2017 MIPS Improvement Activities

In this document:

Overview

In this new performance category for 2017, you're rewarded for care focused on care coordination, beneficiary engagement, and patient safety. The Improvement Activities category is worth 15% of your total MIPS score.

You may select activities that match your practice's goals from a list of more than 90 options. Medium weighted activities are worth 10 points, and heavily weighted activities are worth 20 points. You must select different activities every year.

Small and Rural Practices

Rural practices have fewer opportunities to select from, so they get more points for the activities they complete. You'll need to attest that you completed **up to two medium activities for a minimum of 90 days**.

Large Practices

If your group has more than 15 eligible clinicians, you'll need to attest that you completed **up to four improvement activities for a minimum of 90 days.**

You may complete two high activities; one high and two medium activities; or four medium activities.

Activities

The following table lists activities that are most applicable to eyecare practices. To see a complete list of improvement activities, go to https://qpp.cms.gov/mips/improvement-activities.

Weight	Subcategory	Activity Name	Activity Description	Validation	Suggested Documentation
High	Population Management	**IA_PM_3** 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.	Participation in RHC, HIS, or FQHC occurs and clinical quality improvement occurs	• Name of RHC, HIS or FQHC—Identified name of RHC, IHS, or FQHC in which the practice participates in ongoing engagement activities; and • Continuous Quality Improvement Activities—Documented continuous quality improvement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality and benchmarking improvement that ultimately benefits patients
High	Care Coordination	**IA_CC_4** TCPI participation	Participation in the CMS Transforming Clinical Practice Initiative.	Active participation in TCP Initiative	Confirmation of participation in the TCP Initiative for that year (e.g. CMS confirmation email)

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High	Beneficiary Engagement	**IA_BE_6** Collection and follow-up on patient experience and satisfaction data on beneficiary engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.	Patient experience and satisfaction data on beneficiary engagement is collected and follow up occurs through an improvement plan	• Follow-Up on Patient Experience and Satisfaction—Documentation of collection and follow-up on patient experience and satisfaction (e.g. survey results); and • Patient Experience and Satisfaction Improvement Plan—Documented patient experience and satisfaction improvement plan
High	Achieving Health Equity	**IA_AHE_1** Engagement of new Medicaid patients and follow-up	Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare.	Functionality of practice in seeing new and follow-up Medicaid patients in a timely manner including patients dually eligible	• Timely Appointments for Medicaid and Dually Eligible Medicaid/Medicare Patients—Statistics from certified 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 • Appointment Improvement Activities—Assessment of new and follow-up visit appointment statistics to identify and implement improvement activities

Weight	Subcategory	Activity Name	Activity Description	Validation	Suggested Documentation
High	Emergency Response & Preparedness	**IA_ERP_2** 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.	Participation in domestic or international humanitarian volunteer work of at least a continuous 60 days duration	Documentation of participation in domestic or international humanitarian volunteer work of at least a continuous 60 days duration including registration and active participation, e.g., identification of location of volunteer work, timeframe, and confirmation from humanitarian organization
Medium	Expanded Practice Access	**IA_EPA_2** Use of telehealth services that expand practice access	Use of telehealth services and analysis of data for such quality improvement as participation in remote specialty care consults or teleaudiology pilots that assess ability to still deliver quality care to patients.	Documented use of telehealth services and participation in data analysis assessing provision of quality care with those services	• Use of Telehealth Services—Documented use of telehealth services through: – claims adjudication (may use G codes to validate); – certified EHR; or – other medical record document showing specific telehealth services, consults, or referrals performed for a patient; and • 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)

Weight	Subcategory	Activity Name	Activity Description	Validation	Suggested Documentation
Medium	Expanded Practice Access	**IA_EPA_3** 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.	Development and use of access to care improvement plan based on collected patient experience and satisfaction data	• Access to Care Patient Experience and Satisfaction Data—Patient experience and satisfaction data on access to care; and • Improvement Plan—Access to care improvement plan
Medium	Population Management	**IA_PM_11** Regular review practices in place on targeted patient population needs	Implementation of regular reviews of targeted patient population needs which includes access to reports that show unique characteristics of eligible clinician's patient population, identification of vulnerable 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.	Participation in reviews of targeted patient population needs including access to reports and community resources	• Targeted Patient Population Identification—Documentation of method for identification and ongoing monitoring/ review for a targeted patient population; and • Report with Unique Characteristics—Reports that show unique characteristics of patient population and identification of vulnerable patients; and • Tailored Clinical Treatments—Medical records demonstrating ways clinical treatment needs are being tailored to meet unique needs including additional community resources, if necessary

