

2022 MIPS Data Validation – Improvement Activities Performance Category Criteria

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
IA_EPA_1	Expanded Practice Access	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: • Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); • Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or • Provision of same-day or next-day access to a MIPS eligible clinician, group or care team when needed for urgent care or transition management.	High	Objective: Increase patient access to eligible clinicians who work in an outpatient setting with the goal of reducing unnecessary emergency room visits. Validation Documentation: Evidence of demonstrated patient care provided outside of normal business hours through expanded practice hours and by eligible clinicians with real-time access to patient's electronic health record (EHR), or that patients received needed urgent care in a timely way. Expanded Business Hours are defined as hours that are outside of a practice's standard business hours of operation. Include at least one of the following elements: 1) Patient record from EHR – A patient record from an EHR with date and timestamp indicating services provided outside of the practice's normal business hours for that eligible clinician (a certified EHR may be used for documentation purposes, but is not required unless attesting for the Promoting Interoperability bonus); OR 2) Patient encounter/medical record/claim – Patient encounter/medical record/claim indicating patient was seen or services provided outside of the practice's normal business hours for that eligible clinician, including use of telehealth visits, or that the services were provided at an alternative location (e.g., senior centers, assisted living centers, centers for independent living, area agencies on aging); OR 3) Same or next-day patient encounter/medical record/claim – Patient encounter/medical record/claim indicating patient was seen same-day or next-day by an eligible clinician or practice for urgent care or transition management.	2017



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IA_EPA_2	Expanded Practice Access	Use of telehealth services that expand practice access	Create and implement a standardized process for providing telehealth services to expand access to care.	Medium	<u>Objective:</u> Improve health outcomes by expanding patient access to telehealth services that are delivered through standardized processes. <u>Validation Documentation:</u> Evidence of the creation and implementation of standardized processes for providing telehealth services. Telehealth services may include care provided over the phone, online, etc., and are not limited to the Medicare-reimbursed telehealth service criteria. Include both of the following elements: 1) Standardized processes – Creation of standardized processes for the provision of telehealth services. Examples of documentation include a) description of standardized telehealth processes in an eligible clinician or practice procedures manual; b) workflow diagrams depicting standardized telehealth processes used regularly by an eligible clinician or practice; AND 2) Implementation documentation – Implementation of standardized processes for providing telehealth services. Examples of documentation include a) claims adjudication (may use G-codes to validate); b) electronic health record (EHR); or c) other medical record document showing specific telehealth services, consults, or referrals performed for a patient in accordance with standardized processes. <u>Information:</u> How to get or provide remote health care website provides best practices for clinicians looking to improve their telehealth services: https://telehealth.hhs.gov/	2017
IA_EPA_3	Expanded Practice Access	Collection and use of patient experience and satisfaction data on access	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.	Medium	<u>Objective:</u> Develop an improvement plan informed by patient experience and satisfaction data, including any differences across demographic groups, so that eligible clinicians can use data-driven approaches to improve patient access and quality of care. <u>Validation Documentation:</u> Evidence of documented improvement plan for access to care and quality based on collected and	2017

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					stratified patient experience and satisfaction data. The goals for improvement can be defined broadly or within certain population strata. CMS examples of stratification may include patient demographics such as race/ethnicity, disability status, sexual orientation, sex, gender identity, or geography. (It is acknowledged that some stratification data may not be available). Include both of the following elements: 1) Patient experience and satisfaction data on access to care – Data collected through a patient experience survey for a population defined by the eligible clinician. For example, eligible clinicians could give the survey to all patients seen within a defined study period. Data can be prepared in any useful format, or as they were collected; AND 2) Improvement plan – Documentation of an improvement plan, which should include specific activities, goals, and outcomes for addressing access to care. For example, an eligible clinician may observe that non-English-speaking patients were not confident in their interactions with eligible clinicians because of language barriers. A possible plan could include using translators, remote translation services, or language training. The improvement plan would include details regarding who would be trained with timelines for completion.	
IA_EPA_4	Expanded Practice Access	Additional improvements in access as a result of QIN/QIO TA	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).	Medium	<u>Objective:</u> Use learnings from engagement with Quality Innovation Network-Quality Improvement Organization (QIN-QIO) technical assistance to design, plan, and initiate implementation of new activities, ultimately improving access to services or care coordination. <u>Validation Documentation:</u> Evidence of implementation of newly added processes, practices, resources, or technology to improve access to services or improve care coordination as a result of receiving QIN-QIO technical assistance. Include both of the following elements: 1) Relationship with QIN-QIO technical assistance –	2017

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					Confirmation of technical assistance and documentation of relationship with QIN-QIO (e.g., signed letter of agreement, email exchange); AND 2) Activities – Documentation of planned and/or tested activities that improve access or improve care coordination, including support for newly offered services.	
IA_EPA_5	Expanded Practice Access	Participation in User Testing of the Quality Payment Program Website (https://qpp.cms.gov/)	User participation in the Quality Payment Program website testing is an activity for eligible clinicians who have worked with CMS to provide substantive, timely, and responsive input to improve the CMS Quality Payment Program website through product user-testing that enhances system and program accessibility, readability and responsiveness as well as providing feedback for developing tools and guidance thereby allowing for a more user-friendly and accessible clinician and practice Quality Payment Program website experience.	Medium	<u>Objective:</u> Help CMS improve the content provided on the Quality Payment Program (QPP) website. <u>Validation Documentation:</u> Evidence of user participation and implementation of website testing for the QPP. Eligible clinicians must be verified on CMS User/Tester list and be able to share at least one of the following elements: 1) Improvement input – Documentation of specific input to improve the CMS QPP website through product user-testing aimed at enhancing system and program accessibility, readability, and responsiveness (e.g., saved emails, Word document with notes); OR 2) Tool/guidance development feedback – Documentation of specific feedback for developing tools and guidance for a more efficient and accessible clinician and practice QPP website experience (e.g., saved emails, Word document with notes).	2018
IA_PM_2	Population Management	Anticoagulant management improvements	Individual MIPS eligible clinicians and groups who prescribe anti-coagulation medications (including, but not limited to oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors) must attest that for 75 percent of their ambulatory care patients receiving these medications are being managed with support from one or more of the following improvement activities: • Participation in a systematic	High	<u>Objective:</u> Improve patient understanding and adherence while reducing the risk of medication errors and adverse drug events. <u>Validation Documentation:</u> Evidence of participation by patients who have anti-coagulation medication prescriptions in one or more of the clinical practice improvement activities listed in the Activity Description. Include all of the following elements: 1) Patients receiving anti-coagulation medications – Total number of outpatients prescribed oral Vitamin K antagonist therapy (e.g., claims, electronic health record report); AND 2) Percentage of that total being managed by one of the methods of care in the Activity Description – Number of	2017



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			anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program); • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or		outpatients prescribed oral Vitamin K antagonist therapy and who are being managed by one or more of the four activities in the Activity Description; AND 3) Patient-centered plan – Documentation that the plan addresses patients' language and communication needs, literacy level, and cognitive and functional limitations.	

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			patient-self-management (PSM) program.			
IA_PM_3	Population Management	RHC, IHS or FQHC quality improvement activities	Participating in a Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center in ongoing engagement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality improvement and benchmarking improvement which will ultimately benefit patients. Participation in Indian Health Service, as an improvement activity, requires MIPS eligible clinicians and groups to deliver care to federally recognized American Indian and Alaska Native populations in the U.S. and in the course of that care implement continuous clinical practice improvement including reporting data on quality of services being provided and receiving feedback to make improvements over time.	High	<u>Objective:</u> Improve quality of care and formal quality improvement and reporting for Native Americans, Alaskan Natives, populations served by Rural Health Clinics (RHC), and Federally Qualified Health Centers (FQHC). <u>Validation Documentation:</u> Evidence of quality improvement activity participation as part of RHC, Indian Health Service (IHS), or FQHC participation. By vulnerable populations/patients, CMS is referring to racial and ethnic minorities, refugees, those who are elderly, financially disadvantaged, or without health insurance, and those who have a disability or medical condition which are associated with disparities in outcomes across populations. Include both of the following elements: 1) Name of RHC, IHS or FQHC – Identified name of RHC, IHS, or FQHC in which the eligible clinician participates in ongoing engagement activities; AND 2) Continuous quality improvement activities - Documented continuous quality improvement activities aimed at services provided to RHC, IHS, or FQHC patients. To the extent possible, these quality improvement activities should contribute to more formal quality reporting, and should include receiving quality data back for broader quality and benchmarking improvement (e.g., data reports or dashboards tied to quality improvement projects).	2017
IA_PM_4	Population Management	Glycemic management services	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	High	<u>Objective:</u> Improve diabetes care by defining and documenting individualize glycemic control goals. <u>Validation Documentation:</u> Evidence of report identifying diabetic patients who are taking diabetes medication and have documented glycemic treatment goals based on patient-specific factors. Include all of the following elements: 1) Diabetic patients prescribed antidiabetic agents – Total number of outpatients who are diabetic and prescribed	2017

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			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.		antidiabetic agents; AND 2) Percentage of that total with glycemic treatment goals – Percentage of outpatient Medicare beneficiaries, who are diabetic and prescribed antidiabetic agents, with documented glycemic treatment goals. The goals must encompass patient-specific factors, including at least: a) age, b) comorbidities, and c) risk for hypoglycemia; AND 3) Annual assessment – Documented evidence of annual assessment for patients receiving glycemic treatment services (e.g., list of patients flagged for reassessment the following year, dated chart notes in an electronic health record). <u>Information:</u> • A catalog of diabetes prevention resources tailored to various audiences, including racial and ethnic minorities, lesbian, gay, bisexual, transgender, queer and others (LGBTQ+) communities, people with disabilities, and people with limited English proficiency: https://www.cms.gov/files/document/culturally-and-linguistically-tailored-type-2-diabetes-prevention-resource.pdf • Provider Directory to facilitate diabetes treatment for primary care teams, particularly providers working with Medicare beneficiaries and vulnerable populations who experience a higher prevalence of type 2 diabetes and its complications: https://www.cms.gov/files/document/diabetes-provider-resource-directory.pdf	
IA_PM_5	Population Management	Engagement of community for health status improvement	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	Medium	<u>Objective:</u> Improve specific chronic condition health outcomes for community populations served by an eligible clinician or practice by implementing evidence-based practices and partnership with a Quality Improvement Organization (QIO). <u>Validation Documentation:</u> Evidence of implementation of activity to improve specific chronic condition (e.g., diabetes, chronic kidney disease, hypertension) for specific identified population within the community. Include both of the following elements:	2017

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			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.		1) Documentation of partnership in the community – Screenshot of QIO website or other correspondence that identifies your organization as one of the key partners and stakeholders and that lists the activity that will be implemented, with details on the specific chronic condition and population targeted; AND 2) Plan for improving community health – QIO report, document, or correspondence detailing steps being taken to satisfy the activity. May include: timeline, purpose, anticipated outcome(s), and relevant tools (e.g., Population Health Toolkit).	
IA_PM_6	Population Management	Use of toolsets or other resources to close healthcare disparities across communities	Address inequities in health outcomes by using population health data analysis tools to identify health inequities in the community and practice and assess options for effective and relevant interventions such as Population Health Toolkit or other resources identified by the clinician, practice, or by CMS. Based on this information, create, refine, and implement an action plan to address and close inequities in health outcomes and/or health care access, quality, and safety.	Medium	<u>Objective:</u> Decrease healthcare inequities and improve health status in underserved communities. <u>Validation Documentation:</u> Evidence of activity to decrease healthcare inequities. Include both of the following elements: 1) Population health data analysis resources used – Documentation of resources used to identify health inequities in the practice's population and to assess options for intervention; AND 2) Implementation report – Report with action plan for implementing the selected intervention (including the health inequity targeted, detailed plan for improvement, and the specific outcomes targeted for improvement), and results from its implementation. <u>Example(s):</u> • National Rural Health Resource Center Population Health Toolkit: https://www.ruralcenter.org/population-health-toolkit • CMS Network of Quality Improvement and Innovation Contractor (NQIIC) program health equity resource page: https://qi.ipro.org/health-equity/; https://qi.ipro.org/health-equity-resources/ • Novartis Foundation Urban Population Health Toolkit (cardiovascular disease focus): https://www.novartisfoundation.org/urban-population-health-toolkit	2017

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IA_PM_7	Population Management	Use of QCDR for feedback reports that incorporate population health	Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.	High	Objective: Increase knowledge of practice patterns and treatment outcomes to better serve patients, including vulnerable populations. Validation Documentation: Evidence of use of qualified clinical data registry (QCDR) data and support to identify local/geographical practice patterns and clinical outcomes, particularly among underserved, vulnerable, and special-needs populations. By vulnerable populations/patients, CMS is referring to racial and ethnic minorities, refugees, those who are elderly, financially disadvantaged, or without health insurance, and those who have a disability or medical condition which are associated with disparities in outcomes across populations. Include at least one of the following elements: 1) QCDR agreement – Documented arrangement with a QCDR to generate feedback reports summarizing local practice patterns and treatment outcomes, including for vulnerable populations; OR 2) Feedback reports – Copies of feedback reports provided by a QCDR that summarize local practice patterns and treatment outcomes with focus on vulnerable populations.	2017
IA_PM_11	Population Management	Regular review practices in place on targeted patient population needs	Implement regular reviews of targeted patient population needs, such as structured clinical case reviews, which include access to reports that show unique characteristics of MIPS eligible clinician's patient population, identification of underserved patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources. The review should consider how structural inequities, such as racism, are influencing patterns of	Medium	Objective: Improve understanding of targeted populations' unique needs to tailor clinical treatments, address structural inequities, and better utilize community resources. Validation Documentation: Evidence of participation in identification and reviews of targeted patient population needs. Include all of the following elements: 1) Targeted patient population identification – Documentation of method/s for identification and ongoing monitoring of a targeted patient population (e.g., policy or protocol), including stratification of patient data by demographic characteristics and, as needed, health-related social needs to appropriately identify differences among populations and assess drivers of gaps and inequities, as well as identifying interventions appropriate for the needs the	2017



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			care and consider changes to acknowledge and address them. Reviews should stratify patient data by demographic characteristics and health related social needs to appropriately identify differences among unique populations and assess the drivers of gaps and disparities and identify interventions appropriate for the needs of the sub-populations.		targeted population; AND 2) Review of targeted population's unique characteristics and needs – Report that compiles information on the unique characteristics of the targeted patient population, including inequities in relevant outcomes; ways to tailor clinical treatments to meet needs and reduce inequities (e.g., clinicians treating Black men, who have a higher incidence of prostate cancer, may choose to evaluate that population for consistency of screening); and lists of community resources that can further support patients with these needs outside of the clinical setting; AND 3) Implementation Report – Report with action plan detailing steps the practice has taken to address the results of its targeted population identification and needs assessment. <u>Information:</u> • Health-related social needs (HRSN) screening tools that meet the recommended criteria for this activity include: - o The Centers for Medicare & Medicaid Services' Accountable Health Communities screening tool: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf. - o National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) assessment: https://www.nachc.org/wp-content/uploads/2020/04/PRAPARE-One-Pager-9-2-16-with-logo-and-trademark.pdf - o Health Lead's Screening Tool: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/ • Background on identifying and addressing health-related social needs at primary care settings: https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/tools-and-materials/social-needs-tool.pdf.	

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IA_PM_12	Population Management	Population empanelment	Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team. Empanelment is a series of processes that assign each active patient to a MIPS eligible clinician or group and/or care team, confirm assignment with patients and clinicians, and use the resultant patient panels as a foundation for individual patient and population health management. Empanelment identifies the patients and population for whom the MIPS eligible clinician or group and/or care team is responsible and is the foundation for the relationship continuity between patient and MIPS eligible clinician or group /care team that is at the heart of comprehensive primary care. Effective empanelment requires identification of the “active population” of the practice: those patients who identify and use your practice as a source for primary care. There are many ways to define “active patients” operationally, but generally, the definition of “active patients” includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal acute or preventive health care.	Medium	<u>Objective:</u> Strengthen patient-clinician relationships, making it possible to provide comprehensive, patient-centered primary care. <u>Validation Documentation:</u> Evidence of patient population empanelment including use of panels for health management. Include both of the following elements: 1) Active population empanelment – Identification and selected operational definition of “active population” of the practice with empanelment and assignment confirmation linking patients to eligible clinician or care team (e.g., electronic health record report, Excel document); AND 2) Process for updating panel – Documented policy and/or process for review and update of panel assignments (e.g., detailed policy about frequency of review, stepwise guidance document for how to empanel new patients or reassign existing patients).	2017

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IA_PM_13	Population Management	Chronic care and preventative care management for empaneled patients	In order to receive credit for this activity, a MIPS eligible clinician must manage chronic and preventive care for empaneled patients (that is, patients assigned to care teams for the purpose of population health management), which could include one or more of the following actions: • 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; and plan of care for chronic conditions; • Use evidence based, condition-specific pathways for care of chronic conditions (for example, hypertension, diabetes, depression, asthma, and heart failure). These might include, but are not limited to, the NCQA Diabetes Recognition Program (DRP) and the NCQA Heart/Stroke Recognition Program (HSRP); • Use pre-visit planning, that is, preparations for conversations or actions to propose with patient before an in-office visit to optimize preventive care and team management of patients with chronic conditions; • Use panel support tools, (that is, registry functionality) or other technology that can use clinical data to	Medium	<u>Objective:</u> Improve effectiveness, efficiency, and patient-centeredness of preventive and chronic care provided to empaneled patients. <u>Validation Documentation:</u> Evidence of chronic and preventative care management for empaneled patients via an individualized plan of care as appropriate to age and health status, including a) health risk appraisal; b) gender, age, and condition-specific preventive care services (e.g., managing cardiovascular risk in patients with diabetes); and c) plan of care for chronic conditions (could use electronic health record [EHR] or medical records). Include at least one of the following elements: 1) Individualized plan of care – Documented indication of annual opportunity for development and/or adjustment of an individualized plan of care appropriate to age and health status (e.g., EHR alert or dated medical record note). Plan of care may include disease-specific services, such as Diabetes Self-Management Education and Support (DSME/S) services and Medical Nutrition Therapy (MNT); OR 2) Condition-specific pathways – Documented use of evidenced-based condition-specific pathways for chronic conditions (e.g., hypertension, diabetes, depression, asthma, heart failure). These might include, but are not limited to, the National Committee for Quality Assurance (NCQA) Diabetes Recognition Program (DRP) and the NCQA Heart/Stroke Recognition Program (HSRP); OR 3) Pre-visit planning – Use of pre-visit planning to optimize preventive care and team management (e.g., workflow indicating pre-visit planning process); OR 4) Panel support tools – Use of panel support tools (e.g., registry or other technology) to identify services that are due in patient records; OR 5) Reminders and outreach – Use of reminders and outreach (e.g., phone calls, emails, postcards, patient portals) to alert and	2017

