MIPS Quality Measure: Controlling High Blood Pressure

Quality (45% of final score - 2019 performance period)

As part of the Quality Payment Program (QPP), eligible clinicians (ECs) will need to report six quality measures, including an outcome measure.

AKA: CMS165v7, Quality ID 236 or NQF 0018

High Priority Measure

Domain: Effective Clinical Care

Description: Percentage of patients aged 18-85 with a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mmHg) during the measurement period.

Numerator: The number of patients in the denominator with most recent blood pressure measurements considered to be adequately controlled during the measurement period. A patient's BP is considered to be "adequately controlled" when their systolic BP is less than 140 and the diastolic BP is less than 90 mmHg.

Denominator: Patients 18-85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.

Notes: This measure is included in the Specialty Measure set for Internal Medicine, Cardiology, Obstetrics/Gynecology, Preventive Medicine, Rheumatology, Vascular Surgery and General Practice/Family Medicine.

Measure specifications: https://qpp.cms.gov/mips/quality-measures

Improvement Activities (15% of final score)

As part of the QPP, ECs will need to attest to a combination of high- and medium- weighted improvement activities for a minimum of 90 consecutive days.

Looking to improve? Try these related MIPS improvement activities (IAs)

Chronic Care and Preventative Care Management for Empaneled Patients
(Activity ID IA_PM_13)
Manage chronic and preventive care for empaneled patients (that is, patients assigned to care teams for the purpose of population health management).

Implementation of medication management practice improvements
(Activity ID IA_PM_16)
Manage medications to maximize efficiency, effectiveness and safety by: reconciling and coordinating medications, providing medication management across transitions of care, integrating a pharmacist into the care team and/or conducting periodic, structured medication reviews.

Evidence-based techniques to promote self-management into usual care
(Activity ID IA_BE_16)
Incorporate evidence-based techniques to promote self-management into usual care using techniques such as goal setting with structured follow-up, Teach Back, action planning or motivational interviewing.

Engagement of patients through implementation of improvements in patient portal
(Activity ID IA_BE_4)
Access to an enhanced patient portal that provides up-to-date information related to relevant chronic disease health or blood pressure control, and includes interactive features allowing patients to enter health information and/or enables bidirectional communication about medication changes and adherence.

For more information and questions, visit http://www.mpro.org/diabetes-hypertension-project.