</th>
<th>Categories</th>
<th>Status</th>
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<td>Improvement Activities</td>
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<td>45</td>
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<tr>
<td>Advancing Care Information</td>
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<td>100</td>
<td>100</td>
<td>0</td>
<td>95%</td>
<td>5.00</td>
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<tr>
<td>Quality</td>
<td>82.00</td>
<td>60</td>
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<td>0</td>
<td>95%</td>
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<td>Cost</td>
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<td>N/A</td>
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<td></td>
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</tr>
</tbody>
</table>

TOTAL ESTIMATED MIPS SCORE: 82.00
Translating Your MIPS Score Into an Action Plan for Improvement – Steps to Success

Operationalizing MIPS Categories

1. Gather data to enter into MIPS Estimator (or other tool)
2. Obtain score
3. Analyze and validate data
4. Compare to benchmarks
5. Improvement: Plan Do Study Act (PDSA) Cycles
   1. Identify and Prioritize areas for improvement
   2. Develop improvement plan
   3. Implement workflows
   4. Monitor
   5. Reevaluate
Gather Data To Enter Into MIPS Estimator (or other)

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Completed</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Measure Completed</th>
<th>Numerator</th>
<th>Denominator</th>
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<td>365</td>
<td>457</td>
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<td>562</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
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</tr>
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<td>Investigator/Principal Reporting</td>
<td>Yes</td>
<td>37</td>
<td>57</td>
<td>30</td>
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<td>Patient-Specific Education</td>
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<td>Secure Messaging</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>View, Download, or Examine</td>
<td>No</td>
<td>217</td>
<td>502</td>
<td>43</td>
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</table>

Obtain Your Score

Example of Quality Score in MIPS Estimator

Your Base QM Score
Your Total Bonus Points
Your Total QM Score
Maximum Possible Score

28

29
Analyze and Validate Data

STRATIS HEALTH

MEDICARE MERIT-BASED INCENTIVE PAYMENT SYSTEM

MIPS ESTIMATOR 2017

A/D Data Entry Page

For clinicians, focus measures are analyzed using automated and statistical methods. The physician information is updated on an annual basis. The focus measures are updated annually, and emphasis is placed on measuring the MIPS performance and ensuring accuracy. Reporting alternative data sources are validated for accuracy and completeness for reporting. The focus measure data is used to calculate the MIPS score, which is used to determine the payment for the next year.

The focus measures include a variety of areas, such as quality, patient safety, and patient experience. The focus measure data is collected through various sources, including electronic health records, surveys, and patient interviews. The focus measure data is then analyzed using statistical methods to identify trends and patterns.

The focus measure data is used to calculate the MIPS score, which is used to determine the payment for the next year. The MIPS score is calculated by taking into account the focus measure data, as well as other factors, such as the practice setting and the number of patients treated.

The focus measure data is reviewed and validated annually to ensure accuracy and completeness. The focus measure data is then used to make improvements to the MIPS program and to improve the quality of care provided to patients.

Analyze and Validate Data

Quality Improvement Organizations

Lake Superior Quality Innovation Network
Analyze and Validate Data

<table>
<thead>
<tr>
<th>Activity ID</th>
<th>Activity Description</th>
<th>Available Data for Certification?</th>
<th>Available Data for Audit?</th>
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<tr>
<td>BCR_111</td>
<td>Create a data dictionary and metadata file</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>BCR_112</td>
<td>Develop and validate measurement instrument for each activity</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>BCR_113</td>
<td>Collect and validate data for each activity</td>
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<tr>
<td>BCR_114</td>
<td>Analyze and report data for each activity</td>
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Compare to Benchmarks