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			identify trends or data points in patient records to identify services due; • Use predictive analytical models to predict risk, onset and progression of chronic diseases; and/or • 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.		educate patients about services due and/or routine medication reconciliation (e.g., workflow indicating reminder and outreach process, outreach language, screenshot of reminders); OR 6) Risk prediction report – Documentation of the predictive analytical models used to predict risk, onset, and progression of chronic diseases for patient population.	
IA_PM_14	Population Management	Implementation of methodologies for improvements in longitudinal care management for high risk patients	Provide longitudinal care management to patients at high risk for adverse health outcome or harm that could include one or more of the following: • Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; • Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or • Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.	Medium	<u>Objective:</u> Improve health outcomes and patient-centeredness of care for patients at high-risk for adverse health outcomes or harm. <u>Validation Documentation:</u> Evidence of longitudinal, or relationship-based, care management of patients at high-risk for adverse health outcomes as defined by the eligible clinician. Include both of the following elements: 1) List of high-risk patients – Identification of patients at high-risk for adverse health outcome or harm; AND 2) Use of longitudinal care management – Documented use of longitudinal care management methods including at least one of the following: a) empaneled patient risk assignment and risk stratification into actionable risk cohorts; b) personalized care plans for patients at high risk for adverse health outcome or harm; or c) evidence of use of care managers to monitor and coordinate care for highest risk cohorts. <u>Example(s):</u> A cardiologist practice learns that a high percentage of their congestive heart failure (CHF) patients are being re-admitted to the hospital within 30 days of a previous admission for CHF. The cardiology group undertakes practice changes to minimize total CHF hospital admissions. Initially, they identify their population in a manner most appropriate to their practice.	2017

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					Examples might include the stage of CHF or patients with any hospital admission within a certain period of time. Then they team with their nursing staff to create a plan that includes an initial discussion with each patient and plans for monitoring weight and diet daily and on a regular basis by phone, email, or electronic medical record patient portal. Additionally, the patients in the cohort are given access to a direct nursing phone line for questions or with specific concerns such as sudden weight gain. An example of a goal would be identification of sudden weight gain with subsequent temporary increases in diuretic dosing, all completed at home.	
IA_PM_15	Population Management	Implementation of episodic care management practice improvements	Provide episodic care management, including management across transitions and referrals that could include one or more of the following: • Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management; and/or • Managing care intensively through new diagnoses, injuries and exacerbations of illness.	Medium	<u>Objective:</u> Use episodic care management to improve quality of care and communication across referrals and transitions of care. <u>Validation Documentation:</u> Evidence of episodic care management practice improvements. Include at least one of the following elements: 1) Follow-up on hospitalizations, emergency department (ED), or other visits, and medication management – Routine and timely follow-up to hospitalizations, ED, or other institutional visits, and medication reconciliation and management (e.g., documented in medical record or electronic health record [EHR]); OR 2) New diagnoses, injuries and exacerbations – Intensive care management at time of new diagnoses, injuries, and exacerbations of illness documented in medical record or EHR. <u>Example(s):</u> An oncology practice chooses to implement processes to streamline the initial evaluation and care planning of cancer patients. The practice noted previous inefficiencies as related to biomarker testing and therefore, as part of the process development, they identified attributes to biomarker testing that will be beneficial to efficiency improvements: • Implement and document frequent multidisciplinary meetings	2017

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					that engage medical oncologists early in biomarker testing workflow. • Set up direct lines of communication between payers and practices to prevent unnecessary back-and-forth clarifications. • Codify prior authorization requirements for the most common payer organizations to streamline coverage decisions. • Institute standard reflexive policies of most common tests for first line treatment decisions triggered by diagnosis. • Implement modern electronic forms for test ordering and communication platforms between medical oncologists and pathology. • Enact and document specimen logistics best practices that streamline shipping to external labs.	
IA_PM_16	Population Management	Implementation of medication management practice improvements	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: • Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; • Integrate a pharmacist into the care team; and/or • Conduct periodic, structured medication reviews.	Medium	<u>Objective:</u> Maximize the efficiency, effectiveness, and safety of care across settings by strengthening medication management. <u>Validation Documentation:</u> Evidence of newly implemented medication management practice improvements. Eligible clinicians should include all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements a patient is currently taking within the purview of the medication management process. Include at least one of the following elements: 1) Documented medication reconciliation – Patient medical records demonstrating periodic structured medication reviews or reconciliation, which includes updating, reviewing, or obtaining each medication's name, dosage, frequency, and administered route; OR 2) Integrated pharmacist – Evidence of pharmacist integrated into care team; OR 3) Reconciliation across transitions – Patient medical record demonstrating medication reconciliation at the time of the transition. For example, when a patient is being discharged from hospital to home, the reconciliation would be completed at	2017

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					discharge from a hospital by the discharging eligible clinician and at follow-up by the outpatient and/or primary eligible clinician; OR 4) Medication management improvement plan – Report detailing medication management practice improvement plan, and outcomes, if available. For example, the "Agency for Healthcare Research and Quality (AHRQ) Create a Safe Medicine List Together" strategy could be implemented.	
IA_PM_17	Population Management	Participation in Population Health Research	Participation in federally and/or privately funded research that identifies interventions, tools, or processes that can improve a targeted patient population.	Medium	<u>Objective:</u> Contribute to the development of evidence-based interventions, tools, or processes for improving health outcomes. <u>Validation Documentation:</u> Evidence supporting participation in a federally and/or privately funded research initiative to identify systems, tools, or strategies that improve patient outcomes for a targeted population. Include both of the following elements: 1) Confirmed participation – Documentation of participation in a federally and/or privately funded research initiative; AND 2) Research intervention details – List of the interventions, tools, or processes used in the research including identified population(s) and health outcomes targeted.	2018
IA_PM_18	Population Management	Provide Clinical-Community Linkages	Engaging community health workers to provide a comprehensive link to community resources through family-based services focusing on success in health, education, and self-sufficiency. This activity supports individual MIPS eligible clinicians or groups that coordinate with primary care and other clinicians, engage and support patients, use of health information technology, and employ quality measurement and improvement processes. An example of this community based program is the NCQA Patient-Centered Connected Care (PCCC) Recognition Program or	Medium	<u>Objective:</u> Help patients and families access the right community resources for improving/maintaining health, education, and self-sufficiency with support from community health workers. <u>Validation Documentation:</u> Evidence of engagement with community health workers to provide a comprehensive link to community resources and family-based services with an emphasis on improving health, education, and self-sufficiency. Include all of the following elements: 1) Community health worker engagement – Documentation of active engagement with community health workers to collaborate in helping patients served by the practice address risk factors related to social determinants of health (e.g., electronic health records referencing community health worker engagement, paperwork related to engagement of community health workers);	2018



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			other such programs that meet these criteria.		AND 2) Coordination and patient engagement –Documentation of coordination with primary care and other eligible clinicians to engage and support patients (e.g., use of health information technology); AND 3) Measure and monitoring – Evidence of use of quality measurement and improvement processes (e.g., National Committee for Quality Assurance’s Patient-Centered Connected Care [PCCC] Recognition Program or similar programs) to continuously improve engagement and coordination with community health workers and other clinicians in an effort to improve patient wellbeing and health (e.g., dashboards, reports). <u>Example(s)</u>: A primary healthcare practice may work with community health workers to help patients with limited English language skills understand and adhere to new plans for diet and medication, learn how to use and manage medical equipment, and provide information on local support groups for people with diabetes. The community health workers report back to the eligible clinicians at the primary healthcare practice; the eligible clinicians then communicate as relevant to other eligible clinicians providing care to the patients and monitor to improve community health worker engagement and the outcomes of the patients they see. <u>Information</u>: • Centers for Disease Control and Prevention’s (CDC’s) Community Health Workers Toolkit: https://www.cdc.gov/dhdsp/pubs/toolkits/chw-toolkit.htm • Association of State and Territorial Health Officials Clinical to Community Connections: https://www.astho.org/Community-Health-Workers/	

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IA_PM_19	Population Management	Glycemic Screening Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the 2018 performance period and 75 percent in future years, of electronic medical records with documentation of screening patients for abnormal blood glucose according to current US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines.	Medium	<u>Objective:</u> Screen more patients at risk for diabetes. <u>Validation Documentation:</u> Evidence demonstrating the implementation of an abnormal blood glucose screening program focused on at-risk populations. The population/s for this activity are to be defined by the eligible clinician and might include (but are not limited to): patients over a certain Body Mass Index, patients with a family history of diabetes, or patients of an at-risk race or ethnicity. Include both of the following elements: 1) At-risk population identified – Total stratified number of Medicare patients at risk for abnormal blood glucose; AND 2) Percent of population screened – Total number and percentage of at-risk population screened for abnormal blood glucose as outlined by the US Preventive Services Task Force and/or American Diabetes Association guidelines.	2018
IA_PM_20	Population Management	Glycemic Referring Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the CY 2018 performance period and 75 percent in future years, of medical records with documentation of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.	Medium	<u>Objective:</u> Refer more patients with pre-diabetes to a recognized preventive program to help prevent or slow disease progression. <u>Validation Documentation:</u> Evidence demonstrating the implementation of a comprehensive approach for screening for prediabetes. Include both of the following elements: 1) Identified Medicare patients at-risk – Total stratified number of Medicare patients at risk for abnormal blood glucose as outlined by the US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines; AND 2) Percentage of patients receiving diabetes prevention program referral – Total number and percentage of the at-risk population receiving referral to a Centers for Disease Control and Prevention recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.	2018
IA_PM_21	Population Management	Advance Care Planning	Implementation of practices/processes to develop advance care planning that includes: documenting the advance	Medium	<u>Objective:</u> Increase the frequency and quality of advanced care planning and documentation.	2018

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			care plan or living will within the medical record, educating clinicians about advance care planning motivating them to address advance care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare policy side of advance care planning.		<u>Validation Documentation:</u> Evidence supporting implementation of practices/processes to improve advance care planning. Include all of the following elements: 1) Documentation approach – Standardized approach to documenting advance care plan or living will within the medical record (e.g., a medical record template or other defined, standardized method to include specific attributes defined by the eligible clinician) and storage of any relevant copies of patient documents when appropriate; AND 2) Patient identification – Identification of the population of patients, as defined by the eligible clinician (e.g., all patients over 65, patients with specific diagnoses, all patients) who would be subject to the eligible clinician's practices/processes for encouraging advance care planning; AND 3) Eligible clinician education on advance care planning – Documentation of eligible clinician education (e.g., training curriculum or agenda, training materials) on approaches to advance care planning at the level of the individual patient.	
IA_CC_1	Care Coordination	Implementation of use of specialist reports back to referring clinician or group to close referral loop	Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.	Medium	<u>Objective:</u> Improve clinician-to-clinician communication to prevent delayed and/or inappropriate treatment while increasing patient satisfaction and adherence to treatment. <u>Validation Documentation:</u> Evidence that relevant records from patient/consultant (internal or external specialist) interactions are sent to the referring eligible clinician. Include one of the following elements: 1) Report – Evidence that the consultant always sends a report to the referring eligible clinician; OR 2) Process for capturing referral information – Evidence that the referring eligible clinician has a defined method for capturing reports in the medical record (e.g., a) reports transmitted between electronic health records [EHRs]; b) documents that are electronically scanned and linked to the patient's EHR; or c) chart	2017

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					documentation of the relevant details of the consultant patient interaction such as notes written into a progress note).	
IA_CC_2	Care Coordination	Implementation of improvements that contribute to more timely communication of test results	Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.	Medium	<u>Objective:</u> Reduce risk of patient harm that occurs when abnormal test results are not delivered in a timely way. <u>Validation Documentation:</u> Evidence of a process that reduces the time needed before communicating test results to the patient. The eligible clinician may define the population of patients within their practice for the improvement based on specific test ordered, patient diagnosis, or another factor. Include all of the following elements: 1) Population identified – Characteristics of the population targeted and methods for capturing the entire population within your practice; AND 2) Documentation of method/s of communication and benchmark for timeliness of communication – The benchmark for timeliness of communication can be determined and measured in a variety of ways and should be defined by the eligible clinician in a way that will best meet the goals of the activity (e.g., actual times from an electronic health record or improvements in customer service reviews); AND 3) Improvement strategies – The strategies used to improve timeliness are defined and must be documented by the eligible clinician. <u>Example(s):</u> • An internal medicine eligible clinician chooses to follow their population of diabetic patients with a focus on the HbA1c blood test. Traditionally, they do not communicate those test results outside of patient visits. The plan to meet the activity is to communicate normal results with a congratulatory note by email or mail and to communicate abnormal results by phone to ensure the patient understands the need for management of blood sugar more effectively. In this case, the eligible clinician improved the	2017



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					timely communication to meet the activity and also added context relevant to the patient population. • A radiology group that has a busy mammography practice routinely communicates normal mammogram results within 1-2 weeks and abnormal results are followed up with a phone call by a nurse. The radiology group decides to focus on all patients with a prior diagnosis of breast cancer. They develop a process to capture 100% of patients with prior history at the time of their mammogram and they provide real-time results to those patients by the radiologist. They improve the time to results on the identified population and significantly reduce the anxiety of waiting for a group of patients who are most prone to anxiety.	
IA_CC_7	Care Coordination	Regular training in care coordination	Implementation of regular care coordination training.	Medium	<u>Objective:</u> Utilize preferred practice patterns within your practice to improve care coordination. <u>Validation Documentation:</u> Evidence of participation in/implementation of regular care coordination training within the attestation period. Include the following element: 1) Care coordination training – Examples include availability of care coordination training curriculum/training materials and attendance or training certification registers/documents.	2017
IA_CC_8	Care Coordination	Implementation of documentation improvements for practice/process improvements	Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure).	Medium	<u>Objective:</u> Develop and utilize processes that improve care coordination outcomes. <u>Validation Documentation:</u> The eligible clinician identifies an area within their practice in which improved care coordination will improve an outcome. The area(s) for improvement, intervention strategies, and the outcome goals are to be defined by the eligible clinicians involved. Evidence of newly implemented processes and practices to improve care coordination, including both of the following elements: 1) Care coordination process documentation – Documentation of the implementation of practices/processes that document care coordination activities (e.g., record of meeting minutes to discuss	2017

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					changes, swim lane workflow diagram, agenda noting training on new practices/processes for staff, copy of old and new practices/processes on documenting care coordination activities); AND 2) Care coordination outcomes – Documentation of, or ability to demonstrate evidence of, the outcomes from newly implemented practices/processes. <u>Example(s)</u>: An eligible family practice (FP) clinician frequently sees patients in follow-up after emergency department (ED) visits. The eligible clinician does not have immediate access to the ED records and the process of requesting the records is cumbersome and not practical at the time of follow-up. The eligible clinician works with the ED to create an automatic process within the electronic health record so that a brief summary of the ED visit is forwarded to the eligible clinician doing the follow-up. This would require that the eligible ED clinicians always document a brief summary even when they have not completed the full record and it would require information technology support to generate the email/fax, etc. All eligible clinicians involved (FP and ED) get credit for this activity.	
IA_CC_9	Care Coordination	Implementation of practices/processes for developing regular individual care plans	Implementation of practices/processes, including a discussion on care, to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s). Individual care plans should include consideration of a patient's goals and priorities, as well as desired outcomes of care.	Medium	<u>Objective</u>: Develop, maintain, and share personalized care plans with at-risk patients to promote patient-centered care and improve patient experience. <u>Validation Documentation</u>: Evidence of processes for developing and updating individual care plans for at-risk patients and sharing them with beneficiary and/or caregiver. Areas of focus and consideration might include social determinants of health, language and communication preferences, physical or cognitive limitations, as well as desired outcomes of care. Include both of the following elements: 1) Individual care plans for at-risk patients – Documentation of process for developing individual care plans for clinician-defined	2017

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					at-risk patients (e.g., template care plan, standardized type of note in the health record); AND 2) Use of care plan with beneficiary – Patient medical records demonstrating the documentation of the care plan using a standardized approach. <u>Example(s)</u>: An eligible internal medicine clinician has a population within the practice of frail elderly patients who periodically miss appointments and have not refilled prescriptions. Many are at risk of falls. A plan is developed to identify all of these patients and create a template portion of the electronic health record that asks specific questions regarding caregiver support, ability to travel to appointments and the pharmacy, and the ability to get help whenever needed. The eligible clinician and staff work to help the patient identify solutions to problems.	
IA_CC_10	Care Coordination	Care transition documentation practice improvements	In order to receive credit for this activity, a MIPS eligible clinician must document practices/processes for care transition with documentation of how a MIPS eligible clinician or group carried out an action plan for the patient with the patient's preferences in mind (that is, a "patient-centered" plan) during the first 30 days following a discharge. Examples of these practices/processes for care transition include: staff involved in the care transition; phone calls conducted in support of transition; accompaniments of patients to appointments or other navigation actions; home visits; patient information access to their medical records; real time communication between PCP and consulting clinicians; PCP included on	Medium	<u>Objective</u>: Define and implement a standardized process for transitions of care that are relevant to the eligible clinician's patient population. <u>Validation Documentation</u>: Evidence of processes for preparing and implementing patient-centered care transition plans for the first 30 days following a discharge. Include at least two of the following elements: 1) Patient-centered care transition action plans – Documented plans to include out-patient follow-up, medication reconciliation, and post-discharge support. May include: a) patient communications and language preferences; b) available supports and services (medication availability and travel capability); c) patient's discharge environment, or d) out-patient follow-up plan; OR 2) Implementation of action plan within first 30 days of discharge – May include: a) documentation of staff involved in the care transition; b) records of real-time communication between eligible primary care clinicians and consulting eligible	2017

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			specialist follow-up or transition communications.		clinicians; or c) records of eligible primary care clinicians included on specialist follow-up transition communication, etc.; OR 3) Patient communication and delivery of support services according to patient preferences within first 30 days of discharge – Examples from patient records that demonstrate conformity with patient preferences. May include: a) patient-preferred communication activities such as phone calls conducted in support of transition; b) accompaniments of patient to appointments or other navigation actions; c) home visits; patients' access to their medical records; or d) translated discharge materials, etc.; OR 4) Processes for care transition planning – Documentation that defines the steps the eligible clinician will take to prepare and implement the patient-centered care transition plan with every patient. <u>Information:</u> Guide to reducing disparities in readmissions: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf	
IA_CC_11	Care Coordination	Care transition standard operational improvements	Establish standard operations to manage transitions of care that could include one or more of the following: • 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 • Partner with community or hospital-based transitional care services.	Medium	<u>Objective:</u> Enhance communication during care transitions to improve patient outcomes by establishing standard operations, or preferred practice patterns, for transition communications. <u>Validation Documentation:</u> Evidence of information flow during transitions of care. Include at least one of the following elements: 1) Communication lines with local settings – Documentation of standardized lines of communication to manage transitions of care between settings. Communication can occur in whatever format is most useful based on the circumstances of the eligible clinicians; OR 2) Partnership with community or hospital-based transitional care services – Documentation showing partnership with community or hospital-based transitional care services (e.g., written agreement, workflow documentation).	2017



