Table 14: 34 Improvement Activities—Detailed Listings

These listings are drawn from CMS materials. The improvement activity listings below are based on CMS materials available at time of press. For each listing, the "Description," "Requirements" (which is referred to as "Validation" in CMS materials), and "Suggested documentation" use CMS' own language.

Some explanations added. The Academy has added some explanatory notes [including text in square brackets], plus some tips on how the IRIS Registry can help. For the most up-to-date information on these improvement activities, bookmark aao.org/medicare/improvement-activities.

Make sure your documentation includes dates. CMS states that your documentation should include dates to show that the improvement activity was performed for the 90-day (or longer) performance period that you select for improvement activities.

HIGH-WEIGHTED ACTIVITIES

IA_AHE_1: Engagement of new Medicaid patients and follow-up

Scoring: High weighted.
EHR required? No.
Description: Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. A timely manner is defined as within 10 business days for this activity.
Requirements: Functionality of practice in seeing new and follow-up Medicaid patients in a timely manner including patients dually eligible. "Engaging" patients may include, but is not limited to:
• Establishing patient-provider relationship,
• assisting patient with care management plan,
• medication management and reconciliation,
• use of patient portal, [and/or]

• use of community health worker or other provider(s) to help patients navigate health care services.
Suggested documentation: 1) Timely Appointments for Medicaid and Dually Eligible Medicaid/Medicare Patients—Statistics from EHR or scheduling system (may be manual) on time from request for appointment to first appointment offered or appointment made by type of visit for Medicaid and dual eligible patients; and
2) Improvement Activities—Assessment of new and follow-up visit appointment statistics and other patient-level data to identify and implement improvement activities. Documentation should include planned and in-progress improvement activities and intended aims.

IA_AHE_6: Provide education opportunities for new clinicians

Scoring: High weighted.
EHR required? No.
Description: 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. [This activity is not intended for preceptors of rotations in metropolitan areas.]
Requirements: Participation as a preceptor for clini-

cians-in-training that encourage clinical rotations in community practices in small, underserved, or rural areas.
Suggested documentation: Documentation of participation as a preceptor for clinicians-in-training that encourages clinical rotations in community practices in small, underserved, or rural areas.
Academy note: CMS specifically states that "this activity is intended to support clinicians-in-training in community practices in small, underserved, or rural areas, not metropolitan areas."

IA_BE_6: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement

Scoring: High weighted.
EHR required? No.
Description: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan. [Surveys must be administered by a third-party survey administrator/vendor, as indicated in the CMS suggested documentation, below.]
Requirements: Patient experience and satisfaction data on beneficiary engagement is collected and follow up occurs through an improvement plan. [Surveys must be

administered by a third-party survey administrator/vendor, as indicated in the CMS suggested documentation, below.]
Suggested documentation: 1) Follow-Up on Patient Experience and Satisfaction—Documentation of collection and follow-up on patient experience and satisfaction (e.g., survey results) which must be administered by a third-party survey administrator/vendor; and
2) Patient Experience and Satisfaction Improvement Plan—Documented patient experience and satisfaction improvement plan.

IA_EPA _1: Provide 24/7 access to MIPS eligible clinicians or groups who have real-time access to patient's medical record

Scoring: High weighted.

EHR required? No.

Description: Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team to access 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 practice to provide alternate hour office visits and urgent care); [and/or]
• 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 consistent MIPS eligible clinician, group, or care team when needed for urgent care or transition management.

Requirements: Demonstration of patient care provided outside of normal business hours through 24/7 or expanded practice hours with access to medical records or ability to increase access through alternative access methods or same-day or next-day visits.

Suggested documentation: 1) Patient Record From EHR—A patient record from an EHR with date and timestamp indicating services provided outside of normal business hours for that clinician (a certified EHR may be used for documentation purposes, but is not required); or 2) Patient Encounter/Medical Record/Claim—Patient encounter/medical record claims indicating patient was seen or services provided outside of normal business hours for that clinician including use of alternative visits; or 3) Same or Next Day Patient Encounter/Medical Record/Claim—Patient encounter/medical record claims indicating patient was seen same-day or next-day to a consistent clinician for urgent or transitional care.