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Medium	Care Coordination	**IA_CC_1** 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 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 certified EHR technology.	Functionality of providing information by specialist to referring clinician or inquiring clinician receives and documents specialist report	• Specialist Reports to Referring Clinician—Sample of specialist reports reported to referring clinician or group (e.g. within EHR or medical record); or • Specialist Reports from Inquiries in Certified EHR—Specialist reports documented in inquiring clinicians certified EHR or medical records

Weight	Subcategory	Activity Name	Activity Description	Validation	Suggested Documentation
Medium	Care Coordination	**IA_CC_12** 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; • Track patients referred to specialist through the entire process; and/or • Systematically integrate information from referrals into the plan of care.	Functionality of effective care coordination and referral management	• Care Coordination Agreements—Sample of care coordination agreements with frequently used consultant that establish documented flow of information and provides patients with information to set consistent expectations; or • Tracking of Patient Referrals to Specialists—Medical record or EHR documentation demonstrating tracking of patients referred to specialists through the entire process; or • Referral Information Integrated into the Plan of Care—Samples of specialist referral information systematically integrated into the plan of care

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Medium	Care Coordination	**IA_CC_13** Practice improvements for bilateral exchange of patient information	Ensure that there is bilateral exchange of necessary patient information to guide patient care that could include one or more of the following: • Participate in a Health Information Exchange if available; and/or • Use structured referral notes.	Functionality of bilateral exchange of patient information to guide patient care	• 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 • Structured Referral Notes—Sample of patient medical records including structured referral notes
Medium	Beneficiary Engagement	**IA_BE_1** Use of certified EHR to capture patient reported outcomes	In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (e.g., home blood pressure, blood glucose logs, food diaries, at-risk health factors such as tobacco or alcohol use, etc.) or patient activation measures through use of certified EHR technology, containing this data in a separate queue for clinician recognition and review.	Functionality of patient reported outcomes in certified EHR	• Patient Reported Outcomes in EHR—Report from the certified EHR, showing the capture of PROs or the patient activation measures performed; or • Separate Queue for Recognition and Review—Documentation showing the call out of this data for clinician recognition and review (e.g. within a report or a screen-shot)
Medium	Beneficiary Engagement	**IA_BE_13** Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.	Conduct of regular assessments of patient care experience	Documentation (e.g. survey results, advisory council notes and/or other methods) showing regular assessments of the patient care experience to improve the experience

Weight	Subcategory	Activity Name	Activity Description	Validation	Suggested Documentation
Medium	Beneficiary Engagement	**IA_BE_15** 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 certified EHR technology.	Inclusion of patients, family and caregivers in plan of care and prioritizing goals for action, as documented in certified EHR.	Report from the certified EHR, showing the plan of care and prioritized goals for action with engagement of the patient, family and caregivers, if applicable
Medium	Patient Safety & Practice Assessment	**IA_PSPA_12** Participation in private payer CPIA	Participation in designated private payer clinical practice improvement activities.	Participation in private payer clinical practice improvement activities	Documents showing participation in private payer clinical practice improvement activities

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Medium	Patient Safety and Practice Assessment	**IA_PSPA_19** 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: • 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; and/ or • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.	Implementation of a formal model for quality improvement and creation of a culture in which staff actively participates in one or more improvement activities	• Adopt Formal Quality Improvement Model and Create Culture of Improvement—Documentation of adoption of a formal model for quality improvement and creation of a culture in which staff actively participate in improvement activities; and • Staff Participation—Documentation of staff participation in one or more of the six identified; including, training, integration into staff duties, identifying and testing practice changes, regular team meetings to review data and plan improvement cycles, share practice and panel level quality of care, patient experience and utilization data with staff, or share practice level quality of care, patient experience and utilization data with patients and families

Weight	Subcategory	Activity Name	Activity Description	Validation	Suggested Documentation
Medium	Emergency Response & Preparedness	**IA_ERP_1** 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.	Participation in Disaster Medical Assistance Team or Community Emergency Responder Team for at least 6 months as a volunteer	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, etc.
Medium	Behavioral and Mental Health	**IA_BMH_2** 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 Quality measure 226) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.	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	Report from certified 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