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					<u>Example(s):</u> • A busy hospitalist group in a community hospital has heard complaints from eligible out-patient care primary care clinicians, who report that they are following up on discharged patients without understanding the details of the admission or the changes in medications made. To address this complaint, the hospitalist group creates an electronic health record-based system by which a discharge summary is completed within 24 hours of discharge and which is automatically sent to the patient's eligible primary care clinician (email, fax, etc.). The summary includes medication reconciliation information. • Emergency departments see many patients with chest pain daily. An emergency department (ED) eligible clinician group meets with the cardiology eligible clinician group to arrange for immediate follow-up on moderate-risk chest pain patients after patients have been cleared for discharge by the ED. A telephone conversation occurs between the eligible ED clinician and the eligible cardiologist for every discharged patient who will be seen within 24 hours for evaluation and exercise stress test.	
IA_CC_12	Care Coordination	Care coordination agreements that promote improvements in patient tracking across settings	Establish effective care coordination and active referral management that could include one or more of the following: • Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings. Provide patients with information that sets their expectations consistently with the care coordination agreements;	Medium	<u>Objective:</u> Improve processes for care coordination and active referral management, thus making care more effective and efficient, preventing risky delays and under-treatment, and increasing patient satisfaction and adherence to treatment. <u>Validation Documentation:</u> Evidence of care coordination and referral management. Include at least one of the following elements: 1) Care coordination agreements – Documentation of care coordination agreements that establish flow of information and provide patients with information to set consistent expectations; OR 2) Tracking of patient referrals to specialists – Medical record or electronic health record documentation demonstrating tracking	2017

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			- Track patients referred to specialist through the entire process; and/or - Systematically integrate information from referrals into the plan of care.		of patients referred to specialists through the entire process; OR 3) Referral information integrated into the plan of care – Samples of specialist referral information systematically integrated into the plan of care.	
IA_CC_13	Care Coordination	Practice improvements for bilateral exchange of patient information	Ensure that there is bilateral exchange of necessary patient information to guide patient care, such as Open Notes, that could include one or more of the following: - Participate in a Health Information Exchange if available; and/or - Use structured referral notes.	Medium	<u>Objective:</u> Utilize a program or process that provides an open exchange of necessary patient information between care teams and patients to guide patient care. <u>Validation Documentation:</u> Evidence of exchange of patient information (between care team and patient) to guide patient care. Include at least one of the following elements: 1) Participation in a Health Information Exchange (HIE) – Confirmation of participation in a health information exchange (e.g., email confirmation, screenshots demonstrating active engagement with HIE); OR 2) Utilization of OpenNotes – Clinical documentation from a medical record available in a patient portal. <u>Information:</u> If an eligible clinician is using a patient portal for bidirectional patient-client communication without employing Open Notes, they may find IA_BE_4, “Engagement of patients through implementation of improvements in patient portal” an applicable improvement activity to attest to.	2017
IA_CC_14	Care Coordination	Practice improvements that engage community resources to support patient health goals	Select and screen for the health-related social needs (HRSN) that are relevant for your patient population using tools that have been tested with underserved populations. If possible, use a screening tool that is health IT-enabled and includes standards-based, coded question/field for the capture of data. After screening, address HRSNs identified through at least one of the following:	High	<u>Objective:</u> Improve the health and well-being of patients with health-related social needs (HRSN) by connecting them with appropriate community resources. <u>Validation Documentation:</u> Evidence of screening for HRSN, specified by the MIPS eligible clinician for this activity, and documentation of actions taken to address any identified needs. In addition to the HRSNs listed in the activity description, HRSNs prioritized by the MIPS eligible clinician may include those listed in the activity description, or others (e.g., access to transportation, federal and state benefits enrollment support, access to assistive	2017



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			• Maintain formal relationships with community- based organizations to strengthen the community service referral process, implementing closed-loop referrals where feasible; or • Update a guide to available community resources, or work with community partners to provide a community resource guide and provide it to patients who are found to be at risk in one or more HRSN area; or • Record findings of screening and trigger follow-up within the electronic health record (EHR); then analyze EHR data on patients with one or more HRSN needed to identify and implement approaches to better serve their holistic needs through linkages with community resources. HRSNs prioritized by your practice might include health-harming legal needs, which require both health and legal support to resolve, areas such as food and housing insecurity, or needs such as exercise, nutrition, or chronic disease self-management.		technology). Include the first element and one of the following elements: 1) Use of a patient HRSN screening tool – Copy of implemented screening tool (e.g., completed survey or completed verbal assessment) used to identify patients with one or more specified. If feasible, the screening tool is electronically enabled and includes standards-based, coded question(s)/field(s) for the capture of data; AND 2) Provision of community resource guides – Medical record note/field indicating provision of a guide to community resources to meet specified HRSNs to those patients with identified needs. The MIPS eligible clinician should update this guide, or obtain an updated guide from community partners, at least once during the performance year; OR 3) Community referrals – Evidence (e.g., email, Memorandum of Understanding, meeting minutes, data sharing agreement) demonstrating formal relationships with established referral processes between the MIPS eligible clinician and one or more community-based organizations; OR 4) Electronic Health Record (EHR)/registry data analysis – Record of analysis of EHR or registry data that identifies patients with a HRSN and documents follow-up with identified patient(s). <u>Information:</u> • HRSN Screening Tools that meet the recommended criteria for this activity include: CMS's Accountable Health Communities screening tool: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf; National Association of Community Health Centers' PRAPARE assessment: https://www.nachc.org/wp-content/uploads/2020/04/PRAPARE-One-Page-9-2-16-with-logo-and-trademark.pdf; Health Lead's Screening Tool: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/ • Other tools in Kaiser Permanente's screening tool database:	

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					https://sdh-tools-review.kpwwashingtonresearch.org/find-tools/submit/715 . • Map screening findings to Z-Codes within EHR systems: https://www.cms.gov/files/document/zcodes-infographic.pdf • Background on health-related social needs at primary care settings: https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/tools-and-materials/social-needs-tool.pdf .	
IA_CC_15	Care Coordination	PSH Care Coordination	Participation in a Perioperative Surgical Home (PSH) that provides a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated patient care, which coordinates care from pre-procedure assessment through the acute care episode, recovery, and post-acute care. This activity allows for reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a PSH. The clinician must perform one or more of the following care coordination activities: • Coordinate with care managers/navigators in preoperative clinic to plan and implementation comprehensive post discharge plan of care; • Deploy perioperative clinic and care processes to reduce post-operative visits to emergency rooms; • Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients;	High	<u>Objective:</u> Participate in a Perioperative Surgical Home (PSH) model to improve coordination of patient care through the acute-care episode, recovery, and post-acute care. <u>Validation Documentation:</u> Evidence of participation in a PSH model that provides a patient-centered, clinician-led, interdisciplinary, and team-based system of coordinated patient care. Include at least one of the following elements: 1) Coordination with care managers/navigators in preoperative clinic – Documented conversations with care managers/navigators (e.g., electronic health record note) to plan and implement comprehensive post-discharge plan of care that could take into account patients' post-discharge environment and support system out of the hospital; OR 2) Perioperative care process improvements – Documentation of evidence-informed perioperative clinic and care processes implemented to standardize care across the spectrum of surgical patients (e.g., workflow diagrams, word document of written policies and procedures); OR 3) Patient education and improvement – Implement processes to ensure effective communication of and education on patients' discharge instructions, taking into account patients' literacy level, language and communication preferences, and cognitive or functional impairments.	2018



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			or • Implement processes to ensure effective communications and education of patients' post-discharge instructions.			
IA_CC_16	Care Coordination	Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients	The primary care and behavioral health practices use the same electronic health record system for shared patients or have an established bidirectional flow of primary care and behavioral health records.	Medium	<u>Objective:</u> Improve whole-person care by establishing bidirectional communication between eligible primary care clinicians and behavioral health practices for shared patients. <u>Validation Documentation:</u> Evidence of collaboration and bidirectional flow of patient information between eligible primary care clinician(s) and behavioral health practice/s where electronic health records (EHRs) share common patients. Include the following element: 1) Communication exchange – Documentation of established bidirectional communication and information-sharing between primary care and behavioral health practices that share common patients or use the same EHR systems. <u>Example(s):</u> A small primary care practice of eligible clinicians finds that they often are not aware of the mental health issues their patients are being treated for, and in particular, are often unaware of additions or changes in psychiatric medications. The group does not have the ability to connect their electronic medical record with that of the mental healthcare clinicians and there is no health information exchange available. To solve their problem, they identified all patients with psychiatric medications prescribed outside their practice and all patients known to be receiving mental health treatment. With the patient's permission, the notes from the mental health visits and associated medication information are faxed or emailed and medication reconciliation occurs with all medication changes.	2018
IA_CC_17	Care Coordination	Patient Navigator Program	Implement a Patient Navigator Program that offers evidence-based resources and tools to reduce avoidable hospital	High	<u>Objective:</u> Reduce avoidable hospital readmissions and make hospital stays less stressful and recovery periods more supportive for patients.	2018

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			readmissions, utilizing a patient-centered and team-based approach, leveraging evidence-based best practices to improve care for patients by making hospitalizations less stressful, and the recovery period more supportive by implementing quality improvement strategies.		<u>Validation Documentation:</u> Evidence of participation in a Patient Navigator Program (PNP) designed to meet this activity's objective. Include all of the following elements: 1) PNP participation – Confirmation of participation in PNP. PNP should take into account patients' language and communication preferences, literacy level, and cognitive and physical disabilities; AND 2) Documentation of tools to reduce avoidable hospital readmissions – Tools should be evidence-based whenever possible; AND 3) Quality improvement strategies – Implementation of systems, tools, and strategies as part of the PNP that aim to achieve the objective of this activity. May include workflows and approaches that assist patients with communicating with eligible healthcare clinicians regarding their questions, obtaining information about their procedures/treatments, and arranging for test or appointments.	
IA_CC_18	Care Coordination	Relationship-Centered Communication	In order to receive credit for this activity, MIPS eligible clinicians must participate in a minimum of eight hours of training on relationship-centered care tenets such as making effective open-ended inquiries; eliciting patient stories and perspectives; listening and responding with empathy; using the ART (ask, respond, tell) communication technique to engage patients, and developing a shared care plan. The training may be conducted in formats such as, but not limited to: interactive simulations practicing the skills above, or didactic instructions on how to implement improvement action plans, monitor	Medium	<u>Objective:</u> Improve quality of patient-clinician communication and interaction by attending training on relationship-centered care and communication techniques. <u>Validation Documentation:</u> Evidence that the eligible clinician spent a minimum of eight hours of training focused on relationship-centered care. Include both of the following elements: 1) Certificate of completion – Documentation of completing 8 hours of training with patient-centered care training title, eligible clinician's name, and date of completion (e.g., certificate of completion, screenshot of module completion). The training may be conducted in formats such as, but not limited to: interactive simulations practicing the skills listed in the activity description, or didactic instructions on how to a) implement improvement action plans; b) monitor progress; and c) promote stability around improved clinician communication; AND	2019

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			progress, and promote stability around improved clinician communication.		2) Details on patient-centered care training – Provide details on patient-centered care training components. Training should include such topics as: a) making effective open-ended inquiries; b) eliciting patient stories and perspectives; c) listening and responding with empathy; d) using a specific technique such as ART (ask, respond, tell) to engage patients; or e) developing a shared care plan.	
IA_CC_19	Care Coordination	Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes.	To receive credit for this improvement activity, a MIPS eligible clinician must attest that they reported MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a minimum of a continuous 90-day period within the performance period. Reporting the PRC modifiers enables the identification of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service. See the CY 2018 PFS final rule (82 FR 53232 through 53234) for more details on these codes.	High	<u>Objective:</u> Increase the utilization of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) patient relationship codes (PRC) using the applicable Healthcare Common Procedure Coding System (HCPCS) modifiers on Medicare claims. Using PRC ensure that appropriate attribution is assigned to the appropriate eligible clinician. For example, it would be inappropriate to attribute the cost of an aortic aneurysm repair to the ophthalmologist who performed a cataract surgery in the same calendar year. <u>Validation Documentation:</u> Documentation that MIPS eligible clinician(s) reported MACRA PRC using the applicable HCPCS modifiers on 50% or more of their Medicare claims MACRA patient relationship codes articulate the relationship and responsibility of an eligible clinician with a patient at the time of furnishing an item or service, thereby facilitating the attribution of patients and episodes to one or more eligible clinicians for purposes of cost measurement. Include the following element: 1) MACRA PRC HCPCS modifiers on 50% of Medicare claims – Documentation could be captured in the patient chart or electronic health record; note that the eligible clinician reported MACRA PRC using the applicable HCPCS modifiers on 50% or more of their Medicare claims for a continuous 90-day minimum reporting period within the performance year.	2020
IA_BE_1	Care Coordination	Use of certified EHR to capture	To improve patient access, perform activities beyond routine care that enable capture of patient reported	Medium	<u>Objective:</u> Improve patient engagement through patient/clinician review of patient collected information or through assessment of a patient's understanding, confidence, and ability to perform self-	2017

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		patient reported outcomes	outcomes (for example, related to functional status, symptoms and symptom burden, health behaviors, or patient experience) or patient activation measures (that is, measures of patient involvement in their care) through use of certified electronic health record technology, and record these outcomes data for clinician review.		care. <u>Validation Documentation:</u> Evidence of patient reported data and/or outcomes in the certified electronic health record technology (CEHRT). Include the following element: 1) Patient reported outcomes/self-management – Documentation demonstrating use of one or more measures that assess patients' involvement in their care or their understanding, confidence, and ability to care for oneself. The eligible clinician should incorporate the results of the assessment into the patient's overall plan of care, as deemed most appropriate for their population. As necessary or helpful, also include patient's data in the CEHRT. <u>Example(s)/Information:</u> • Examples of online questionnaires for collecting patient-reported data: - o Quick and full online health check-up: www.HealthConfidence.org - o www.MedicareHealthAssess.org • Inventory of patient-reported outcome measures: www.healthmeasures.net/explore-measurement-systems/promis • The Patient Activation Measure: https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=327	
IA_BE_3	Beneficiary Engagement	Engagement with QIN-QIO to implement self-management training programs	Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs such as diabetes.	Medium	<u>Objective:</u> Become more equipped to help patients self-manage their chronic conditions. <u>Validation Documentation:</u> Evidence of Quality Innovation Network-Quality Improvement Organization (QIN-QIO) relationship to implement self-management training programs. Include the following element: 1) QIN-QIO engagement – Documentation from QIN-QIO of eligible clinician or group's engagement and use of services (e.g., email exchange, participation letter, listed on QIN-QIO website as	2017

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					partner) to assist with participation in self-management training program(s) such as the Diabetes Self-Management Program (DSMP).	
IA_BE_4	Beneficiary Engagement	Engagement of patients through implementation of improvements in patient portal	To receive credit for this activity, MIPS eligible clinicians must provide access to an enhanced patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange. The primary use of this portal should be clinical and not administrative. Examples of the use of such a portal include, but are not limited to: brief patient reevaluation by messaging; communication about test results and follow up; communication about medication adherence, side effects, and refills; blood pressure management for a patient with hypertension; blood sugar management for a patient with diabetes; or any relevant acute or chronic disease management.	Medium	<u>Objective:</u> Increase patient engagement, adherence to treatment plans, and self-management of chronic conditions through the availability of a patient portal within the electronic health record (EHR). <u>Validation Documentation:</u> Evidence of a functioning patient portal that includes patient interactive features or up-to-date information on disease or symptom management. Include at least one of the following elements: 1) Enhanced patient portal screenshots – Documentation through screenshots of an enhanced patient portal that displays at least one of the following functions or features: a) bidirectional communication between patient and eligible clinician or care team (e.g., messaging for questions, medication refills, appointment scheduling); or b) availability of health information and education regarding the patient's conditions; OR 2) Patient portal use reports – Reports of patient portal engagement detailing patient use of interactive functions (e.g., bidirectional communication between patient and eligible clinician or care team about medication changes and adherence). <u>Information:</u> If an eligible clinician is using Open Notes (https://protect2.fireeye.com/url?k=193efc00-456bf5d0-193ecd3f-0cc47a6a52de-68b30e439d31f40b&u=https://www.opennotes.org/) for bidirectional patient-clinician communication, they may find IA_CC_13, "Practice Improvements for Bilateral Exchange of Patient Information", an applicable activity to attest to.	2017
IA_BE_5	Beneficiary Engagement	Enhancements/regular updates to practice	Enhancements and ongoing regular updates and use of websites/tools that include consideration for compliance	Medium	<u>Objective:</u> Ensure eligible clinicians' website content and tools more accessible to people with disabilities.	2017

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		websites/tools that also include considerations for patients with cognitive disabilities	with section 508 of the Rehabilitation Act of 1973 or for improved design for patients with cognitive disabilities. Refer to the CMS website on Section 508 of the Rehabilitation Act https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/Section508/index.html?redirect=/InfoTechGenInfo/07_Section508.asp that requires that institutions receiving federal funds solicit, procure, maintain and use all electronic and information technology (EIT) so that equal or alternate/comparable access is given to members of the public with and without disabilities. For example, this includes designing a patient portal or website that is compliant with section 508 of the Rehabilitation Act of 1973.		<u>Validation Documentation:</u> Evidence that updated practice website/tools are compliant with Section 508 and thus provide improved access for patients with disabilities. Include both of the following elements: 1) Regular updates and Section 508 compliance process – Documentation of a process for regular updates and ensuring Section 508 compliance for the eligible clinician's patient portal or website; AND 2) Compliant website/tools – Screenshots or hard copies of the practice's website/tools demonstrating key aspects of Section 508 compliance. <u>Information:</u> Find 508 compliance information at https://www.section508.gov/.	
IA_BE_6	Beneficiary Engagement	Regularly Assess Patient Experience of Care and Follow Up on Findings	Collect and follow up on patient experience and satisfaction data. This activity also requires follow-up on findings of assessments, including the development and implementation of improvement plans. To fulfill the requirements of this activity, MIPS eligible clinicians can use surveys (e.g., Consumer Assessment of Healthcare Providers and Systems Survey), advisory councils, or other mechanisms. MIPS eligible clinicians may consider implementing patient surveys in multiple	High	<u>Objective:</u> Improve patients' experience of and satisfaction with care by gathering and applying learnings from relevant data to make care more patient-centered. <u>Validation Documentation:</u> Evidence that patient experience and satisfaction data are collected, and that follow-up occurs through an improvement plan. Include at least two of the following elements: 1) Report of patient experience and satisfaction – Report including collected data on patient experience and satisfaction (e.g., survey results). Report may include description of effort to implement patient surveys in multiple languages based on the needs of the patient population. The eligible clinician or practice	2017

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			languages, based on the needs of their patient population.		may use a third-party administrator; AND/OR 2) Follow-up on patient experience and satisfaction – Documentation that the eligible clinician's practice has implemented changes based on the results of the patient experience and satisfaction data gathered and analyzed (e.g., specific improvements made to practices/processes in response to survey results); AND/OR 3) Patient experience and satisfaction improvement plan – Documentation of a patient experience and satisfaction improvement plan. <u>Example(s)</u>: A practice offers patients the option to fill out a questionnaire after their visit. A) The practice finds that a consistent complaint is the long wait times and that the practice is losing patients as a result. The practice develops a plan to address wait times. B) The practice finds that there are multiple complaints about a single eligible clinician that include poor listening skills and a tendency to rush in and out of the room so fast that questions are not answered. The practice creates an education plan for the eligible clinician and also identifies and addresses environmental issues, or provides support to address personal issues, that lead the eligible clinician to feel pressure to rush through patient visits. <u>Information</u>: • Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for Healthcare Research and Quality: https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html and https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/MIPS • Tools and advisory councils: https://www.ahrq.gov/topics/patient-and-family-engagement.html • Patient experience surveys: https://www.ahrq.gov/cahps/surveys-guidance/index.html	