IA_PM_7: Use of QCDR for feedback reports that incorporate population health

Scoring: High weighted.

EHR required? Yes. IRIS Registry–EHR integration facilitates performance of this activity.

Description: Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.

Requirements: Involvement with a QCDR to generate local practice patterns and outcomes reports including vulnerable populations.

Suggested documentation: Participation in QCDR for population health, e.g., regular feedback reports provided by QCDR that summarize local practice patterns and treatment outcomes, including vulnerable populations.

If you have integrated your EHR system with the IRIS Registry, how do you document your participation in that QCDR? CMS recommends that you keep a copy of your quarterly updates to your IRIS Registry dashboard, if you can. And if you are audited, you can ask the IRIS Registry to provide you with a letter confirming that it received electronically submitted data and that it provided you with feedback reports summarizing treatment outcomes.

IA_PM_17: Participation in population health research

Scoring: High weighted.

EHR required? No.

Description: Participation in federally funded research that identifies interventions, tools, or processes that can improve a targeted patient population.

Requirements: Evidence supporting participation in a federally funded research initiative to identify systems, tools, or strategies that improve patient outcomes for a targeted population.

Suggested documentation: 1) Documentation of participation in federally funded research; and 2) Documentation of the interventions, tools, or processes used in the research; and 3) Documentation of the identified target population, and health outcomes targeted.

CMS note: Attestation for IA_PM_9 [which isn't reportable via the IRIS Registry] and IA_PM_17 utilizing the same research project is prohibited.

IA_PSPA_11: Participation in CAHPS [Consumer Assessment of Healthcare Providers and Systems] or other supplemental questionnaire

Scoring: High weighted.

EHR required? No.

Description: Participation in the Consumer Assessment of Healthcare Providers and Systems Survey [www.ahrq.gov/cahps] or other supplemental questionnaire items (e.g., Cultural Competence or Health Information Technology supplemental item sets).

Requirements: Participation in CAHPS or other supplemental questionnaire.

Suggested documentation: 1) CAHPS—CAHPS participation report; or 2) Other Patient Supplemental Questionnaire Items—Other supplemental patient safety questionnaire items, e.g., cultural competence or health information technology item sets must be administered by a third-party administrator/vendor.

MEDIUM-WEIGHTED ACTIVITIES

IA_AHE_4: Leveraging a QCDR for use of standard questionnaires

Scoring: Medium weighted.

EHR required? Yes. IRIS Registry–EHR integration will facilitate performance of this activity via a questionnaire that can be administered electronically (in development at time of press).

Description: Participation in a QCDR, demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status (e.g., use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment).

Requirements: Participation in a QCDR and demonstrated performance of activities for use of standard questionnaires for assessing improvement in health disparities related to functional health status.

Suggested documentation: Participation in QCDR, to use of standard questionnaires for assessing improvements in health disparities, e.g., regular feedback reports from QCDR, demonstrating performance of activities for using standard questionnaires for assessing improvements in health disparities related to functional health status.

If you have integrated your EHR system with the IRIS Registry, how do you document your participation in that QCDR? CMS recommends that you keep a copy of your quarterly updates to your IRIS Registry dashboard, if you can. And if you are audited, you can ask the IRIS Registry to provide you with a letter confirming that it received electronically submitted data and that it provided you with feedback reports summarizing treatment outcomes.

Academy note: The IRIS Registry is adding a new feature (still in development at time of press) that will enable physicians and practices to electronically administer questionnaires to patients on their visual function and other patient-reported outcomes. Once this new feature launches, practices using it can perform this activity. More information will be posted at aao.org/iris-registry.