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<tr>
<th>Measure Name</th>
<th>Measure ID</th>
<th>Measure Type</th>
<th>Measure Unit</th>
<th>Measure Value</th>
<th>Measure Year</th>
<th>Measure Year Value</th>
<th>Measure Year Value Difference</th>
<th>Measure Type</th>
<th>Measure Unit</th>
<th>Measure Value</th>
<th>Measure Year</th>
<th>Measure Year Value</th>
<th>Measure Year Value Difference</th>
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<th>Measure Value</th>
<th>Measure Year</th>
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<tr>
<td>Breast Cancer Screening</td>
<td>111</td>
<td>Claims</td>
<td>Y</td>
<td>48.86</td>
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<td>48.02</td>
<td>48.46</td>
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<td>Numerator</td>
<td>Denominator</td>
<td>Measure Rate</td>
<td>Measure Used?</td>
<td>Measured for all eligible cases?</td>
<td>Measured for all cases?</td>
<td>Percentage of NOs/Registries (DoE)?</td>
<td>DoE Status</td>
<td>Measure Score</td>
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<td>Discharge of Current Medicaions at Hospital Discharge</td>
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<td>Yes</td>
<td>75%</td>
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<tr>
<td>Brand Name vs. Generic Medications</td>
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<td>50%</td>
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*Identify & Prioritize Opportunities for Improvement*
Plan, Do, Study, Act (PDSA) Cycles

What changes are we going to make based on our findings?

What exactly are we going to do?

What were the results?

When and how did we do it?

Thinking Through Your Improvement Initiative

1. What are you trying to accomplish?

2. How will you know that change is an improvement?

3. What change can you make that will result in an improvement?
Developing a SMART Aim/Goal

Specific
Measurable
Achievable
Relevant
Time bound

Developing a SMART Aim/Goal - continued

To develop SMART aim, use the template below and fill in the blanks:
By ___/___/___, [WHEN—Time bound]
___________________________[WHO/WHAT—Specific]
from _________ to __________
[MEASURE (number, rate, percentage of change and baseline)—Measurable]
__________________________________________
[HOW—Intervention]

Adapted from http://www.cdc.gov/dhdsp/state_program/evaluation_guides/pdfs/smart_objectives.pdf
SMART Aim/Goal for Breast Cancer Screening

By December 1, 2017,

The providers in Clinic A will see an increase in the number of women over 50 who are screened for breast cancer

From 49% to 53%

By sending annual reminder letters and providing education regarding benefits of early detection.

Plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>List your action steps along with person(s) responsible and time line.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What change are you testing with the PDSA cycle(s)?</td>
<td></td>
</tr>
<tr>
<td>What do you predict will happen and why?</td>
<td></td>
</tr>
<tr>
<td>Who will be involved in this PDSA? (e.g., one staff member or resident, one shift?). Whenever feasible, it will be helpful to involve direct care staff.</td>
<td></td>
</tr>
<tr>
<td>Plan a small test of change. How long will the change take to implement?</td>
<td></td>
</tr>
<tr>
<td>What resources will be needed?</td>
<td></td>
</tr>
<tr>
<td>What data needs to be collected?</td>
<td></td>
</tr>
</tbody>
</table>

Step 6 Change and Measure—PDSA Cycle Worksheet - 2
Plan

List your action steps along with person(s) responsible and timeline.

The change we are testing with the PDSA cycle is to see an increase in the number of women over 50 who are screened for breast cancer from 49% to 53% by December 1 by sending annual reminder letters and providing education regarding benefits of early detection.

We predict that we will be successful because we have the support of leadership and the buy-in of all staff to work towards this goal.

We will be testing this with all physicians in Clinic A for three months beginning September 1 (see process map for workflow and participants).

Resources needed: staff time, education resources, IT support for reminder letters

QI director will run “X” reports monthly from EHR. One report will show aggregate findings and other will report by providers and report back to all staff involved in effort in monthly QI meetings.

Do

Carry out the test on a small scale.

Document observations, including any problems and unexpected findings.

Collect data identified as needed during the ‘plan’ stage.