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					• Other available surveys: https://www.rand.org/health-care/surveys_tools/psq.html	
IA_BE_7	Beneficiary Engagement	Participation in a QCDR, that promotes use of patient engagement tools.	Participation in a Qualified Clinical Data Registry (QCDR), that promotes patient engagement, including: • Use of processes and tools that engage patients for adherence to treatment plans; • Implementation of patient self-action plans; • Implementation of shared clinical decision making capabilities; or • Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.	Medium	Objective: Increase patient engagement through use of qualified clinical data registry (QCDR)'s tools for promoting positive patient behavior such as consistent exercise. Validation Documentation: Evidence of participation in a QCDR that promotes patient engagement tools (e.g., patient portal, secure email, and online mobile scheduling). Include at least one of the following elements: 1) QCDR Feedback Reports – Copies of feedback reports provided by the QCDR detailing activities promoting the use of patient engagement tools (e.g., implementation of patient self-action plans, shared clinical decision-making) as part of efforts to improve processes of care; OR 2) QCDR patient experience reports – Copies of QCDR patient experience data reports used to inform and advance improvements in beneficiary engagement. Example(s): Patient engagement tools may include, but are not limited to telemedicine/virtual visits, patient portals, patient outreach, remote patient monitoring, and patient education. Note: Patient experience data provided by QCDRs capture performance measurement and submission of measure results to help eligible clinicians identify opportunities to improve patient outcomes and the healthcare delivery system.	2017
IA_BE_8	Beneficiary Engagement	Participation in a QCDR, that promotes collaborative learning network opportunities	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.	Medium	Objective: Increase involvement of interactive collaborative learning networks with support of qualified clinical data registry (QCDR) promotion and feedback reports. Validation Documentation: Evidence of participation in a QCDR that promotes interactive collaborative learning network opportunities. Include both of the following elements:	2017

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Objective & Validation Documentation	First PY
		that are interactive.			1) QCDR participation – Documentation of participation in QCDR (e.g., QCDR agreement documentation); AND 2) Collaborative learning network opportunities – Documentation that interactive collaborative learning network opportunities are promoted through the QCDR (e.g., regular feedback reports provided by the QCDR that promote interactive collaborative learning networks). <u>Information:</u> If you currently work with a QCDR, that QCDR will have relevant information for use of this activity.	
IA_BE_12	Beneficiary Engagement	Use evidence-based decision aids to support shared decision-making.	Use evidence-based decision aids to support shared decision-making.	Medium	<u>Objective:</u> Increase use of evidence-based decision aids to encourage shared decision-making with beneficiaries. <u>Validation Documentation:</u> Documented use of evidence-based decision aids to support shared decision-making, a collaborative process aimed at improving beneficiary-clinician communication and informed consent in healthcare. Include the following element: 1) Use of decision-aids – Documentation (e.g., checklist, algorithms, tools, screenshots) showing the use of evidence-based decision aids (e.g., https://decisionaid.ohri.ca/AZlist.html and https://shareddecisions.mayoclinic.org/decision-aid-information/decision-aids-for-chronic-disease/) to support shared decision-making with beneficiary.	2017
IA_BE_14	Beneficiary Engagement	Engage patients and families to guide improvement in the system of care.	Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-to-work and patient quality of life improvement. Platforms and devices that collect patient-generated health data (PGHD) must do so with an active feedback	High	<u>Objective:</u> Use active devices and platforms to allow the patient and the clinical care team to share information on a patient's status, adherence, comprehension, and indicators of clinical concern in a timely manner. <u>Validation Documentation:</u> Evidence of engagement with patients and families by using digital tools for ongoing guidance and assessments outside the encounter. Include both of the following elements: 1) Use of digital tool or platform – Documentation of the	2017

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			loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient, including patient reported outcomes (PROs). Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bi-directional systems, and other devices that transmit clinically valid objective and subjective data back to care teams. Because many consumer-grade devices capture PGHD (for example, wellness devices), platforms or devices eligible for this improvement activity must be, at a minimum, endorsed and offered clinically by care teams to patients to automatically send ongoing guidance (one way). Platforms and devices that additionally collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient (e.g. automated patient-facing instructions based on glucometer readings). Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and platforms can inform the patient or the clinical care team in a timely		practice's adoption of an endorsed clinical tool or platform for digital collection and use of patient data that can create an active feedback loop between patient and clinical care team (e.g., license for tool/platform); AND 2) Collection of patient-generated health data (PGHD) and participation in active feedback loop with patients – Documentation of PGHD submission in real- or near-real-time to the care team, or reports generating clinically endorsed real- or near-real-time automated feedback to the patient, including patient reported outcomes (PROs); may be used for patients and families who need additional support because of disability or plans to improve their quality of life or return to work.	



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			manner of important parameters regarding a patient's status, adherence, comprehension, and indicators of clinical concern.			
IA_BE_15	Beneficiary Engagement	Engagement of patients, family and caregivers in developing a plan of care	Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the electronic health record (EHR) technology.	Medium	<u>Objective:</u> Increase engagement with patients, family, and caregivers and ensure care provided aligns with their priorities and needs. <u>Validation Documentation:</u> Evidence of inclusion of patients, family, and caregivers in developing plan of care with prioritization of goals for action, as documented in the electronic health record (EHR). The eligible clinician will identify the patient population that will participate in this activity. Include the following element: 1) Patient, family, and caregiver involvement – Report or screenshot from the EHR showing the plan of care and prioritized goals for action with notes from engagement of patients and/or their families and caregivers. May use another electronic platform to systematically capture patient preferences/value through a validated patient experience measure instrument. <u>Example(s):</u> An eligible oncologist chooses to implement a plan for all cancer patients with a likely lifespan of less than 3 years. The practice facilitates completion of the Qual-E validated Quality of Life instrument and incorporates results into treatment plan when possible and incorporates families and caregivers into the decision-making discussion when appropriate. This helps facilitate planning for aggressiveness of treatment, end-of-life planning (Do Not Resuscitate (DNR) orders, advance directives, etc.), and family/caregiver congruence.	2017
IA_BE_16	Beneficiary Engagement	Promote Self-management in Usual Care	To help patients self-manage their care, incorporate culturally and linguistically tailored evidence-based techniques for promoting self-management into usual care, and provide patients with tools	Medium	<u>Objective:</u> Improve health outcomes by helping patients improve self-management. <u>Validation Documentation:</u> Documented use of culturally and linguistically tailored evidence-based techniques to promote self-	2017

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			and resources for self-management. Examples of evidence-based techniques to use in usual care include: goal setting with structured follow-up, Teach-back methods, action planning, assessment of need for self-management (for example, the Patient Activation Measure), and motivational interviewing. Examples of tools and resources to provide patients directly or through community organizations include: peer-led support for self-management, condition-specific chronic disease or substance use disorder self-management programs, and self-management materials.		management into usual care. Include both of the following elements: 1) Patient literacy and language capture – Documentation of patient literacy level and/or language preference captured in the medical record (e.g., screenshot, electronic health record [EHR] report); AND 2) Provision of appropriate self-management care techniques – Documented use of evidence-based techniques to promote self-management into usual care (e.g., eligible clinicians' completed office visit checklist, electronic health record report of completed checklist, copies of goal-setting tools or techniques, motivational interviewing script/questions, action planning tool with patient feedback, record of condition-specific self-management coaching). Materials must be provided in a format appropriate for the patient's literacy and/or language preference. <u>Example(s)</u>: A primary care practice identifies cultural and educational variability, and associated variability in health literacy, in its patient population. To meet the needs of their patient population, the eligible practice clinicians review all self-management materials used by the practice and make changes to ensure all are written at the 6th-grade level or lower and are available in all languages needed for the patient population. If materials are not in all languages needed for patient population, the practice connects with an organization to translate the materials into languages not previously covered. Materials provided to the patient are referenced specifically in the EHR. <u>Information</u>: • Context, recommendations, and resources on Health Literacy: https://www.aafp.org/afp/2005/0801/p463.html • Overview and resources: https://www.ahrq.gov/ncepcr/tools/self-mgmt/self.html • Center for Disease Control and Prevention's chronic disease	



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					self-management program: https://www.cdc.gov/arthritis/interventions/programs/cdsmp.htm ; https://www.cdc.gov/arthritis/marketing-support/1-2-3-approach/docs/pdf/provider_fact_sheet_cdsmp.pdf • Approaches for language assistance services to patients with limited English proficiency: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Lessons-from-the-Field.pdf • Guide to ensure meaningful access to programs: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan.pdf • Catalog of diabetes prevention resources tailored to various audiences: https://www.cms.gov/files/document/culturally-and-linguistically-tailored-type-2-diabetes-prevention-resource.pdf • Medicare benefits for diabetes self-management training, with links to multi-language resources: https://www.medicare.gov/coverage/diabetes-self-management-training • Find Administration for Community Living funded resources for self-management in your area: https://acl.gov/programs/aging-and-disability-networks	
IA_BE_19	Beneficiary Engagement	Use group visits for common chronic conditions (e.g., diabetes).	Use group visits for common chronic conditions (e.g., diabetes).	Medium	<u>Objective:</u> Give patients with common chronic conditions opportunities to learn about self-management topics and discuss shared concerns while improving efficiency in the delivery of quality care. <u>Validation Documentation:</u> Documented use of group visits for chronic conditions. Could be supported by claims. Include the following element: 1) Provision of group visit(s) – Medical claims or referrals showing group visit and chronic condition codes in conjunction with care provided.	2017

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					<u>Information:</u> https://www.aafp.org/about/policies/all/shared-medical-appointments.html	
IA_BE_22	Beneficiary Engagement	Improved practices that engage patients pre-visit	Implementation of workflow changes that engage patients prior to the visit, such as a pre-visit development of a shared visit agenda with the patient, or targeted pre-visit laboratory testing that will be resulted and available to the MIPS eligible clinician to review and discuss during the patient's appointment.	Medium	<u>Objective:</u> Increase the efficiency and effectiveness of visit time with patients, and promote patient engagement and satisfaction with care. <u>Validation Documentation:</u> Evidence that a pre-visit agenda was shared and/or developed with patients prior to visit. Include at least one of the following elements: 1) Pre-visit communication with patient – Documentation of communication with patient (letter, email, discussion, portal screenshot, etc.) that shows a pre-visit agenda was shared with and/or developed with the patient; OR 2) Patient engagement workflow – Documentation of the practice's patient engagement workflow clearly showing pre-visit agenda sharing process (e.g., staff responsible, timing, method of sharing); OR 3) Co-creation of visit agenda – Documented strategies to engage patients and their family members to co-create a visit agenda (e.g., workflow diagram, policy or process document).	2017
IA_BE_23	Beneficiary Engagement	Integration of patient coaching practices between visits	Provide coaching between visits with follow-up on care plan and goals.	Medium	<u>Objective:</u> Provide additional direct support to patients in achieving their goals, thus improving patient satisfaction, adherence to plans, and health outcomes. <u>Validation Documentation:</u> Documented use of coaching provided between visits with follow-up on care plan and goals, for a population of the eligible clinician's choosing (e.g., patients with a specific condition). Include the population identified for this activity and at least one of the following elements: 1) Use of coaching codes – Medical claims with codes for coaching provided between visits; OR 2) Coaching plan and goals – Copy of documentation provided to patients (e.g., letter, email, portal screenshot) that includes coaching on care plan and goals; OR	2017



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					3) Coaching tools used – Examples of coaching tools used by staff (e.g., coaching scripts, tools, materials). <u>Information:</u> Clinician coaching https://clinicalhealthcoach.com/coaching-conversation-example/	
IA_BE_24	Beneficiary Engagement	Financial Navigation Program	In order to receive credit for this activity, MIPS eligible clinicians must attest that their practice provides financial counseling to patients or their caregiver about costs of care and an exploration of different payment options. The MIPS eligible clinician may accomplish this by working with other members of their practice (for example, financial counselor or patient navigator) as part of a team-based care approach in which members of the patient care team collaborate to support patient- centered goals. For example, a financial counselor could provide patients with resources with further information or support options, or facilitate a conversation with a patient or caregiver that could address concerns. This activity may occur during diagnosis stage, before treatment, during treatment, and/or during survivorship planning, as appropriate.	Medium	<u>Objective:</u> Help patients navigate the stress and risks associated with paying for healthcare, and, when relevant, help them explore alternative options that address their holistic needs. <u>Validation Documentation:</u> Demonstration that the practice provides patients with estimates of the costs of the types of healthcare services it will furnish in advance (for services that can be scheduled in advance) and financial counseling to patients or their caregivers about payment options. Financial counseling may occur during diagnosis stage, before treatment, during treatment, and/or during survivorship planning, as appropriate. Include both of the following elements: 1) Estimated cost of care provided – Documentation that an estimate of the cost to the patient of the types of healthcare services to be furnished by the eligible clinician(s) was provided to patient in advance (for services that can be scheduled in advance); AND 2) Financial counseling provided – Documentation of financial counseling provided to patients and/or their caregivers about costs of care with evidence that different payment options were provided.	2019
IA_BE_25	Beneficiary Engagement	Drug Cost Transparency	Provide counseling to patients and/or their caregivers regarding: costs of medications using a real time benefit tool (RTBT) which provides to the prescriber real-time patient-specific formulary and benefit information for	High	<u>Objective:</u> Help patients navigate the stress and risks associated with paying for healthcare by providing information on the patients' share of the costs for medications in the drug formulary; help patients explore alternative options that address their holistic needs.	2020

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			drugs, including cost-sharing for a beneficiary.		<u>Validation Documentation:</u> Documented provision of counseling to patients and/or their caregivers regarding the costs of medications using the Real-Time Benefit Tool (RTBT). Include both of the following elements: 1) Use of RTBT – Evidence of RTBT used in practice (e.g., workflow diagram, screenshot of tool) to provide real-time patient-specific formulary and benefit information for medications, including cost-sharing for a beneficiary and counselling on medication costs; AND 2) Discussion of alternative medications and assistance programs – Documentation (e.g., EHR or medical record note) of discussion/counseling with patients about the availability of any alternative medications (such as generics) and the patients' eligibility for patient assistance programs that provide free medications for patients who are unable to afford to buy their medicine. For this activity, patient assistance programs pertain to patients who require assistance to purchase necessary medications <u>Information:</u> • Real-time benefit tool (RTBT): www.covermymeds.com/main/insights/rtbc-scorecard/ • Patient Assistance Program Center: www.rxassist.org/providers	
IA_PSPA_1	Beneficiary Engagement	Participation in an AHRQ-listed patient safety organization.	Participation in an AHRQ-listed patient safety organization.	Medium	<u>Objective:</u> Adopt and implement Patient Safety Organization (PSO) methodologies through data collection, analysis, reporting, and education to promote the quantifiable reduction of avoidable medical errors and deficiencies identified in the quality of care provided. <u>Validation Documentation:</u> Evidence of participation in an Agency for Healthcare Research and Quality (AHRQ)-listed PSO. Include the following element: 1) Confirmation of participation – Documentation from an AHRQ-listed PSO confirming the eligible clinician or group's	2017



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					participation with the PSO (e.g., welcome email or other communication). <u>Note:</u> PSOs listed by AHRQ are located at http://www.pso.ahrq.gov/listed, and information regarding how to choose a PSO can be found at https://pso.ahrq.gov/work-with/choose.	
IA_PSPA_2	Patient Safety & Practice Assessment	Participation in MOC Part IV	In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. Maintenance of Certification (MOC) Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results. Some examples of activities that can be completed to receive MOC Part IV credit are: the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or	Medium	<u>Objective:</u> Maintain certifications with a Maintenance of Certification (MOC)-approved specialty board to increase/update knowledge and apply it to practice and safety improvements. <u>Validation Documentation:</u> Evidence of participation in MOC Part IV. Include the following element: 1) Confirmation of participation – Documentation of participation in MOC Part IV. <u>Information:</u> Review appropriate information within the appropriate board certifying entity as it relates to MOC IV.	2017

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			national outcomes registry or quality assessment program; specialty- specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules.			
IA_PSPA_3	Patient Safety & Practice Assessment	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or other similar activity.	For MIPS eligible clinicians not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as the Institute for Healthcare Improvement (IHI) Training/Forum Event; National Academy of Medicine, Agency for Healthcare Research and Quality (AHRQ) Team STEPPS®, or the American Board of Family Medicine (ABFM) Performance in Practice Modules.	Medium	Objective: Obtain a Maintenance of Certification (MOC)-approved specialty board certification or other similar program to increase/update knowledge and apply it to practice and safety improvements. Validation Documentation: Evidence of participation in Institute for Healthcare Improvement (IHI) Training/Forum Event: National Academy of Medicine, AHRQ Team STEPPS®, or other similar activity. Include the following element: 1) Certificate of participation – Certificate or letter of participation from an IHI Training/Forum Event: National Academy of Medicine, AHRQ Team STEPPS®, or the American Board of Family Medicine Performance in Practice Modules, or other similar activity, for eligible clinicians or groups not participating in MOC Part IV.	2017
IA_PSPA_4	Patient Safety & Practice Assessment	Administration of the AHRQ Survey of Patient Safety Culture	Administration of the AHRQ Survey of Patient Safety Culture and submission of data to the comparative database (refer to AHRQ Survey of Patient Safety Culture website http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html). Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year	Medium	Objective: Create the opportunity to i) Raise staff awareness about patient safety; ii) Elucidate and assess the current status of patient safety culture; iii) Identify strengths and areas for patient safety culture improvement; iv) Evaluate trends in patient safety culture change over time; and v) Evaluate the cultural impact of patient safety initiatives and interventions (from https://www.ahrq.gov/sops/about/faq.html#Q1). Validation Documentation: Evidence of administration of the Agency for Healthcare Research and Quality (AHRQ) survey of Patient Safety Culture and submission of data to the comparative database. Include the following element:	2017