IA_AHE_7: Comprehensive eye exams

Academy note: This improvement activity is new for 2019. To check for any updates, see this activity's listing at aao.org/medicare/improvement-activities.

Scoring: Medium weighted.

EHR required? No.

Description: In order to receive credit for this activity, MIPS eligible clinicians must promote the importance of a comprehensive eye exam, which may be accomplished by providing literature and/or facilitating a conversation about this topic using resources such as the "Think About Your Eyes" campaign and/or referring patients to resources providing no-cost eye exams, such as the American Academy of Ophthalmology's EyeCare America. This activity is intended for:

1) nonophthalmologists/nonoptometrists who refer patients to an ophthalmologist/optometrist;
2) ophthalmologists/optometrists caring for underserved patients at no cost; or
3) 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.

Requirements: Documentation of patient engagement by nonophthalmologists/nonoptometrists on the importance of comprehensive eye examinations targeted at underserved and/or high-risk populations or documentation of ophthalmologists/optometrists providing care for patients at no cost for underserved and/or high-risk populations.

Suggested documentation: 1) Documentation providing evidence that targeted, underserved, and/or high-risk populations are engaged in their ocular health with the aim of improving their access to comprehensive eye exams; and/or
2) Documentation that a discussion with the patient regarding the significance of annual comprehensive eye exams (when indicated) with evidence that ophthalmic resources were distributed to promote ocular health; and/or
3) Demonstrated promotion of the significance of comprehensive eye exams (referring patients to resources and providing no-cost eye exams) via ophthalmic resources with evidence that a conversation about this topic was conducted using resources such as the "Think About Your Eyes" campaign and the American Academy of Ophthalmology's EyeCare America. Evidence of use of these resources in support of this improvement activity may include screenshots of a notation in the medical chart, or copies of the ocular literature provided to the patient; and/or
4) Documentation of providing a free eye exam to the patient.

Get more information on EyeCare America. The Academy's EyeCare America program helps seniors who have not had a medical eye exam in three or more years, and those at increased risk for glaucoma, access eye care. You can make a big difference in the lives of these patients with a minimal time commitment and without leaving your office. To find out how it works, visit aao.org/volunteer.

IA_BE_4: Engagement of patients through implementation of improvements in patient portal

Scoring: Medium weighted.

EHR required? Yes.

Description: [Provide patients] access to an enhanced patient portal that provides up-to-date information related to relevant chronic disease health or blood pressure control, and includes interactive features allowing patients to enter health information and/or enables bidirectional communication about medication changes and adherence.

Requirements: Functionality of patient portal that includes patient interactive features.

Suggested documentation: Documentation through screenshots or reports of an enhanced patient portal, e.g., portal functions that provide up-to-date information related to chronic disease health or blood pressure control, interactive features allowing patients to enter health and demographic information (e.g., race/ethnicity, sexual orientation, sex, gender identity, disability), and/or bidirectional communication about medication changes and adherence.

IA_BE_13: Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms

Scoring: Medium weighted.

EHR required? No.

Description: Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms.

Requirements: Conduct of regular assessments of patient care experience, taking into account specific populations served and including them in this assessment, such as identified vulnerable populations.

Suggested documentation: Documentation (e.g., survey results, advisory council notes, and/or other methods) showing regular assessments of the patient care experience to improve the experience, taking into account specific populations served and including them in this assessment, such as identified vulnerable populations. Surveys should be administered independently to the best extent possible.

IA_BE_16: Evidence-based techniques to promote self-management into usual care

Scoring: Medium weighted.

EHR required? No.

Description: Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with structured follow-up, Teach Back, action planning, or motivational interviewing.

Requirements: Functionality of [i.e., incorporating] evidence-based techniques to promote self-management into usual care. [Also document their use.]

Suggested documentation: Documented evidence-based techniques to promote self-management into usual care; and evidence of the use of the techniques (e.g., clinicians' completed office visit checklist, EHR report of completed checklist, copies of goal-setting tools or techniques, motivational interviewing script/questions, action-planning tool with patient feedback).