Describe what actually happened when you ran the test.
Step 6 Change and Measure—PDSA Cycle Worksheet - 2

**Do**

<table>
<thead>
<tr>
<th>Do</th>
<th>Describe what actually happened when you ran the test.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carry out the test on a small scale.</td>
<td>First test was run from September-November 2017.</td>
</tr>
<tr>
<td>Document observations, including any problems and unexpected findings.</td>
<td>Workflow included medical assistant educational resource to all women &gt;50 in clinic after patient had checked in. Might be more effective to provide resource as patient is being roomed?</td>
</tr>
<tr>
<td>Collect data identified as needed during the “plan” stage.</td>
<td>All three physicians engaged during PDSA</td>
</tr>
</tbody>
</table>

**Study**

<table>
<thead>
<tr>
<th>Study</th>
<th>Describe the measured results and how they compared to the predictions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study and analyze the data.</td>
<td></td>
</tr>
<tr>
<td>Determine if the change resulted in the expected outcome.</td>
<td></td>
</tr>
<tr>
<td>Were there implementation lessons?</td>
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</tr>
<tr>
<td>Summarize what was learned. Look for: unintended consequences, surprises, successes, failures.</td>
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Study

<table>
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<tr>
<th><strong>Study</strong></th>
<th><strong>Describe the measured results and how they compared to the predictions.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Study and analyze the data.</td>
<td>Overall Clinic A achieved an increase to 52%.</td>
</tr>
<tr>
<td>Determine if the change resulted in the expected outcome.</td>
<td>Two of the three physicians in Clinic A met/exceeded goal of 49 to 53%. Physician #3 did not meet goal. Further workflow analysis is needed.</td>
</tr>
<tr>
<td>Were there implementation lessons?</td>
<td>IT needs more lead time to be able to plan for IT needs and resources</td>
</tr>
<tr>
<td>Summarize what was learned. Look for: unintended consequences, surprises, successes, failures.</td>
<td></td>
</tr>
</tbody>
</table>

Act

<table>
<thead>
<tr>
<th><strong>Act</strong></th>
<th><strong>Describe what modifications to the plan will be made for the next cycle from what you learned.</strong></th>
</tr>
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<tbody>
<tr>
<td>Based on what was learned from the test:</td>
<td></td>
</tr>
<tr>
<td>Adapt – modify the changes and repeat PDSA cycle.</td>
<td></td>
</tr>
<tr>
<td>Adopt – consider expanding the changes in your organization to additional residents, staff, and units.</td>
<td></td>
</tr>
<tr>
<td>Abandon – change your approach and repeat PDSA cycle.</td>
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</tbody>
</table>
Act

Based on what was learned from the test:
Adapt – modify the changes and repeat PDSA cycle.
Adopt – consider expanding the changes in your organization to additional residents, staff, and units.
Abandon – change your approach and repeat PDSA cycle.

Describe what modifications to the plan will be made for the next cycle from what you learned.

Since the workflow worked for two/three physicians, will repeat the cycle for Clinic A for three additional months. Will continue to vet process map to determine gaps & opportunities for improvement and re-measure outcomes.

Repeat Until You Get Desired Results

What changes are we going to make based on our findings?
What exactly are we going to do?
What were the results?
When and how did we do it?
QUESTIONS??

Resources and Tools
LSQIN Role in QPP

- Education
- Technical Assistance
- Physician/Eligible Clinician Engagement
- Beneficiary Engagement

Education and Technical Assistance Resources

1. Lake Superior Quality Innovation Network
   Home page: https://www.lsqin.org
   Previous and upcoming webinars and Regional Office Hours: https://www.lsqin.org/events/

2. On-Line MIPS Estimator (coming soon!)
   www.mipsestimator.com

3. QPP – 2017 Benchmark Table
   https://qpp.cms.gov/docs/QPP_Quality_Benchmarks_Overview.zip

4. Stratis Health Plan, Do, Study, Act (PDSA) Worksheet
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https://qpp.cms.gov/sources