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			basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.		1) Survey results data submission – Survey results from the AHRQ Survey of Patient Safety Culture, including proof of administration and submission. <u>Information:</u> https://www.ahrq.gov/sops/index.html <u>Note:</u> This activity may be selected once every 4 years to avoid duplicative information, given that some of the modules may change on a yearly basis but over 4 years there would be reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance score.	
IA_PSPA_6	Patient Safety & Practice Assessment	Consultation of the Prescription Drug Monitoring program	Review the history of controlled substance prescriptions for 90 percent* of patients using state prescription drug monitoring program (PDMP) data prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription lasting longer than 3 days. *Apply exceptions for patients receiving palliative and hospice care.	High	<u>Objective:</u> Use patients' past prescription history to inform decisions about issuing new controlled substance schedule II opioid prescriptions, thus identifying and protecting patients who are at risk of opioid addition and/or overdose. <u>Validation Documentation:</u> Evidence of prescription drug monitoring program (PDMP) consultation before issuance of a controlled substance schedule II (CSII) opioid prescription that lasts longer than 3 days. Include both of the following elements, for the same time period: 1) Number of issuances of CSII Prescription – Total number of issuances of a CSII prescription that lasts longer than 3 days (e.g., screenshot or report from PDMP web portal displaying data); AND 2) Documentation of consulting the PDMP – Total number of patients for which there is evidence of consulting the PDMP prior to issuing an CSII prescription (e.g., copies of patient reports created with the Protected Health Information masked, PDMP website screenshot); AND 3) Documentation for exceptions – Total number of patients receiving hospice and palliative care, and who are exempt from	2017

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					Centers for Disease Control and Prevention (CDC) prescribing guidelines.	
IA_PSPA_7	Patient Safety & Practice Assessment	Use of QCDR data for ongoing practice assessment and improvements	Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including: • Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups); • Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment); • Use of standardized processes for screening for social determinants of health such as food security, employment, and housing; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology; or • Use of QCDR data for quality improvement such as comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and	Medium	<u>Objective:</u> Use qualified clinical data registry (QCDR) data for practice assessment and improvement with primary goal of addressing patient safety for targeted populations. <u>Validation Documentation:</u> Documented use of QCDR data for ongoing practice assessment and improvements in patient safety. Include both of the following elements: 1) Use of QCDR for assessment – Feedback reports provided by the QCDR that demonstrate ongoing practice assessments in patient safety; AND 2) Use of QCDR for improvement – Documentation of how the practice is using QCDR data and documentation of intended improvements in patient safety for the specific populations targeted (e.g., documentation of standard tools, processes for screening, use of standard questionnaires, or use of QCDR data that are used for quality improvement, such as population-level analysis to assess for adverse outcomes). <u>Example(s):</u> An anesthesia group is supported by a QCDR for quality improvement and MIPS reporting. The QCDR provides routine data feedback reports to the eligible clinicians as part of the engagement. In one of the areas of review, the anesthesiologists realize, through the provided data, that they are inconsistently providing appropriately timed dosing of neuromuscular blocker recovery medication. This creates significant potential for complications at the time of extubation following the procedure. As a result, the anesthesiology group develops a plan that includes checklists to prevent this problem moving forward and they successfully eliminate the safety risk.	2017

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			corrective steps to address adverse outcomes.			
IA_PSPA_8	Patient Safety & Practice Assessment	Use of patient safety tools	In order to receive credit for this activity, a MIPS eligible clinician must use tools that assist specialty practices in tracking specific measures that are meaningful to their practice. Some examples of tools that could satisfy this activity are: a surgical risk calculator; evidence based protocols, such as Enhanced Recovery After Surgery (ERAS) protocols; the Centers for Disease Control (CDC) Guide for Infection Prevention for Outpatient Settings predictive algorithms; and the opiate risk tool (ORT) or similar tool.	Medium	Objective: Improve the number of patients tracked and the precision of measurement for patient safety measures, thus allowing specialists to make evidence-based decisions about improving safety for their patients. Validation Documentation: Documented use of patient safety tools implemented for tracking specific patient safety and practice assessment measures that are meaningful to the eligible clinician or group (e.g., tracking HbA1c would be meaningful to an endocrinologist whereas tracking intraocular pressure would be more meaningful to an ophthalmologist). Include both of the following elements: 1) Evidence of safety tools used – Documentation of the use of patient safety tools that assist in tracking patient safety measures (e.g., practice policy or protocol, workflow diagram, screenshot); AND 2) Evidence of measures tracked – Documentation of specific patient safety measures tracked via use of tool (e.g., quality measure report, dashboard, screenshot). Example(s): • Surgical risk calculator • Opiate risk tool • The Centers for Disease Control and Prevention (CDC) Guide for Infection Prevention for Outpatient Settings predictive algorithms. • Use of clinical assessment modalities and diagnostic screening tools in specialty medicine (e.g., World Health Organization's Fracture Risk Assessment (FRAX) Tool); • Use American College of Cardiology Surviving myocardial infarction (MI) • Use American College of Physicians (ACP) Practice Advisor;	2017



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					ACP Quality Connect; • Conduct Disease Activity Measurement to Optimize Treating to Target; • Improve Informed Consent and Shared Decision-Making with Evidence-Based Risk Stratification Strategies; • Implement American Gastroenterological Association Clinical Guidelines Mobile App; • Participate in public health emergency disease outbreak control efforts; • Participate in voluntary surveillance activity; • Conduct population management strategies within a Perioperative Surgical Home; • Use of American Urological Association Symptom Index to increase patient engagement; • Provide leadership of Infection Prevention and Control Program; • Conduct therapeutic drug monitoring for inflammatory bowel disease patients that are on anti-tumor necrosis factor (TNF) therapies; • Deploy predictive analytical models to manage chronic disease in patients; • Perform review of Enhanced Recovery after Surgery protocol and implement improvement plan.	
IA_PSPA_9	Patient Safety & Practice Assessment	Completion of the AMA STEPS Forward program	Completion of the American Medical Association's STEPS Forward program.	Medium	<u>Objective:</u> Gain the knowledge to "improve practice efficiency and ultimately enhance patient care, physician satisfaction and practice sustainability" (from https://edhub.ama-assn.org/steps-forward/pages/About). <u>Validation Documentation:</u> Evidence of completion of American Medical Association's (AMA's) STEPS Forward program. Include at least one of the following elements: 1) Certificate of completion – Certificate of completion from at least one AMA's STEPS Forward program module; OR 2) Evidence of implementation – Documentation of newly	2017

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					implemented care processes based on completion of AMA's STEPS Forward module.	
IA_PSPA_10	Patient Safety & Practice Assessment	Completion of training and receipt of approved waiver for provision of opioid medication-assisted treatments	Completion of training and obtaining an approved waiver for provision of medication -assisted treatment of opioid use disorders using buprenorphine.	Medium	<u>Objective:</u> Become better equipped to help patients overcome their opioid use disorders and, with certification, become a trusted source of care for patients with opioid disorders. <u>Validation Documentation:</u> Evidence of obtaining the approved waiver for provision of medication assisted treatment of opioid use disorders using buprenorphine. Include the following element: 1) Waiver – Substance Abuse and Mental Health Services Administration (SAMHSA) letter confirming presence of waiver and eligible clinician prescribing ID number. Obtaining a waiver requires mandatory training. <u>Information:</u> https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner	2017
IA_PSPA_12	Patient Safety & Practice Assessment	Participation in private payer CPIA	Participation in designated private payer clinical practice improvement activities.	Medium	<u>Objective:</u> Improve the quality of care provided, and health outcomes for patients, by participating in improvement activities designated by private payers. <u>Validation Documentation:</u> Evidence of participation in private payer clinical practice improvement activities. Include the following element: 1) Confirmation of participation – Documents showing participation in private payer clinical practice improvement activities (e.g., quality measure documentation or feedback reports, practice workflow redesign tools developed for or with the payer as part of practice improvement).	2017
IA_PSPA_13	Patient Safety & Practice Assessment	Participation in Joint Commission Evaluation Initiative	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative	Medium	<u>Objective:</u> Implement the Joint Commission's Ongoing Professional Practice Evaluation with goal of identifying negative practice trends earlier. <u>Validation Documentation:</u> Evidence of participation in the Joint Commission's Ongoing Professional Practice Evaluation (OPPE)	2017

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					initiative. Include the following element: 1) Confirmation of participation – Documentation from Joint Commission's OPPE initiative confirming participation in its improvement program(s) (e.g., email or other communication).	
IA_PSPA_15	Patient Safety & Practice Assessment	Implementation of an ASP	Leadership of an Antimicrobial Stewardship Program (ASP) that includes implementation of an ASP that measures the appropriate use of antibiotics for several different conditions (such as but not limited to upper respiratory infection treatment in children, diagnosis of pharyngitis, bronchitis treatment in adults) according to clinical guidelines for diagnostics and therapeutics. Specific activities may include: • Develop facility-specific antibiogram and prepare report of findings with specific action plan that aligns with overall facility or practice strategic plan. • Lead the development, implementation, and monitoring of patient care and patient safety protocols for the delivery of ASP including protocols pertaining to the most appropriate setting for such services (i.e., outpatient or inpatient). • Assist in improving ASP service line efficiency and effectiveness by evaluating and recommending improvements in the management structure and workflow of ASP processes. • Manage compliance of the ASP	Medium	<u>Objective:</u> Reduce inappropriate use of antimicrobials, thus playing a critical role in reducing microbial resistance and the incidence of antimicrobial-caused adverse drug reactions, all of which will help improve patient outcomes and the efficiency of spending. <u>Validation Documentation:</u> Evidence of leadership of an Antimicrobial Stewardship Program (ASP) that measures the appropriate use of antibiotics for several different conditions according to clinical guidelines for diagnostics and therapeutics. Include at least one of the following elements: 1) Antibiogram and report – Documented facility-specific antibiogram and report of findings and specific action plan aligned with overall facility or practice strategic plan; OR 2) ASP patient care and safety protocols – Documentation of the development, implementation, and monitoring of patient care and safety protocols as a result of the process of operating the ASP (e.g., email communication, meeting agendas with eligible clinician's name, staff confirmation); OR 3) ASP evaluation – Documentation of the on-going evaluation and monitoring of the management structure and workflow of ASP processes and involvement therein (e.g., email communication, meeting agendas with eligible clinician's name, reports, staff confirmation); OR 4) ASP education and training – Records of presentation of ASP education and training including curriculum and presentation dates with eligible clinician named as one of the facilitators or presenters; OR 5) ASP policies or practices for high-priority conditions – Documentation of involvement in selecting and implementing	2017

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			policies and assist with implementation of corrective actions in accordance with facility or clinic compliance policies and hospital medical staff by-laws. • Lead the education and training of professional support staff for the purpose of maintaining an efficient and effective ASP. • Coordinate communications between ASP management and facility or practice personnel regarding activities, services, and operational/clinical protocols to achieve overall compliance and understanding of the ASP. • Assist, at the request of the facility or practice, in preparing for and responding to third-party requests, including but not limited to payer audits, governmental inquiries, and professional inquiries that pertain to the ASP service line. • Implementing and tracking an evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions. • Developing and implementing evidence-based protocols and decision-support for diagnosis and treatment of common infections. • Implementing evidence-based protocols that align with recommendations in the Centers for Disease Control and Prevention's Core		evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions; OR 6) ASP protocols and decision supports – Documentation of developing and implementing evidence-based protocols and decision-support for diagnosis and treatment of common infections; OR 7) Alignment with CDC Core Elements of Outpatient Antibiotic Stewardship guidance – Documentation of involvement in the alignment of evidence-based protocols with recommendations in the Centers for Disease Control and Prevention's (CDC's) Core Elements of Outpatient Antibiotic Stewardship guidance. <u>Information:</u> Extensive information on antimicrobial stewardship can be found at the CDC website: https://www.cdc.gov/antibiotic-use/core-elements/index.html. Also, the CDC includes information on ASPs for different practice settings (hospital, outpatient, nursing home, etc.).	

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			Elements of Outpatient Antibiotic Stewardship guidance.			
IA_PSPA_16	Patient Safety and Practice Assessment	Use of decision support and standardized treatment protocols	Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	Medium	<u>Objective:</u> Help eligible clinicians align diagnoses and treatment plans with up-to-date, evidence-based standards and guidelines as part of routine care, thus improving the appropriateness of the care they provide and the health outcomes of their patients. <u>Validation Documentation:</u> Documented use of decision support and standardized treatment protocols to manage team workflows to meet patient needs. Include the following element: 1) Use of decision support and standardized treatment protocols – Documentation (e.g., checklist, order set, algorithm, screenshot) demonstrating use of decision support and standardized treatment protocols to manage team workflows to meet patient needs. May include use of artificial intelligence/machine learning. <u>Example(s)/Information:</u> An eligible clinician group, through peer review, determines that there is significant variability in clinical decision-making for a specific condition. They all agree that standardization of practice is best for patient outcomes. Examples of scenarios: • Emergency Department (ED) treatment of ST elevation Myocardial Infarction (MI): ED staff develop MI standardized orders (order-set) built into the electronic health record (EHR) workflow. The order-set drives specific evaluation and treatment decisions and automatically pages the cardiac catheterization lab and the on-call cardiologist. • Pediatrics primary care office treatment of subcutaneous/skin abscess: Through discussion among peers in a small pediatrics office, the eligible clinicians determine that there is variability in the decision to implement an abscess incision and drainage versus only using antibiotics and there is also variability in the antibiotic used. As a result, they created internal guidelines on	2017



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					how to approach skin infections and antibiotic treatment and, in particular, addressing methicillin-resistant staphylococcus aureus (MRSA). • Opiate prescribing: An eligible general surgeon group completed an internal review of opiate prescribing and learned that there was opportunity to reduce the use of opiates significantly. As a result, they created an order-set within their EHR. The use of the order-set was mandatory for all opiate prescribing and created limits for quantity based on condition. The prescribing surgeon could always make an independent treatment decision as needed.	
IA_PSPA_17	Patient Safety and Practice Assessment	Implementation of analytic capabilities to manage total cost of care for practice population	In order to receive credit for this activity, a MIPS eligible clinician must conduct or build the capacity to conduct analytic activities to manage total cost of care for the practice population. Examples of these activities could include: 1.) Train appropriate staff on interpretation of cost and utilization information; 2.) Use available data regularly to analyze opportunities to reduce cost through improved care. An example of a platform with the necessary analytic capability to do this is the American Society for Gastrointestinal (GI) Endoscopy's GI Operations Benchmarking Platform.	Medium	<u>Objective:</u> Create opportunities to assess total cost of care and identify ways to reduce unnecessary costs. <u>Validation Documentation:</u> Evidence of use or building of analytic capabilities to manage the total cost of care for the practice population. Include at least one of the following elements: 1) Staff training – Documentation of staff training on interpretation of cost and utilization information (e.g., training documentation); OR 2) Cost/resource use data – Availability of cost/resource use data for the practice population that the practice uses regularly to analyze opportunities to reduce cost; OR 3) Participation in regional Total Cost of Care efforts – Engage with local Regional Health Improvement Collaborative (RHIC) to measure and utilize Total Cost of Care (TCOC) to identify opportunities for practice improvement, create a practice improvement plan(s), and execute on the plan(s). Documentation may include communication with RHIC (e.g., email) or a copy of TCOC report(s). <u>Example(s)/Information:</u> • The American Society for Gastrointestinal (GI) Endoscopy's GI Operations Benchmarking Platform is an example of a tool used for identifying opportunities to reduce cost:	2017

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					https://www.asge.org/home/practice-support/gi-operations-benchmarking • The Network for Regional Healthcare Improvement representing regional healthcare collaboratives has information about TCoC: https://www.nrhi.org/	
IA_PSPA_18	Patient Safety and Practice Assessment	Measurement and improvement at the practice and panel level	Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic Surgery (ABOS) Physician Scorecards that could include one or more of the following: • Regularly review measures of quality, utilization, patient satisfaction and other measures; and/or • Use relevant data sources to create benchmarks and goals for performance at the practice or panel levels. MIPS eligible clinicians can apply the measurement and quality improvement to address inequities in quality and outcomes for underserved populations, including racial, ethnic, and/or gender minorities.	Medium	<u>Objective:</u> Enhance the measurement of the quality of care, making quality data relevant at practice and panel levels, and use those data to implement effective quality improvement activities. <u>Validation Documentation:</u> Evidence of quality measurement and improvement for populations at the practice and panel level or for specific populations (e.g., racial and ethnic minorities, individuals with disabilities, sexual and gender minorities, individuals with certain chronic conditions/risk factors, or individuals in rural areas). Include at least one of the following elements: 1) Performance benchmarks and goals – Performance benchmarks and goals to drive overall improvements; OR 2) Quality improvement program/plan at practice and panel level – Copy of a quality improvement program/plan or review of quality, utilization, patient satisfaction (surveys should be administered by a third-party survey administrator/vendor), and other measures to improve one or more elements of this activity; OR 3) Review of and progress on measures – Report showing progress on selected measures, including benchmarks and goals for performance using relevant data sources at the practice and panel level. <u>Example(s):</u> • Obtain diagnostic Imaging Center of Excellence (DICOE) designation • Participate in Endoscopy Unit Recognition Program (EURP) • Participate in Simulation Education Courses approved by the American Society of Anesthesiologist's Simulation Education	2017



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					Network • Use the Centers for Medicare & Medicaid Services' Disparities Impact Statement tool to fulfill this activity and address inequities in quality and outcomes for underserved and vulnerable populations <u>Information:</u> • Toolkit for implementing Culturally and Linguistically Appropriate Services Standards: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf	
IA_PSPA_19	Patient Safety and Practice Assessment	Implementation of formal quality improvement methods, practice changes or other practice improvement processes	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following, such as: • Participation in multisource feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience	Medium	<u>Objective:</u> Expand and formalize quality improvement (QI) activities across the practice, ultimately leading to improvements in the quality of care and fostering a culture of participation among staff. <u>Validation Documentation:</u> Evidence of the implementation of a formal plan for QI and creation of a culture in which staff actively participates in one or more applicable QI activities. This activity allows MIPS clinicians to build the foundations for other activities they pursue in the future. Include both of the following elements: 1) Adopt formal quality improvement plan and create culture of improvement – Documentation of adoption of a formal model for QI and creation of a culture in which staff actively participate in QI activities. Formal QI models are used by eligible clinicians to develop systems, tools, and interventional strategies to improve processes of care for their patient population; AND 2) Staff participation – Documentation of staff participation in one or more of the 6 key areas for improvement*: a) training; b) integration into staff duties; c) identifying and testing practice changes; d) regular team meetings to review data and plan improvement cycles; e) share practice and panel level quality of care; f) patient experience and utilization data with staff; or g) share practice level quality of care, patient experience and utilization data with patients and families.	2017

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			and utilization data with patients and families, including activities in which clinicians act upon patient experience data; • Participation in Bridges to Excellence; • Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.		<u>Example(s)</u>: A cardiology or multi-specialty practice seeks to institute changes to improve the management of patients with elevated low-density lipoprotein cholesterol (LDL-C), which is associated with higher risk of heart disease. The practice develops and implements a formal quality improvement plan with the goals of appropriately identifying, engaging, treating, and monitoring patients with elevated cholesterol. To achieve these goals, the practice takes the following steps: • Methodically identify patients who would benefit from initiating or intensifying lipid-lowering therapy • Implement a systematic effort to increase the proportion of patients who reach threshold LDL-C levels defined in evidence-based guidelines—e.g. by implementing automated scheduling, enhanced use of office screening protocols, flags/alerts in the electronic health record system, clinical team reviews of health plan/patient care gaps • Measure impact through routine follow-up visits and LDL-C testing <u>Information</u>: • *Report with 6 key areas for focus in healthcare quality improvement: http://www.ihl.org/resources/Pages/Publications/CrossingtheQualityChasmANewHealthSystemforthe21stCentury.aspx • "Model for Improvement" on improvement plan focused for eligible clinician/practices and their patients: http://www.ihl.org/resources/Pages/HowtoImprove/default.aspx • The American Academy of Dermatology Quality Innovation Center Collaborative	
IA_PSPA_20	Patient Safety and Practice Assessment	Leadership engagement in regular guidance and	Ensure full engagement of clinical and administrative leadership in practice improvement that could include one or more of the following: • Make	Medium	<u>Objective</u>: Institutionalize quality improvement within the practice by making it an explicit component of leadership's roles and responsibilities, thus strengthening the commitment to care quality across the practice. <u>Validation Documentation</u>: Evidence of	2017