Academy note: CMS has emphasized that you can implement a "Teach-Back strategy to ensure patient's understanding of medical information shared during an encounter."

IA_BE_17: Use of tools to assist patient self-management

Scoring: Medium weighted.

EHR required? No.

Description: Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's My Health).

Requirements: Use of tools to assist patient self-management.

Suggested documentation: Documentation in medical record or EHR showing use of Patient Activation Measure (PAM), How's My Health, or similar tools to assess patient's need for support for self-management. PAM assesses an individual's knowledge, skill, and confidence for managing one's health and healthcare. (You can learn more about the development of the original PAM on the Wiley Online Library site: http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2004.00269.x/full.)

IA_BE_21: Improved practices that disseminate appropriate self-management materials

Scoring: Medium weighted.

EHR required? No.

Description: Provide self-management materials at an appropriate literacy level and in an appropriate language.

Requirements: Provision of self-management materials appropriate for literacy level and language.

Suggested documentation: Documented provision in EHR or medical record of self-management materials, e.g., pamphlet, discharge summary language, or other materials that include self-management materials appropriate for the patient's literacy and language.

IA_BE_22: Improved practices that engage patients pre-visit

Scoring: Medium weighted.
EHR required? No.
Description: Implementation of workflow changes that engage patients [or patients and their family] 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.
Requirements: Pre-visit agenda shared with patient.
Suggested documentation: 1) Documentation of a letter, email, portal screenshot, etc. that shows a pre-visit agenda was shared with patient; and
2) Documentation of the practice's patient engagement workflow.

IA_BMH_2: Tobacco use

Scoring: Medium weighted.
EHR required? No.
Description: 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.*
Requirements: Performance of regular engagement in integrated prevention and treatment interventions including tobacco use screening and cessation interventions for patients with co-conditions of behavioral or mental health and at risk factors for tobacco dependence.
Suggested documentation: Report from EHR, QCDR, clinical registry or documentation from medical charts showing regular practice of tobacco screening for patients with co-occurring conditions of:
• behavioral or mental health and
• at risk factors for tobacco dependence.

IA_CC_1: Implementation of use of specialist reports back to referring clinician or group to close referral loop

Scoring: Medium weighted.
EHR required? No.
Description: Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.
Academy note: This improvement activity involves regularly taking certain actions when you are receiving the referral and when you are the referring clinician. When you receive referrals, regularly provide specialist reports back to the referring MIPS eligible clinician or group to close the referral loop. When you are the referring clinician, regularly initiate inquiries to specialists for specialist reports which could be documented or noted in the EHR.
Requirements: Functionality of providing information by specialist to referring clinician or inquiring clinician receives and documents specialist report.
Academy note: As the clinician receiving the referral, you must be able to provide a summary of care/specialist report to the referring clinician; as the referring clinician, you must be able to receive and document the specialist's report.
Suggested documentation: 1) Specialist Reports [Sent] to Referring Clinician—Sample of specialist reports reported to referring clinician or group (e.g., within EHR or medical record); or
2) Specialist Reports [Received by Referring Clinician] From Inquiries in Certified EHR—Specialist reports documented in inquiring clinician's certified EHR or medical records.

IA_CC_2: Implementation of improvements that contribute to more timely communication of test results

Scoring: Medium weighted.
EHR required? No.
Description: Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.
Requirements: Functionality of reporting abnormal test results in a timely basis with follow-up to streamline the communication process between the provider and patient.
Suggested documentation: EHR reports or medical records demonstrating timely communication of abnormal test results to patient (capturing the communication rate and [documentation of] working toward improvement of that rate).
Academy note: CMS does not define timely. The Academy recommends using the definition that had been used in the EHR meaningful use program, which involved communicating abnormal test results within four business days of receipt of test results.

IA_CC_4: TCPI participation [CMS Transforming Clinical Practice Initiative]

Scoring: Medium weighted.
EHR required? Check with the Practice Transformation Networks and Support and Alignment Network(s) (SANs) that are available to you. In some cases, they may let you join without an EHR system with the expectation that you will adopt one.
Description: Participation in the CMS Transforming Clinical Practice Initiative.
Requirements: Active participation in TCP Initiative.
Suggested documentation: Confirmation of participation in the TCPI for that year (e.g., CMS confirmation email).

For more information on TCPI, visit https://innovation.cms.gov/initiatives/transforming-clinical-practices/.
Academy note: This program is designed to prepare primary care and specialty clinicians for participation in an Alternative Payment Model. TCPI is a multiyear program in which clinicians enroll with one of the 29 practice transformation networks and commit to improving clinical outcomes while reducing unnecessary utilization and cost. There is a time and data commitment associated with TCPI. If you are interested in learning more about TCPI, you can contact TCPI at tcpi.isc@truvenhealth.com.

IA_CC_6: Use of QCDR to promote standard practices, tools, and processes in practice for improvement in care coordination

Scoring: Medium weighted.
EHR required? Yes. IRIS Registry–EHR integration facilitates performance of this activity.
Description: Participation in a QCDR, demonstrating performance of activities that promote use of standard practices, tools, and processes for quality improvement (e.g., documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups).
Requirements: Active participation in QCDR to promote standard practices, tools and processes for quality improvement.
Suggested documentation: Participation in QCDR demonstrating promotion of standard practices, tools, and processes for quality improvement (e.g., regular feedback reports provided by QCDR that demonstrate the use of QCDR data to promote use of standard practices, tools, and processes for quality improvement, including, for example, preventative screenings).
Academy note: You should have regular feedback reports *and* documentation of your quality improvement plan and actions, demonstrating use of data for quality improvement and implemention of best practices and preventive screenings at the individual patient level.
If you have integrated your EHR system with the IRIS Registry, how do you document your participation in that QCDR? CMS recommends that you keep a copy of your

quarterly updates to your IRIS Registry dashboard, if you can. And if you are audited, you can ask the IRIS Registry to provide you with a letter confirming that it received electronically submitted data and that it provided you with feedback reports summarizing treatment outcomes.
How does the IRIS Registry support performance of this activity? For integrated IRIS Registry–EHR users, the IRIS Registry may support performance monitoring for the following quality-improvement measures:
• 19: Diabetic Retinopathy: Communication With the Physician Managing Ongoing Diabetes Care
• 374: Closing the Referral Loop: Receipt of Specialist Report
Screening and preventive care quality measures:
• 12: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
• 110: Preventive Care and Screening: Influenza Immunization
• 111: Pneumonia Vaccination Status for Older Adults
• 117: Diabetes: Eye Exam
• 128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan
• 130: Documentation of Current Medications in the Medical Record
• 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
• 318: Falls: Screening for Future Fall Risk

IA_CC_8: Implementation of documentation improvements for practice/process improvements

Scoring: Medium weighted.
EHR required? No.
Description: 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).

Requirements: Processes and practices are implemented to improve care coordination.
Suggested documentation: Documentation of the implementation of practices/processes that document care coordination activities, e.g., documented care-coordination encounter that tracks clinical staff involved and communications from date patient is scheduled through day of procedure.

IA_CC_13: Practice improvements for bilateral exchange of patient information

Scoring: Medium weighted.
EHR required? Yes.

Description: 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 (HIE) if available; and/or
• Use structured referral notes.
Requirements: Functionality of bilateral exchange of patient information to guide patient care.
Suggested documentation: 1) Participation in an HIE—Confirmation of participation in a health information

exchange (e.g., email confirmation, screen shots demonstrating active engagement with Health Information Exchange); or
2) Structured Referral Notes—Sample of patient medical records including structured referral notes.
Further reading: See "The OpenNotes Movement—Why Doctors Are Sharing Their Notes With Patients" (*EyeNet*, June 2016) at aao.org/eyenet/archive.