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		demonstrated commitment for implementing practice improvement changes	responsibility for guidance of practice change a component of clinical and administrative leadership roles; • Allocate time for clinical and administrative leadership for practice improvement efforts, including participation in regular team meetings; and/or • Incorporate population health, quality and patient experience metrics in regular reviews of practice performance.		clinical and administrative leadership engagement in regular guidance and demonstrated commitment for implementing improvements. Include at least one of the following elements: 1) Clinical and administrative leadership role descriptions – Documentation of clinical and administrative leadership role descriptions that include responsibility for practice improvement change (e.g., position description); OR2) Time for leadership in improvement efforts – Documentation of allocated time for clinical and administrative leadership participating in improvement efforts (e.g., regular team meeting agendas and post meeting summaries); OR3) Population health, quality, and health experience incorporated into performance reviews – Documentation of population health, quality, and health experience metrics incorporated into regular practice performance reviews (e.g., reports, agendas, analytics, meeting notes). <u>Example(s)/Information:</u> • A large group of eligible emergency clinicians determines that a more structured approach to quality improvement is needed. They appoint the medical director of the group and another eligible clinician to administer the program, and they ensure both have time allocated and are compensated for this work. The program has two components: 1) Traditional Peer Review with a formal process for identifying cases. A group of eligible clinicians is identified who commit to meeting on a regularly scheduled basis reviewing all peer review cases. Further, specified team members follow-up with group and individual eligible clinicians for cases that are educational; and 2) Data Review component that allows the Medical Director and the Quality Administrative clinician to identify an area of practice for review. For example, a decision is made to collect data on all intubations for the subsequent 4 months to identify variability in approach. The data could be used as part of education that will roll out in support of standardizing intubation processes within the emergency department. • Institute of Healthcare Improvement's	

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IA_PSPA_21	Patient Safety and Practice Assessment	Implementation of fall screening and assessment programs	Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (e.g., Clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk).	Medium	"Model for Improvement": http://www.ihl.org/resources/Pages/HowtoImprove/default.aspx. Objective: Improve identification of patients who are at risk of falling; then reduce their risk and improve their health outcome, independence, and satisfaction with care. Validation Documentation: Documented implementation of fall screening and assessment programs. Include at least one of the following elements: 1) Implementation of a falls screening and assessment program – Documentation of newly implemented falls screening and assessment program that uses valid and reliable tools to identify patients at risk for falls and address modifiable risk factors (e.g., clinical decision support (CDS)/prompts in the electronic health record (EHR) that help manage the use of medications, such as benzodiazepines, that increase fall risk). The program population should be defined by the eligible clinicians (e.g., all patients over a certain age); OR 2) Implementation progress – Documentation of follow-up after falls screening and assessment with focus on improvement in risk factors. Documentation of follow-up may include: follow-up screening, notes or medication list demonstrating mitigation of the risk or other health record data demonstrating follow-up, etc. Example(s)/Information: Implementation of the Centers for Disease Control and Prevention's Stopping Elderly Accidents, Deaths, and Injuries (CDC STEADI) program for identification of falls risk and actions to take to mitigate falls. https://www.cdc.gov/steady/about.html	2017
IA_PSPA_22	Patient Safety and Practice Assessment	CDC Training on CDC's Guideline for Prescribing	Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course "Applying CDC's Guideline for Prescribing Opioids" that reviews the 2016	High	Objective: Become better equipped to improve prescription practices and thus help reduce patients' risks of addiction and overdose. Validation Documentation: Documented completion with a	2018



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		Opioids for Chronic Pain	“Guideline for Prescribing Opioids for Chronic Pain.” Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.		passing score for all applicable modules available during the performance year of the Centers for Disease Control and Prevention’s (CDC’s) course “Applying CDC’s Guideline for Prescribing Opioids” that reviews the 2016 “Guideline for Prescribing Opioids for Chronic Pain.” Include the following element: 1) Record of completion and passing score – Documented participation in and completion of (e.g., certificate of completion, screenshot) the CDC’s course “Applying CDC’s Guideline for Prescribing Opioids” that reviews the 2016 “Guideline for Prescribing Opioids for Chronic Pain.” <u>Example(s)/Information:</u> The training can be found at the following link. CME can be obtained at no cost by following the instructions on the site. https://www.cdc.gov/drugoverdose/training/online-training.html	
IA_PSPA_23	Patient Safety and Practice Assessment	Completion of CDC Training on Antibiotic Stewardship	Completion of all modules of the Centers for Disease Control and Prevention antibiotic stewardship course. Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.	High	<u>Objective:</u> Reduce inappropriate use of antimicrobials to help reduce microbial resistance and the incidence of antimicrobial-caused adverse drug reactions, all of which will help improve patient outcomes and the efficiency of spending. <u>Validation Documentation:</u> Documented completion with a passing score of all modules of the Centers for Disease Control and Prevention’s (CDC) antibiotic stewardship course. Include the following element: 1) Record of completion and passing score – Documented participation in and completion (e.g., certificate of completion, screenshot) of all modules of the CDC antibiotic stewardship course. <u>Example(s)/Information:</u> https://www.train.org/cdctrain/training_plan/3697	2018

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IA_PSPA_25	Patient Safety and Practice Assessment	Cost Display for Laboratory and Radiographic Orders	Implementation of a cost display for laboratory and radiographic orders, such as costs that can be obtained through the Medicare clinical laboratory fee schedule.	Medium	<u>Objective:</u> Help eligible ordering clinicians easily obtain information on the cost of laboratory and radiography orders, allowing them to manage their costs strategically. <u>Validation Documentation:</u> Demonstration of cost transparency by displaying costs for laboratory and radiography at the point-of-order for ordering clinicians. Include the following element: 1) Cost display for laboratory and radiographic orders – Documentation (e.g., screenshot, report from the electronic health record, written display procedure) of laboratory and radiographic costs at the point-of-order.	2018
IA_PSPA_26	Patient Safety and Practice Assessment	Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event	A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75 percent of case visits that result from a clinically significant adverse drug event, the MIPS eligible clinician provides information, including through the use of health IT to the patient's primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, supratherapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization.	Medium	<u>Objective:</u> Allow primary care doctors to immediately tailor plans of care for patients to prevent further medication errors and achieve better outcomes in the future. <u>Validation Documentation:</u> Documentation of communication regarding clinically significant adverse drug events from the eligible clinician providing unscheduled care to the primary care clinician within 48 hours. Unscheduled care includes emergency room visit, urgent care, or other unplanned encounter. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, supra-therapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment or hospitalization. Include all of the following elements: 1) Documentation of the process for capturing adverse drug events; AND 2) Details of clinically significant adverse drug event – Documentation (e.g., medical record, chart note) of clinically significant adverse event; AND 3) Communication of event within 48 hours – Documentation of communication of the event to the patient's primary care clinician within 48 hours of the unscheduled event (e.g., Health Information Exchange, other Health Information Technology,	2018

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					secure email). Communication to include both details about the unscheduled event and the nature of the adverse drug event. <u>Example(s):</u> • A small internal medicine practice has numerous patients on warfarin. Those patients are managed by the local “Coumadin Clinic” at the hospital. Occasionally, those patients are seen in the local emergency department for bleeding, or are referred to the emergency department from the Coumadin Clinic that is testing the patients’ International Normalized Ratio (INR). The hematology group partners with the emergency department clinician group to develop a process for communicating adverse warfarin reactions. They identify all appropriate diagnosis codes that could be linked to an adverse warfarin level or reaction. They work with IT to create an automatically generated email (fax, etc.) of the clinical record, triggered by the diagnosis code, and have it sent to the primary care clinician. • An emergency department clinician group creates an internal policy that all clinically significant adverse drug reactions are communicated with the eligible primary care clinician. As a result, they create a manual process that requires the emergency physician to contact the eligible primary care clinician and communicate the situation. The eligible clinicians create a specific field in the electronic health record for documenting the brief details of the communication.	
IA_PSPA_27	Patient Safety and Practice Assessment	Invasive Procedure or Surgery Anticoagulation Medication Management	For an anticoagulated patient undergoing a planned invasive procedure for which interruption in anticoagulation is anticipated, including patients taking vitamin K antagonists (warfarin), target specific oral anticoagulants (such as apixaban, dabigatran, and rivaroxaban), and heparins/low molecular weight heparins,	Medium	<u>Objective:</u> Formalize and document a standardized process for management of patients on anti-coagulant medication before, during, and after invasive procedures, thus reducing risk of complications. <u>Validation Documentation:</u> Create a standardized process for managing patient anti-coagulation during the peri-procedural period for planned invasive procedure for which interruption in anticoagulation is anticipated. Include all of the following	2018

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			documentation, including through the use of electronic tools, that the plan for anticoagulation management in the periprocedural period was discussed with the patient and with the clinician responsible for managing the patient's anticoagulation. Elements of the plan should include the following: discontinuation, resumption, and, if applicable, bridging, laboratory monitoring, and management of concomitant antithrombotic medications (such as antiplatelets and nonsteroidal anti-inflammatory drugs (NSAIDs)). An invasive or surgical procedure is defined as a procedure in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice.		elements: 1) Identification of patients needing anticoagulation management – Documentation of a process to identify patients taking anticoagulants including vitamin K antagonists (warfarin), direct oral anticoagulants (such as apixaban, dabigatran, and rivaroxaban), and heparins/low molecular weight heparins for anticoagulation medication management plan; AND 2) Documented discussion – Standardized documentation (e.g., medical record note with standardized components, pre-procedural document maintained in the medical record) of specific plan for managing patient anti-coagulation before, during, and after surgery by relevant eligible clinicians (such as primary care clinician, hospitalist, surgeon, or anesthesiologist); AND 3) Examples of anti-coagulation management plans – Examples of documented plans (e.g., medical record, electronic health record, secure email) for anticoagulation management in the peri-procedural period for planned invasive procedures. The plan should include the following: discontinuation, resumption, and, if applicable, bridging medication, laboratory monitoring, and management of concomitant antithrombotic medications (such as anti-platelet and nonsteroidal anti-inflammatory drugs).	
IA_PSPA_28	Patient Safety and Practice Assessment	Completion of an Accredited Safety or Quality Improvement Program	Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific,	Medium	<u>Objective:</u> Complete an accredited performance improvement continuing medical education (CME) program, ultimately applying program content to address a specific quality or safety gap. <u>Validation Documentation:</u> Documented completion of an accredited performance improvement program that includes active individual participation in the completion of a performance improvement project. Include all of the following elements: 1) Documentation/report of the performance improvement project completed – Documentation to include: a) the specific quality or safety gap and measurable improvement goal; b) the interventions used to result in improvement; and c) data with analysis demonstrating the improvement; AND	2018

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			measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information. An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).		2) Confirmation of participation – Documented confirmation of participation and completion in accredited performance improvement program; AND 3) Program details – Details of accredited program must include: a) definition of meaningful eligible clinician participation in their activity; and b) description of the mechanism for identifying eligible clinicians who meet the requirements. <u>Example(s)/Information:</u> • Performance Improvement Module, such as Asthma IQ: Patient Management and Outcomes, Asthma IQ: Patient Assessment, PI Pro: Food Allergy, Self-Directed Practice Improvement Module https://www.aaaai.org/practice-resources/asthma-iq • Participate in American Society for Gastrointestinal Endoscopy Skills Training Assessment Reinforcement (STAR) Certificate Program https://www.asge.org/home/education/advanced-education-training/star-certificate-programs • American Society of Clinical Oncology Quality Training Program https://practice.asco.org/quality-improvement/quality-programs/quality-training-program • Agency for Healthcare Research and Quality's Making Informed Consent an Informed Choice: Training for Healthcare Professionals https://www.ahrq.gov/health-literacy/professional-training/informed-choice.html • American College of Physicians Advance Quality Improvement Curriculum https://www.acponline.org/practice-resources/acp-quality-improvement/acp-advance/quality-improvement-curriculum	
IA_PSPA_29	Patient Safety and Practice Assessment	Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering	Clinicians attest that they are consulting specified applicable AUC through a qualified clinical decision support mechanism for all applicable imaging services furnished in an applicable setting, paid for under an applicable payment system, and ordered on or	High	<u>Objective:</u> Consult Appropriate Use Criteria (AUC) through a clinical decision support (CDS) mechanism for imaging services to reduce unnecessary and potentially harmful over-imaging. <u>Validation Documentation:</u> Documented consultation of specified AUC through a qualified CDS mechanism for imaging services. Include at least one of the following elements:	2018



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		Advanced Diagnostic Imaging	after January 1, 2018. This activity is for clinicians that are early adopters of the Medicare AUC program (2018 performance year) and for clinicians that begin the Medicare AUC program in future years as specified in our regulation at §414.94. The AUC program is required under section 218 of the Protecting Access to Medicare Act of 2014. Qualified mechanisms will be able to provide a report to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.		1) Early adopter status – Evidence of early adoption of the Medicare AUC program (2018 Performance Year); OR 2) Demonstration of standardized use of AUC in daily patient care – Provide reports, details of agreement with provider of services, detailed information about standardized process, etc.; OR 3) Image-ordering reports – Copies of reports (e.g., paper copy, screenshots) sent to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition. <u>Example(s)/Information:</u> • AUC Criteria program: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program • Qualified AUC mechanisms: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/CDSM	
IA_PSPA_31	Patient Safety and Practice Assessment	Patient Medication Risk Education	In order to receive credit for this activity, MIPS eligible clinicians must provide both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use for patients who are prescribed both benzodiazepines and opioids. Education must be completed for at least 75% of qualifying patients and occur: (1) at the time of initial co-prescribing and again following greater than 6 months of co-prescribing of benzodiazepines and opioids, or (2) at least once per MIPS performance	High	<u>Objective:</u> Educate patients regarding the risks of concurrent opioid and benzodiazepine use, thus reducing their risk of overdose. <u>Validation Documentation:</u> Evidence of both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use provided to patients who are prescribed both benzodiazepines and opioids. Include both of the following elements: 1) Examples of education provided – Copies of written education (e.g., pamphlets, patient portal screenshot) and verbal education (e.g., scripts/descriptions of what must be said) provided; AND 2) Education provided to patients co-prescribed – Education	2019

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			period for patients taking concurrent opioid and benzodiazepine therapy.		must be completed for at least 75% of qualifying patients and occur a) at the time of initial co-prescribing and again following greater than 6 months of co-prescribing of benzodiazepines and opioids; or b) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.	
IA_PSPA_32	Patient Safety and Practice Assessment	Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support	In order to receive credit for this activity, MIPS eligible clinicians must utilize the Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain via clinical decision support (CDS). For CDS to be most effective, it needs to be built directly into the clinician workflow and support decision making on a specific patient at the point of care. Specific examples of how the guideline could be incorporated into a CDS workflow include, but are not limited to: electronic health record (EHR)-based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.	High	<u>Objective:</u> Make Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain via clinical decision support (CDS) part of eligible clinicians' workflow, thus improving prescription practices, protecting patients at risk for addition and/or overdose, and helping to address the opioid epidemic. <u>Validation Documentation:</u> Evidence of eligible clinicians utilizing the CDC Guideline for Prescribing Opioids for Chronic Pain via CDS. Include all of the following elements: 1) CDC Guideline for Prescribing Opioids for Chronic Pain via CDS within eligible clinicians' workflow – Evidence that the CDC Guideline for Prescribing Opioids for Chronic Pain is available to eligible clinician(s) via CDS, and that the guideline is incorporated into eligible clinicians' workflow. May include: electronic health record-based prescribing prompts, chronic pain order sets with opiate prescribing based on CDC Guidelines, or prompts requiring review of guidelines before a subsequent action can be taken in the record; AND 2) Use of Guideline in CDS – Documentation of use of CDC guideline during patient care during the 90 day or year-long attestation period. <u>Information:</u> CDC Guideline: https://www.cdc.gov/drugoverdose/prescribing/guideline.html	2019
IA_PSPA_33	Patient Safety and Practice Assessment	Application of CDC's Training for Healthcare Providers on Lyme Disease	Apply the Centers for Disease Control and Prevention's (CDC) Training for Healthcare Providers on Lyme Disease using clinical decision support (CDS). CDS for Lyme disease should be built	Medium	<u>Objective:</u> Improve health outcomes for patients with Lyme disease by leveraging clinical decision support (CDS) and training tools. <u>Validation Documentation:</u> Evidence of eligible clinicians utilizing	2022

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			directly into the clinician workflow and support decision making for a specific patient at the point of care. Specific examples of how the guideline could be incorporated into a CDS workflow include but are not limited to: electronic health record (EHR) based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.		the Centers for Disease Control and Prevention's (CDC's) Training for Healthcare Providers on Lyme Disease via CDS. Include the following element: 1) CDC Training for Healthcare Providers on Lyme Disease via CDS within eligible clinicians' workflow – Evidence that guidance from the CDC's training is available to eligible clinician(s) via CDS, and that guidance from the training is incorporated into eligible clinicians' workflow. May include: electronic health record-based prescribing prompts and/or Lyme Disease specific order sets, order sets that require review of training guidance, and prompts requiring review of guidelines before a subsequent action can be taken. <u>Information:</u> Agency for Healthcare Research and Quality's resources on CDS: https://cda.ahrq.gov/	
IA_AHE_1	Patient Safety and Practice Assessment	Enhance Engagement of Medicaid and Other Underserved Populations	To improve responsiveness of care for Medicaid and other underserved patients: use time-to-treat data (i.e., data measuring the time between clinician identifying a need for an appointment and the patient having a scheduled appointment) to identify patterns by which care or engagement with Medicaid patients or other groups of underserved patients has not achieved standard practice guidelines; and with this information, create, implement, and monitor an approach for improvement. This approach may include screening for patient barriers to treatment, especially transportation barriers, and providing resources to improve engagement (e.g., state	High	<u>Objective:</u> Ensure timely treatment of patients from underserved populations, to help them achieve improved health outcomes. <u>Validation Documentation:</u> Evidence of eligible clinicians tracking and improving timeliness of care delivered to patients from underserved populations, including those with Medicaid, through analysis and intervention. Include both of the following elements: 1) Analysis of time-to-treat data – Report documenting analysis of trends and inequities in time-to-treat data, disaggregated by beneficiary type (to compare those with and without Medicaid benefits) and by other patient demographics such as race/ethnicity, disability status, sexual orientation, sex, gender identity, or geography. Report should include possible explanations for the trends and inequities identified; AND 2) Implementation Plan and Results – Documentation of plans for activities to address inadequacies in time-to-treat performance, and the outcomes of those activities. Activities may address barriers facing patients (e.g., lack of access to affordable transportation) or barriers presented by the eligible clinician (e.g.,	2017