IA_EPA_2: Use of telehealth services that expand practice access

Scoring: Medium weighted.
EHR required? No.
Description: Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleophthalmology pilots that assess ability to still deliver quality care to patients.
Requirements: Documented use of telehealth services and participation in data analysis assessing provision of quality care with those services.
Suggested documentation: 1) Use of Telehealth Services—Documented use of telehealth services through:
• a) claims adjudication (may use G codes to validate);
• b) EHR; or

• c) other medical record document showing specific telehealth services, consults, or referrals performed for a patient; and
2) Analysis of Assessing Ability to Deliver Quality of Care—Participation in or performance of quality improvement analysis showing delivery of quality care to patients through the telehealth medium (e.g., Excel spreadsheet, Word document, or others).
CMS note: For the purposes of this improvement activity, telehealth services include a "real time" interaction and may be obtained over the phone, online, etc., and are not limited to the Medicare reimbursed telehealth service criteria.

IA_EPA_3: Collection and use of patient experience and satisfaction data on access

Scoring: Medium weighted.
EHR required? No.
Description: 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.
Requirements: Development and use of access to care improvement plan based on collected and stratified patient experience and satisfaction data.

Suggested documentation: 1) Access to Care Patient Experience and Satisfaction Data—Patient experience and satisfaction data on access to care; and
2) Improvement Plan—Access-to-care improvement plan
Please note: CMS examples of stratification may include, patient demographics such as race/ethnicity, disability status (if available), sexual orientation (if available), sex, gender identity (if available), and geography.
Academy tip: Ensure that survey results include dates for each administered survey.

IA_EPA_5: Participation in user testing of the Quality Payment Program website: https://qpp.cms.gov

Scoring: Medium weighted.
EHR required? No.
Description: 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.
Requirements: Evidence of user participation and implementation of website testing for the Quality Payment

Program.
Suggested documentation: 1) Documentation of input to improve the CMS Quality Payment Program website through product user-testing aimed at enhancing system and program accessibility, readability, and responsiveness; and
2) Provide feedback for developing tools and guidance for a more efficient and accessible clinician and practice QPP website experience.
Academy note: CMS is looking for physicians to provide feedback on the QPP website, including products, services, educational materials, and website content. To participate in a feedback session, email CMSQPP Feedback@Ketchum.com.

IA_PM_10: Use of QCDR data for quality improvement such as comparative analysis reports across patient populations

Scoring: Medium weighted.
EHR required? Yes. IRIS Registry–EHR integration facili-

tates performance of this activity.
Description: Participation in a QCDR, clinical data regis-

tries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).
Requirements: Participation and use of QCDR, clinical data, or other registries to improve quality of care.
Suggested documentation: Participation in QCDR for quality improvement across patient populations, e.g.,

regular feedback reports provided by QCDR using data for quality improvement such as comparative analysis reports.
If you have integrated your EHR system with the IRIS Registry, how do you document your participation in that QCDR? CMS recommends that you keep a copy of your quarterly updates to your IRIS Registry dashboard, if you can. And if you are audited, you can ask the IRIS Registry to provide you with a letter confirming that it received electronically submitted data and that it provided you with feedback reports summarizing treatment outcomes.

IA_PSPA_2: Participation in MOC Part IV

Scoring: Medium weighted.
EHR required? No, but if you have an EHR system and integrate it with the IRIS Registry, you can use data from your dashboard to design and track an American Board of Ophthalmology (ABO) improvement project.
Description: In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. 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 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.
Requirements: Participation in MOC Part IV including a local, regional, or national outcomes registry or quality assessment program and performance of monthly activities to assess and address improvement in medical practice.
Suggested documentation: 1) Documentation of participation in MOC Part IV from an American Board of Medical Specialties (ABMS) member board such as 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 Improvement Module, or American Society of Anesthesiologists (ASA) Simulation Education Network, including participation in a local, regional, or national outcomes registry or quality assessment program; and specialty-specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules; and
2) Monthly Activities to Assess Performance—Documented performance of monthly activities across practice to assess performance in practice by reviewing outcomes, addressing areas of improvement, and evaluating the results.
Example of additional activity that qualifies for attestation: CMS has provided these additional examples of activities that qualify for attestation:
• Sub-IA-1: Implement Performance Improvement Module (Performance Improvement in Practice or Practice Biopsy)
• Sub-IA-2: Use of the NCDR Clinical Quality Coach;
• Sub-IA-3: Participate in the Quality Oncology Practice Initiative (QOPI)
• Sub-IA-4: Certification Program (QCP)
• Sub-IA-5: Participate in the American Board of Optometry's Performance in Practice activities
Academy note: If you have integrated your EHR system with the IRIS Registry, you can complete an improvement project that counts toward requirements for the ABO's MOC while also fulfilling this improvement activity. For more information, see page 36 or visit aao.org/iris-registry/maintenance-of-certification.

IA_PSPA_5: Annual registration in the Prescription Drug Monitoring Program

Scoring: Medium weighted.
EHR required? No.
Description: Annual registration by eligible clinician or group in the prescription drug monitoring program of the state where they practice. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups must participate for a minimum of six

months.
Requirements: Annual registration in the prescription drug monitoring program of the state and participation for a minimum of six months.
Suggested documentation: 1) Activation/Registration of a PDMP Account—Documentation evidencing activation/registration/continued participation in a PDMP account

(e.g., an email), and
2) Participation in PDMP—Evidence of participating in the PDMP, i.e., accessing/consulting (e.g., copies of

patient reports created, with the PHI [protected health information] masked).

IA_PSPA_7: Use of QCDR data, for ongoing practice assessment and improvements

Scoring: Medium weighted.
EHR required? Yes. IRIS Registry–EHR integration facilitates performance of this activity.
Description: Use of QCDR data, for ongoing practice assessment and improvements in patient safety.
Requirements: Use of QCDR data for ongoing practice assessment and improvements in patient safety. QCDR data should provide evidence of intended improvements in patient safety for specific targeted populations.
Suggested documentation: Participation in QCDR that promotes ongoing improvements in patient safety, e.g., regular feedback reports provided by the QCDR that demonstrate ongoing practice assessment and improvements in patient safety. Documentation should note how the practice is using QCDR data, and intended improvements in patient safety for specific populations targeted.
Academy note: You should have regular feedback reports from the QCDR *and* documentation of your quality improvement plan and actions, demonstrating use of data for assessment and improvement of patient safety measures for specific targeted populations.
If you have integrated your EHR system with the IRIS

Registry, how do you document your participation in that QCDR? CMS recommends that you keep a copy of your quarterly updates to your IRIS Registry dashboard, if you can. And if you are audited, you can ask the IRIS Registry to provide you with a letter confirming that it received electronically submitted data and that it provided you with feedback reports summarizing treatment outcomes.
How does the IRIS Registry support performance of this activity? For integrated IRIS Registry–EHR users, the IRIS Registry supports performance monitoring for the following patient safety quality measures:
• 130: Documentation of Current Medications in the Medical Record
• 192: Cataracts: Complications Within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
• 238: Use of High-Risk Medications in the Elderly
• 318: Falls: Screening for Future Fall Risk
Note: In order to support monitoring of each measure, the IRIS Registry must be able to extract the relevant data elements from your EHR system.

IA_PSPA_12: Participation in private payer clinical practice improvement activities

Scoring: Medium weighted.
EHR required? No.
Description: Participation in designated private payer clinical practice improvement activities.
Requirements: Participation in private payer clinical practice improvement activities.

Suggested documentation: 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).