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			Medicaid non-emergency medical transportation benefit).		appointment availability does not align with needs of those who lack sick leave). <u>Example(s)</u>: An urban outpatient center is interested in assessing what inequities might exist in their current practice related to access to timely care. First, they analyze time-to-treat data, and look at differences by race/ethnicity, sex, zip code, and beneficiary type. They notice that patients with both Medicare and Medicaid benefits are most likely to miss or arrive late to appointments. They also notice that these patients are located in urban zip codes that have insufficiently accessible public transportation options to the outpatient center. To support these patients, the outpatient center researches Medicaid benefits related to transportation benefits in their state, and builds in EHR prompts for eligible clinicians to provide information about those benefits to all patients with Medicaid and Medicare. The center also institutes a call system that provides the information to Medicaid beneficiaries one week before their scheduled appointment. After several months of implementation, the outpatient center repeats their analysis of time-to-treat data and observes a small but noticeable improvement in timeliness of care for patients with Medicare and Medicaid services. <u>Information</u>: The standardized screening for transportation barriers, adopted by Centers for Medicare & Medicaid Services, is from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool at: https://www.nachc.org/research-and-data/prapare/	
IA_AHE_3	Achieving Health Equity	Promote use of Patient-Reported Outcome Tools	Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data such as the use of PHQ-2 or PHQ-9, PROMIS instruments, patient reported Wound-	High	<u>Objective</u>: Make it possible to use Patient Reported Outcomes (PRO) data as part of routine care, thus increasing patient engagement and health outcomes for all populations. <u>Validation Documentation</u>: Demonstrated performance of activities to promote use of PRO tools and corresponding	2017



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			Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening.		collection of PRO data. Include both of the following elements: 1) Promotion of PRO tools – Evidence that eligible clinicians are promoting use of PRO tools with their patients (e.g., documented notes in electronic health record, PRO materials); AND 2) PRO data collection – Feedback reports demonstrating use of PRO tools and corresponding collection of PRO data <u>Information:</u> • PRO Measurement Information System (PROMIS): https://www.healthmeasures.net/explore-measurement-systems/promis • Patient Health Questionnaire (PHQ): https://www.phgscreeners.com	
IA_AHE_5	Achieving Health Equity	MIPS Eligible Clinician Leadership in Clinical Trials or CBPR	Lead clinical trials, research alliances, or community-based participatory research (CBPR) that identify tools, research, or processes that focus on minimizing disparities in healthcare access, care quality, affordability, or outcomes. Research could include addressing health-related social needs like food insecurity, housing insecurity, transportation barriers, utility needs, and interpersonal safety.	Medium	<u>Objective:</u> Encourage clinicians to minimize disparities in healthcare access, care quality, affordability, or outcomes by contributing to new and improved tools, research, or processes, which may include addressing health-related social needs. <u>Validation Documentation:</u> Evidence of leadership in clinical trials, research alliances, or community-based participatory research (CBPR), focused on minimizing disparities in healthcare access, care quality, affordability, or outcomes. Include the following element: 1) Evidence of research leadership about disparities – Documentation of participation and leadership by eligible clinicians in clinical trials, research alliances, or CBPR focused on addressing disparities to improve healthcare access, care quality, affordability, or outcomes. This research may include developing evidence about the influence of health-related social needs on disparities in health outcomes, and effective strategies for addressing HRSN. <u>Example(s)/Information:</u> • Examples of evidence of participation in research on disparities:	2018



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					- o Documentation that describes the intended or actual aims and/or intended outcomes of research - o Tools developed as part of research activity that identify or help address disparities - o Summary of findings, research results • Background on identifying and addressing health-related social needs at primary care settings: https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/tools-and-materials/social-needs-tool.pdf	
IA_AHE_6	Achieving Health Equity	Provide Education Opportunities for New Clinicians	MIPS eligible clinicians acting as a preceptor for clinicians-in-training (such as medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved, or rural areas.	High	<u>Objectives:</u> Provide clinicians-in-training with diverse experiences, allowing them to gain deep understanding of the challenges facing eligible clinicians and patients in small practices or in underserved or rural areas. <u>Validation Documentation:</u> Evidence of participation as a preceptor for clinicians-in-training and accepting clinical rotations in community practices in small underserved or rural areas. Include all of the following elements: 1) Proof of preceptor role – Documentation of participation as a preceptor for eligible clinicians-in-training (e.g., contract or communications with an academic-based health care organization). Any eligible clinician can serve as a preceptor; AND 2) Specific clinical rotations – Evidence of clinical rotation assignments in community practices in small, underserved, or rural areas. The 2019 CMS Final Rule defines small, underserved, or rural areas by ZIP codes designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set. <u>Information:</u> To confirm eligibility prior to attestation, CMS recommends that practices consult the HRSA Area Health Resource File: https://data.hrsa.gov/tools/shortage-area/by-address.	2018

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					<u>Note:</u> • New eligible clinician training conducted at a practice not deemed to be in an underserved area, or provided at a university or hospital, would not meet the eligibility criteria. • Eligible clinicians who are not located in an underserved area and treat patients who come to the practice from underserved areas do not meet the intent of this activity. • Teaching at a hospital or university does not meet the intent of this activity.	
IA_AHE_7	Achieving Health Equity	Comprehensive Eye Exams	To receive credit for this activity, MIPS eligible clinicians must promote the importance of a comprehensive eye exam, which may be accomplished by any one or more of the following: • providing literature, • facilitating a conversation about this topic using resources such as the “Think About Your Eyes” campaign, • referring patients to resources providing no-cost eye exams, such as the American Academy of Ophthalmology’s EyeCare America and the American Optometric Association’s VISION USA, or • promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment. This activity is intended for: • Non-ophthalmologists / optometrists who refer patients to an ophthalmologist/optometrist;	Medium	<u>Objectives:</u> Improve eye health of underserved and/or high-risk populations, and empower patients in these populations to become more educated consumers of eye care. <u>Validation Documentation:</u> Evidence that eligible clinicians help underserved and/or high-risk populations understand the importance of their eye health and provide support to access comprehensive eye exams. Include all of the following elements: 1) Proof of eligible clinician/group type – Evidence that the attesting eligible clinicians are either: a) providing literature and/or resources on the topic of comprehensive eye exam importance; a) non-ophthalmologists or optometrist who refer patients to an ophthalmologist/optometrist; b) ophthalmologists/optometrist caring for underserved patients at no cost; or c) eligible clinicians; AND 2) Promotion of comprehensive eye exam – Documentation that literature and/or conversation about the importance of comprehensive eye exams were provided to targeted underserved and/or high-risk populations (e.g., visit note made in medical record; copy of literature provided); AND 3) Referrals to no-cost eye exams – Documentation of patient referrals made to resources providing no-cost eye exams (e.g., American Academy of Ophthalmology’s EyeCare America,	2019



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			• Ophthalmologists/optometrists caring for underserved patients at no cost; or • Any clinician providing literature and/or resources on this topic. This activity must be targeted at underserved and/or high-risk populations that would benefit from engagement regarding their eye health with the aim of improving their access to comprehensive eye exams or vision rehabilitation services.		American Optometric Association's VISION USA) for targeted underserved and/or high-risk populations.	
IA_AHE_8	Achieving Health Equity	Create and Implement an Anti-Racism Plan	Create and implement an anti-racism plan using the CMS Disparities Impact Statement or other anti-racism planning tools. The plan should include a clinic-wide review of existing tools and policies, such as value statements or clinical practice guidelines, to ensure that they include and are aligned with a commitment to anti-racism and an understanding of race as a political and social construct, not a physiological one. The plan should also identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones for addressing prioritized issues and gaps. This may also include an assessment and drafting of an organization's plan to prevent and address racism and/or improve language access and	High	<u>Objective:</u> Begin to address inequities in health outcomes by creating and implementing an anti-racism plan. <u>Validation Documentation:</u> Evidence of a practice-wide review and implementation of an anti-racism plan. Please note that, although the CMS Disparities Statement does not mention racism, it can be effectively used to facilitate the completion of the requirements of this activity. Include all of the following elements: 1) Review – Documentation of a practice-wide review of existing tools and policies; AND 2) Assessment memo – Completion of an assessment memo summarizing the results of the above review; AND 3) Anti-Racism Plan –A new or updated anti-racism plan, which includes actions, intended outcomes, and timeline for completion for the eligible clinician's practice; this plan must identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones, and the eligible clinician or practice should also consider including training on anti-racism to support identifying explicit and implicit biases in patient care and addressing historic health inequities experienced by people of color; AND 4) Plan Implementation – Report with results from implementing	2022



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			accessibility to ensure services are accessible and understandable for those seeking care. The MIPS eligible clinician or practice can also consider including in their plan ongoing training on anti-racism and/or other processes to support identifying explicit and implicit biases in patient care and addressing historic health inequities experienced by people of color. More information about elements of the CMS Disparities Impact Statement is detailed in the template and action plan document at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf.		the new or updated anti-racism plan. <u>Example(s)</u>: A practice-wide review indicated that existing website and human-resources documents do not mention a commitment to anti-racism or an awareness of racism in medicine, and that, in a decision aid used in the practice, heart failure risk is estimated lower for individuals socially identified as Black than for patients socially identified as White, potentially making Black patients less likely to seek and/or receive needed care. The practice updated its website and human-resources materials to reflect its commitment to anti-racism, and stopped using the heart failure risk decision aid that was biased against patients identified as Black, as part of a comprehensive anti-racism plan the practice developed and implemented. <u>Information</u>: • CMS (healthequityTA@cms.hhs.gov) offers Health Equity technical assistance to organizations that would like support improving equity, including those who are using the Disparities Impact Statement: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf • This 2018 article by Camara Phyllis Jones that details launching a National Campaign Against Racism with three tasks: 1) naming racism; 2) asking “how is racism operating here?” and 3) organizing and strategizing to act and an Anti-Racism Collaborative. “Toward the science and practice of anti-racism: Launching a national campaign against racism”: www.doi.org/10.18865/ed.28.S1.231 • A 2021 study by Hassen et. al. describes a scoping review conducted to identify existing anti-racism interventions in healthcare settings and synthesize the key findings, challenges and unintended consequences of this work. “Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review”:	



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					https://www.mdpi.com/1660-4601/18/6/2993/htm • A 2020 Health Affairs article by Olayiwola et. al. describes the process of making anti-racism a core value in health care and the four pillars of an anti-racist action plan. "Making Anti-Racism A Core Value In Academic Medicine": https://www.healthaffairs.org/doi/10.1377/hblog20200820.931674/full/ • A 2020 Health Affairs article by Legha describes the five core components to an anti-racist approach to clinical care. "Getting Our Knees Off Black People's Necks: An Anti-Racist Approach to Medical Care": https://www.healthaffairs.org/doi/10.1377/hblog20201029.167296/full/ • University of San Francisco Gleeson Library's anti-racism resources list for health sciences. "Anti-Racism and Healthcare Research Guide": https://guides.usfca.edu/anti-racism-healthcare	
IA_AHE_9	Achieving Health Equity	Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols	Create or improve, and then implement, protocols for identifying and providing appropriate support to: a) patients with or at risk for food insecurity, and b) patients with or at risk for poor nutritional status. (Poor nutritional status is sometimes referred to as clinical malnutrition or undernutrition and applies to people who are overweight and underweight.) Actions to implement this improvement activity may include, but are not limited to, the following: • Use Malnutrition Quality Improvement Initiative (MQii) or other quality improvement resources and standardized screening tools to assess and improve current food insecurity and	Medium	<u>Objective:</u> Reduce food insecurity and improve nutritional outcomes for at-risk patients. <u>Validation Documentation:</u> Evidence of screening for food insecurity and malnutrition risk and implementing protocols to support patients who are identified as at risk. Include both of the following: 1) Protocols for identifying at-risk patients created or improved – Documentation of screening tools—preferably standardized tools that have been tested in underserved communities—applied within clinician workflow and information stored within health information systems; AND 2) Implementation Plan and Results – Documentation of the plan to advance support to patients who have been identified as having the greatest risk for food insecurity and/or malnutrition, with specific rationale for the interventions selected and documentation of the results achieved. Example: A practice selects and adapts two standardized tools for	2022

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			nutritional screening and care practices. • Update and use clinical decision support tools within the MIPS eligible clinician's electronic medical record to align with the new food insecurity and nutrition risk protocols. • Update and apply requirements for staff training on food security and nutrition. • Update and provide resources and referral lists, and/or engage with community partners to facilitate referrals for patients who are identified as at risk for food insecurity or poor nutritional status during screening. Activities must be focused on patients at greatest risk for food insecurity and/or malnutrition—for example patients with low income who live in areas with limited access to affordable fresh food, or who are isolated or have limited mobility.		screening patients for food insecurity and malnutrition into their electronic health record (EHR) system and begins screening all new patients and existing patients each year. The Quality Improvement team at the practice also establishes a new process whereby, during the visit when the screening occurs, the practice provides those identified as having risk of food insecurity or malnutrition with a) information and counseling about the national Supplemental Nutrition Assistance Program (SNAP) enrollment and b) an information sheet with referrals to food pantries and other community resources in the area. The Quality Improvement group also establishes protocols for calling patients who received counselling and information 3 weeks after their visit to follow-up. At the end of the year, the Quality Improvement group documents within their EHR an increase in SNAP enrollment among their patient population. <u>Information:</u> • The following screening tools are tested and standardized, and include screening questions for food insecurity: - o Accountable Health Communities screening tool at: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf - o Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool at: https://www.nachc.org/research-and-data/prapare/ - o Health Leads' Screening Toolkit at: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/ • The following screening tools for nutrition/malnutrition are tested and recommended, though there are many other tools that would be appropriate to use: - o Malnutrition Screening Tool (MST) - o Subjective Global Assessment (SGA) - o Mini Nutritional Assessment (MNA)	



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					- o Malnutrition Universal Screening Tool (MUST) • Search for other tools using Kaiser Permanente’s screening tool database: https://sdh-tools-review.kp.washingtonresearch.org/find-tools/submit/715 • Agency for Healthcare Research and Quality’s resources on CDS: https://cde.ahrq.gov/ • Search for local Aging and Disability Resource Centers and Area Agencies of Aging to find out how they can help connect Medicare beneficiaries to funded home delivered meals, congregate meals and other nutrition services provided through the Older Americans Act as well as other state and local food programs (assistance applying for SNAP benefits, connection to local food pantries etc.).	
IA_ERP_1	Achieving Health Equity	Participation on Disaster Medical Assistance Team, registered for 6 months.	Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of 6 months as a volunteer for disaster or emergency response.	Medium	Objective: Provide sustained support to communities facing the impact of disasters, filling immediate needs, and contributing to a faster, better recovery. Validation Documentation: Evidence of participation in Disaster Medical Assistance Team or Community Emergency Responder Team for at least 6 months as a volunteer. Include the following element: 1) Details and confirmation of participation – Documentation of participation in Disaster Medical Assistance or Community Emergency Responder Teams for at least 6 months including registration and active participation (e.g., attendance at training, on-site participation).	2017
IA_ERP_2	Emergency Response & Preparedness	Participation in a 60-day or greater effort to support domestic or international humanitarian needs.	Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater.	High	Objective: Provide sustained support to communities across the globe that need humanitarian volunteer support, thus helping to alleviate suffering, save lives, and maintain human dignity. Validation Documentation: Evidence of participation in domestic or international humanitarian volunteer work for at least a continuous 60 day duration. Include the following element: 1) Details and confirmation of participation – Documentation of	2017

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					participation in domestic or international humanitarian volunteer work for at least a continuous 60 day duration including registration and active participation (e.g., identification of location of volunteer work, timeframe, and confirmation from humanitarian organization).	
IA_ERP_3	Emergency Response & Preparedness	COVID-19 Clinical Data Reporting with or without Clinical Trial	To receive credit for this improvement activity, a MIPS eligible clinician or group must: (1) participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study; or (2) participate in the care of patients diagnosed with COVID-19 and simultaneously submit relevant clinical data to a clinical data registry for ongoing or future COVID-19 research. Data would be submitted to the extent permitted by applicable privacy and security laws. Examples of COVID-19 clinical trials may be found on the U.S. National Library of Medicine website at https://clinicaltrials.gov/ct2/results?cond=COVID-19 . In addition, examples of COVID-19 clinical data registries may be found on the National Institute of Health website at https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=COVID19+registries&commit=Search . For purposes of this improvement activity, clinical data registries must	High	<u>Objective:</u> Contribute to the development of clinically proven treatments for COVID-19. <u>Validation Documentation:</u> Evidence of participation in the COVID-19 clinical trial. Include both of the following elements: 1) Clinical trial details – Details to verify participation in an acceptable COVID-19 clinical trial. The type of clinical trial could include designs ranging from the traditional double-blinded placebo-controlled trial to an adaptive design or pragmatic design that flexes to workflow and clinical practice context. It may be conducted in large organized clinical trials led by academic medical centers or healthcare systems. In addition, we intend for this activity to be applicable to eligible clinicians who are reporting their COVID-19 related patient data to a clinical data repository, such as Oracle's COVID-19 Therapeutic Learning System (https://covid19.oracle.com/); AND 2) Clinical data submission – Evidence of submission of clinical data to the clinical data repository or registry supporting the COVID-19 clinical trial (e.g., screenshot from the participating clinical data repository or clinical data registry). <u>Example(s):</u> Data registries may include: • Healthcare Worker Exposure Response & Outcomes (HERO) Registry: https://protect2.fireeye.com/url?k=b5fdaaa2-e9a9b3de-b5fd9b9d-0cc47adc5fa2-990d9a8e6607466a&u=http://www.heroesresearch.org/ • American Heart Association (AHA) COVID-19 cardiovascular disease (CVD) registry: https://www.heart.org/en/professional/quality-improvement/covid-	2020



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			meet the following requirements: (1) the receiving entity must declare that they are ready to accept data as a clinical registry; and (2) be using the data to improve population health outcomes. Most public health agencies and clinical data registries declare readiness to accept data from clinicians via a public online posting. Clinical data registries should make publically available specific information on what data the registry gathers, technical requirements or specifications for how the registry can receive the data, and how the registry may use, re-use, or disclose individually identifiable data it receives. For purposes of credit toward this improvement activity, any data should be sent to the clinical data registry in a structured format, which the registry is capable of receiving. A MIPS-eligible clinician may submit the data using any standard or format that is supported by the clinician's health IT systems, including but not limited to, certified functions within those systems. Such methods may include, but are not limited to, a secure upload function on a web portal, or submission via an intermediary, such as a health information exchange. To ensure interoperability and versatility of the data submitted, any electronic data should be submitted to the clinical data		19-cvd-registry <u>Information:</u> For more information on the COVID-19 clinical trials we refer readers to the U.S. National Library of Medicine website at https://clinicaltrials.gov/ct2/results?cond=COVID-19 .	