IA_PSPA_15: Implementation of an antibiotic stewardship program

Scoring: Medium weighted.
EHR required? No.
Description: Leadership of an Antimicrobial Stewardship Program (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 policies and assist with implementation of corrective actions in accordance with facility or practice compliance policies and facility or practice 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 Elements of Outpatient Antibiotic Stewardship guidance.
Requirements: Leadership of an antibiotic stewardship program.
Suggested documentation: Documentation of leadership of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions according to clinical guidelines for diagnostics and therapeutics and identifies improvement actions:
1) Documentation of the report of findings and specific action plan; or
2) Documentation of the development, implementation, and monitoring of patient care and safety protocols; or
3) Documentation of the ongoing evaluation and monitoring of the management structure and workflow of ASP processes; or
4) Records of presentation of ASP education and training including curriculum and presentation dates; or
5) Documentation of communications regarding ASP

compliance; or
6) Documentation of preparation of and/or participation in payer audits, government inquiries, or professional inquiries pertaining to the ASP; or
7) Documentation of evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions; or
8) Documentation of developing and implementing evidence-based protocols and decision-support for diagnosis and treatment of common infections; or
9) Documentation of the alignment of evidence-based protocols with recommendations in the CDC's Core Elements of Outpatient Antibiotic Stewardship guidance.
Example of additional activity that qualifies for attestation: CMS has provided these additional examples of activities that qualify for attestation:
• Sub-IA-1: Provide leadership of a Bio-Security, Bio-Preparedness, & Emerging Infectious Diseases (BBEID) Program
• Sub-IA-2: Provide leadership of an Antimicrobial Stewardship Program
• Sub-IA-3: Provide leadership of Outpatient Parenteral Antimicrobial Therapy Hospital Admission/Readmission Avoidance Program

IA_PSPA_16: Use of decision support and standardized treatment protocols

Scoring: Medium weighted.
EHR required? No.
Description: Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.
Requirements: Use of decision support and treatment

protocols to manage workflow in the team to meet patient needs.
Suggested documentation: Documentation (e.g., checklist, algorithm, screenshot) showing use of decision support and standardized treatment protocols to manage workflow in the team to meet patient need.

IA_PSPA_18: Measurement and improvement at the practice and panel level

Scoring: Medium weighted.
EHR required? No.
Description: 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 that may be useful at the practice level and at the level of the care team or MIPS eligible clinician or group (panel); and/or
• Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level. [Surveys should be administered by a third-party survey administrator/vendor, as indicated in the CMS suggested documentation, next column.]
Requirements: Measure and improve quality at the practice and panel level. Practice and panel performance benchmarks and goals may also include benchmarks/goals for specific populations (e.g., racial and ethnic minorities, individuals with disabilities, sexual and gender minorities, individuals in rural areas) to drive overall im-

provements, and individuals with certain chronic conditions or risk factors.
Suggested documentation: 1) 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
2) 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.
Because this activity is so broad, CMS provided the following examples:
• Obtain Diagnostic Imaging Center of Excellence (DICOE) designation
• Participate in Endoscopy Unit Recognition Program (EURP)
• Participate in Simulation Education Courses approved by the ASA Simulation Education Network

IA_PSPA_20: Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes

Scoring: Medium weighted.

EHR required? No.

Description: Ensure full engagement of clinical and administrative leadership in practice improvement that could include one or more of the following:
• Make 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.

Requirements: Functionality of leadership engagement in regular guidance and demonstrated commitment for implementing improvements.

Academy note: The practice's clinical and administrative leadership should show this engagement and commitment.

Suggested documentation: 1) Clinical and Administrative Leadership Role Descriptions—Documentation of clinical and administrative leadership role descriptions include responsibility for practice improvement change (e.g., position description); or
2) Time for Leadership in Improvement Activities—Documentation of allocated time for clinical and administrative leadership participating in improvement efforts, e.g., regular team meeting agendas and post-meeting summary; or
3) Population Health, Quality, and Health Experience Incorporated Into Performance Reviews—Documentation [showing use] of population health, quality, and health experience metrics incorporated into regular practice performance reviews, e.g., reports, agendas, analytics, meeting notes.