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			registry using appropriate vocabulary standards for the specific data elements, such as those identified in the United States Core Data for Interoperability (USCDI) standard adopted in 45 CFR 170.213.			
IA_ERP_4	Emergency Response & Preparedness	Implementation of a Personal Protective Equipment (PPE) Plan	Implement a plan to acquire, store, maintain, and replenish supplies of personal protective equipment (PPE) for all clinicians or other staff who are in physical proximity to patients. In accordance with guidance from the Centers for Disease Control and Prevention (CDC) the PPE plan should address: • Conventional capacity: PPE controls that should be implemented in general infection prevention and control plans in healthcare settings, including training in proper PPE use. • Contingency capacity: actions that may be used temporarily during periods of expected PPE shortages. • Crisis capacity: strategies that may need to be considered during periods of known PPE shortages. The PPE plan should address all of the following types of PPE: • Standard precautions (e.g., hand hygiene, prevention of needle-stick or sharps injuries, safe waste management, cleaning and disinfection of the environment)	Medium	<u>Objective:</u> Ensure the safety of patients and staff by maintaining a sufficient supply of personally protective equipment (PPE) for all clinicians and other health workers. <u>Validation Documentation:</u> Documentation of a PPE plan that describes PPE controls and/or a control plan. Include all of the following elements: 1) Plans for conventional, contingency and crisis capacity situations; AND 2) Documentation of training – (e.g., curriculum, materials that will be conducted for staff in the use of PPE); AND 3) Documentation of procurement or existing inventory – This should include all of the following types of PPE: • Standard precautions (e.g., hand hygiene, prevention of needle-stick or sharps injuries, safe waste management, cleaning and disinfection of the environment) • Eye protection • Gowns (including coveralls or aprons) • Gloves • Facemasks • Respirators (including N95 respirators)	2022



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			• Eye protection • Gowns (including coveralls or aprons) • Gloves • Facemasks • Respirators (including N95 respirators)			
IA_ERP_5	Emergency Response & Preparedness	Implementation of a Laboratory Preparedness Plan	Develop, implement, update, and maintain a preparedness plan for a laboratory intended to support continued or expanded patient care during COVID-19 or another public health emergency. The plan should address how the laboratory would maintain or expand patient access to health care services to improve beneficiary health outcomes and reduce healthcare disparities. For laboratories without a preparedness plan, MIPS eligible clinicians would meet with stakeholders, record minutes, and document a preparedness plan, as needed. The laboratory must then implement the steps identified in the plan and maintain them. For laboratories with existing preparedness plans, MIPS eligible clinicians should review, revise, or update the plan as necessary to meet the needs of the current PHE, implement new procedures, and maintain the plan. Maintenance of the plan in this activity could include additional hazard assessments, drills, training, and/or developing checklists to facilitate	Medium	<u>Objective:</u> Ensure preparedness and safety of staff working in laboratories providing patient care during COVID-19 or another public health emergency. <u>Validation Documentation:</u> Documentation of an existing or in-progress laboratory preparedness plan. Include the following elements: 1) Details on safety – Procedures and plans for maintaining safety, applicable to new/ongoing public health emergencies; AND 2) Details on implementation – Evidence of maintenance and implementation of this new or existing plan, which may include documentation of materials, results, etc. from a drill, training, checklist, assessment or debrief conducted.	2022

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			execution of the plan. Participation in debriefings to evaluate the effectiveness of plans are additional examples of engagement in this activity.			
IA_BMH_1	Behavioral and Mental Health	Diabetes screening	Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.	Medium	<u>Objective:</u> Improve rates of screening for patients with schizophrenia or bipolar disorder, who have higher risk or higher prevalence of diabetes relative to the general population, thus increasing eligible clinicians' ability to detect and respond early to positive diagnoses, potentially reducing the burden and complications of the disease. <u>Validation Documentation:</u> Demonstration of diabetes screening for patients with schizophrenia or bipolar disease who are using antipsychotic medication. Include both of the following elements: 1) Identification of patients – Evidence of regular identification of patients with schizophrenia or bipolar disease who are using antipsychotic medication and who should receive diabetes screening (e.g., report from the electronic health record [EHR], flag or note in the EHR or medical chart, registry, other population health management tracking report); AND 2) Documented diabetes screenings – Percentage of patients identified in element “1)” (for example, annually) who receive a diabetes screening, with supporting documentation from EHR reports, medical charts, or claims.	2017
IA_BMH_2	Behavioral and Mental Health	Tobacco use	Tobacco use: 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.	Medium	<u>Objective:</u> Help patients at high risk for tobacco dependence and with behavioral or mental conditions to avoid or end addiction to tobacco. <u>Validation Documentation:</u> Demonstration of regular engagement in integrated prevention and treatment interventions including tobacco use screening and cessation interventions for patients with a diagnosis of behavioral or mental health disorders with risk factors for tobacco dependence. Include all of the following elements:	2017



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					1) Identification of patients with behavioral or mental health conditions and tobacco dependence risk factors – Report from the electronic health record (EHR), qualified clinical data registry (QCDR), clinical registry, or other system demonstrating that the eligible clinician tracks patients with conditions of behavioral health or mental health with risk factors for tobacco dependence; AND 2) Evidence of screening – Report from EHR, QCDR, clinical registry, or documentation from medical charts showing regular practice of tobacco screening for patients with conditions of behavioral or mental health with risk factors for tobacco dependence; AND 3) Evidence of cessation interventions – Report from EHR, QCDR, clinical registry, or documentation from medical charts showing regular practice of tobacco cessation interventions for patients with behavioral or mental health disorders with risk factors for tobacco dependence.	
IA_BMH_4	Behavioral and Mental Health	Depression screening	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.	Medium	<u>Objective:</u> Improve the identification of depression among patients with behavioral or mental health conditions and sustain patient-centered support and treatment for those diagnosed with depression. <u>Validation Documentation:</u> Demonstration of regular engagement in integrated prevention and treatment interventions including depression screening and follow-up plan for patients diagnosed with behavioral or mental health disorders. Include both of the following elements: 1) Identification of patients with behavioral or mental health conditions and depression risk factors – Report from the electronic health record (EHR), qualified clinical data registry (QCDR), clinical registry, or other system demonstrating that the eligible clinician tracks patients with conditions of behavioral health or mental health and with risk factors for depression; AND 2) Evidence of depression screening – Report from the	2017



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					electronic health record (EHR), qualified clinical data registry (QCDR), clinical registry, or documentation from medical charts showing regular practice for depression screening for patients with diagnosed behavioral or mental health disorders; AND 3) Evidence of depression follow-up – Report from EHR, QCDR, clinical registry, or documentation from medical charts showing depression follow-up plan for patients with positive screen.	
IA_BMH_5	Behavioral and Mental Health	MDD prevention and treatment interventions	Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment (refer to NQF #0104) for mental health patients with co-occurring conditions of behavioral or mental health conditions.	Medium	<u>Objective:</u> Increase patient-centered support and treatment for patients with conditions of behavioral or mental health conditions to prevent severe depression and suicide. <u>Validation Documentation:</u> Demonstration of regular engagement in prevention and treatment interventions including suicide risk assessment for mental health patients with conditions of behavioral or mental health. Include all of the following elements: 1) Identification of patients with behavioral or mental health conditions and depression risk factors – Report from the electronic health record (EHR), qualified clinical data registry (QCDR), clinical registry or other system demonstrating that the eligible clinician tracks patients with conditions of behavioral health or mental health and with risk factors for depression; AND 2) Evidence of screening – Report from the electronic health record (EHR), qualified clinical data registry (QCDR), clinical registry, or documentation from medical charts showing regular practice for screening, including suicide risk assessment for mental health patients with behavioral or mental health disorders; AND 3) Evidence of prevention and treatment – Report from EHR, QCDR, clinical registry, or documentation from medical charts showing patients receiving prevention and/or treatment services based on screening results.	2017

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IA_BMH_6	Behavioral and Mental Health	Implementation of co-location PCP and MH services	Integration facilitation and promotion of the colocation of mental health and substance use disorder services in primary and/or non-primary clinical care settings.	High	<u>Objective:</u> Integrate mental health and substance use disorder services with primary and/or non-primary clinical care through the co-location and co-promotion of these services. <u>Validation Documentation:</u> Evidence of integrated mental health and substance use disorder services in primary and/or non-primary clinical care settings and promotion to patients. Include both of the following elements: 1) Co-location of services – Documentation of integration and promotion of co-located mental health and substance use disorder services in primary and/or non-primary clinical care settings, (e.g., list of National Provider Identifiers [NPIs] for clinicians who participate as behavioral health specialists, mental health clinicians or primary care clinicians in co-located settings or patient claims showing mental health and substance use disorder services co-located in primary and/or non-primary clinical care settings); AND 2) Promotion of co-located services – Evidence that co-located services are promoted or advertised to patients and regularly utilized in care (e.g., record of warm handoffs, promotion materials in waiting room, promotion of services in patient portal).	2017
IA_BMH_7	Behavioral and Mental Health	Implementation of Integrated Patient Centered Behavioral Health Model	Offer integrated behavioral health services to support patients with behavioral health needs who also have conditions such as dementia or other poorly controlled chronic illnesses. The services could include one or more of the following: • Use evidence-based treatment protocols and treatment to goal where appropriate; • Use evidence-based screening and case finding strategies to identify individuals at risk and in need of	High	<u>Objective:</u> Support patients with behavioral health needs and poorly controlled chronic illnesses through integrated behavioral health services and the use of evidence-based tools or other initiatives. <u>Validation Documentation:</u> Evidence of integrated behavioral health services to support patients with behavioral health needs and poorly controlled chronic conditions (may use certified electronic health records (EHR), qualified clinical data registry (QCDR), clinical registry, or medical records). Include at least one of the following elements: 1) Use of evidence-based tools – Documented use of evidence-based tools (e.g., treatment protocols, screening tools); OR	2017

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			services; • Ensure regular communication and coordinated workflows between MIPS eligible clinicians in primary care and behavioral health; • Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment; • Use of a registry or health information technology functionality to support active care management and outreach to patients in treatment; • Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible; and/or • Participate in the National Partnership to Improve Dementia Care Initiative, which promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training, and revised surveyor guidance.		2) Communication between primary care and behavioral health – Documentation could include EHR note that shows that the patient saw a behavioral health professional who communicated with the eligible primary care clinician or practice team, a record of a referral by the eligible primary care clinician to a behavioral health specialist, or documentation of staffing or behavioral health co-located in the primary care practice; OR 3) Behavioral health integration in primary care – Documented integration of behavioral health services with primary care to support patients with behavioral health needs (e.g., dementia) and poorly controlled chronic conditions (e.g., hypertension, diabetes, chronic kidney disease); OR 4) Active care management and outreach – Use of a clinical registry or certified EHR to support active care management and outreach to patients receiving treatment; OR 5) Participation in a relevant program or initiative – Participation in a program or initiative with a multidimensional approach to support patients with behavioral health needs and poorly controlled chronic conditions (e.g., National Partnership to Improve Dementia Care in Nursing Homes).	
IA_BMH_8	Behavioral and Mental Health	Electronic Health Record Enhancements for BH data capture	Enhancements to an electronic health record to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (e.g., capture of additional BH data results in additional depression screening for at-risk patient not previously identified).	Medium	Objective: Continually improve the care provided to behavioral health populations through evidence-based interventions and the use of electronic health record technology (EHR). Validation Documentation: Documented use of EHR to capture data on behavioral health populations and use data to inform clinical decision-making. Include both of the following elements: 1) Screenshots of data capture – Screenshots from EHR or from other software/tools integrated with the EHR displaying behavioral health data capture (e.g., capture of additional behavioral health data results in additional depression screening for at risk patient not previously identified); AND	2017



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					2) Data reports – Reports showing how additional behavioral health data are captured and used for decision-making (e.g., dashboards, improvement plans). <u>Example(s)</u>: An eligible clinician or practice expands data capture for behavioral health populations to include information on substance use, potential eating disorders, and social determinants of health. This eligible clinician or practice also ensures that all data on chronic medical conditions is being captured for these individuals. Through this improved data capture, the eligible clinician or practice identifies a subgroup of patients misusing substances and works to engage these patients in cognitive behavioral therapy.	
IA_BMH_9	Behavioral and Mental Health	Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients	Individual MIPS eligible clinicians or groups must regularly engage in integrated prevention and treatment interventions, including screening and brief counseling (for example: NQF #2152) for patients with co-occurring conditions of mental health and substance abuse. MIPS eligible clinicians would attest that 60 percent for the CY 2018 Quality Payment Program performance period, and 75 percent beginning in the 2019 performance period, of their ambulatory care patients are screened for unhealthy alcohol use.	High	<u>Objective</u>: Help patients better manage or overcome their alcohol and/or other substance abuse challenges through screenings and counseling. <u>Validation Documentation</u>: Evidence of regular integrated prevention and treatment interventions with documented screening and brief counseling for patients with diagnosed coexistence of a mental health disorder and substance abuse. Include both of the following elements: 1) Documented screening and brief counseling – Screenshots from electronic health record (EHR) or from other software/tools demonstrating integrated prevention and treatment interventions (e.g., evidence of screening and brief counseling for patients with mental health and substance abuse disorders); AND 2) Evidence of percent of patients screened – 75% of ambulatory care patients are screened for unhealthy alcohol use.	2018
IA_BMH_10	Behavioral and Mental Health	Completion of Collaborative Care Management	To receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychiatric Association (APA)	Medium	<u>Objective</u>: Develop strategies to improve integration of behavioral health into primary care practices, ultimately improving patient-centeredness of care and health outcomes for mental health patients.	2019

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		Training Program	Collaborative Care Model training program available to the public, in order to implement a collaborative care management approach that provides comprehensive training in the integration of behavioral health into the primary care practice.		<u>Validation Documentation:</u> Documented completion of a collaborative care management training program such as the American Psychological Association Collaborative Care Model training program. Include at least one of the following elements: 1) Certificate of completion – Eligible clinicians and groups must provide authentic documentation of collaborative care management training program completion (electronic or paper); OR 2) Implementation of approach – Documented implementation of a collaborative care management approach that provides comprehensive training in the integration of behavioral health into the primary care practice (e.g., a workflow diagram, listed staff and clinician roles and responsibilities, documented policies and procedures for approach).	
IA_BMH_11	Behavioral and Mental Health	Implementation of a Trauma-Informed Care (TIC) Approach to Clinical Practice	Create and implement a plan for trauma-informed care (TIC) that recognizes the potential impact of trauma experiences on patients and takes steps to mitigate the effects of adverse events in order to avoid re-traumatizing or triggering past trauma. Actions in this plan may include, but are not limited to, the following: • Incorporate trauma-informed training into new employee orientation • Offer annual refreshers and/or trainings for all staff • Recommend and supply TIC materials to third party partners, including care management companies and billing services • Identify patients using a screening methodology • Flag charts for patients with one or	Medium	<u>Objective:</u> Ensure delivery of responsive care for patients and clinicians who have experienced physical or mental trauma. <u>Validation Documentation:</u> Documentation of an implemented plan for delivering care to patients who have experienced trauma, and for addressing needs of clinicians and staff who have experienced trauma. Include the first element and one of the following elements: 1) Implementation of a Trauma-Informed Care (TIC) plan – Documentation of the creation and implementation of a TIC plan; AND 2) Training materials – Documentation of materials on TIC integrated into new employee orientation or annual employee training; OR 3) TIC education materials – Documentation that materials on TIC are supplied to third-party partners, such as care management companies and billing services, to ensure a system-wide approach to TIC; OR 4) Adverse events screener – Copy of implemented survey tool or prompt in electronic health record is used to assess and	2022

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			more adverse events that might have caused trauma • Use ICD-10 diagnosis codes for adverse events when appropriate TIC is a strengths-based healthcare delivery approach that emphasizes physical, psychological, and emotional safety for both trauma survivors and their providers. Core components of a TIC approach are: awareness of the prevalence of trauma; understanding of the impact of past trauma on services utilization and engagement; and a commitment and plan to incorporate that understanding into training, policy, procedure, and practice.		identify if a patient has experienced one or more adverse events that may have caused trauma. <u>Information:</u> • Centers for Disease Control and Prevention's Guiding Principles to Trauma-Informed Approach: https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm • Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). TIP 57: Trauma-informed care in behavioral health services: https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816?referer=from_search_result.	
IA_BMH_12	Behavioral and Mental Health	Promoting Clinician Well-Being	Develop and implement programs to support clinician well-being and resilience—for example, through relationship-building opportunities, leadership development plans, or creation of a team within a practice to address clinician well-being—using one of the following approaches: • Completion of clinician survey on clinician well-being with subsequent implementation of an improvement plan based on the results of the survey. • Completion of training regarding clinician well-being with subsequent implementation of a plan for improvement.	High	<u>Objective:</u> Improve the well-being of clinicians and the quality and safety of care they deliver. <u>Validation Documentation:</u> Evidence of activities to improve clinician well-being, defined by Chari et al. (2019) as a "concept that characterizes quality of life with respect to an individual's health and work-related environmental, organizational, and psychosocial factors. Well-being is the experience of positive perceptions and the presence of constructive conditions at work and beyond that enables workers to thrive and achieve their full potential." Include one of the following first two elements and the third element: 1) Report on clinician well-being – Report including collected data on clinician well-being and resilience (e.g., survey results); OR 2) Staff training – Documentation of staff training on clinician well-being (e.g., training certificate, letter, training materials); AND	2022



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					3) Implementation of a clinician well-being improvement plan – Documentation of a clinician well-being and resilience improvement plan, based on the results of the clinician well-being survey or staff training. <u>Information:</u> Chari et al. (2019). Expanding the Paradigm of Occupational Safety and Health: A New Framework for Worker Well-Being. Accessed September 5, 2021. Expanding the Paradigm of Occupational Safety and Health: A... : Journal of Occupational and Environmental Medicine (lww.com)	
IA_PCMH	Behavioral and Mental Health		N/A		<u>Objective:</u> Obtaining Patient-Centered Medical Home™ certification drives significant and sustainable practice improvements including population care quality, efficiency, and improved patient satisfaction all directly linked to better health outcomes. <u>Validation Documentation:</u> Evidence of meeting performance standards and expectations pertaining to the Patient-Centered Medical Home™ model. Include the following element: 1) Recognition certificate – Documented recognition as a Patient-Centered Medical Home™ from a regional or state program, private payer, or other body that certifies at least 500 or more practices for Patient-Centered Medical Home™ accreditation or comparable specialty practice certification. <u>Information:</u> Any clinician or group interested in attesting to IA_PCMH as their improvement activity must meet the criteria for recognition as a Patient-Centered Medical Home™ or comparable specialty practice participant. Information about criteria for a practice to be certified or recognized as a patient-centered medical home or comparable specialty practice can be found at the following in the Code of Federal Regulations (CFR [§ 414.1380(b)(3)(ii)]).	2017

Version History

Date	Change Description
1/31/2023	Updated to remove IA_PSPA_30 PCI Bleeding Campaign.
7/19/2022	Updated to reflect changes to IA_CC_1, IA_BMH_1, IA_PSPA_22 and IA_PSPA_30.
1/7/2022	Original version.