GENERAL DYNAMICS
Information Technology

HealthInsight

Deliverable 11: IA TEP Summary Report

Merit-based Incentive Payment System (MIPS) Improvement Activities (IA) Technical Expert Panel (TEP) Summary Report

HHSM-500-2013-13008I
Task Order: HHSM-500-T0001

March 14, 2018

Prepared for:
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Submitted by:
General Dynamics Information Technology
3211 Jermantown Road
Fairfax, VA 22030

In Partnership with:
HealthInsight
2020 SW Fourth Avenue
Portland, OR 97201

Table of Contents

This Report is intended to fulfill Deliverable 11, Expert Input Report, in Chapter 3 of the Measure and Instrument Development and Support (MIDS) Umbrella Statement of Work (USOW), which maps to Deliverable 20 in the MIPS Practice Improvement and Measures Management Support (PIMMS) Task Order (TO) contract Schedule of Deliverables (SOD).

Background

The Centers for Medicare & Medicaid Services (CMS) contracted with General Dynamics Information Technology (GDIT), through the Practice Improvement and Measures Management Support (PIMMS) contract: HHSM-500-2013-13008I, Task Order: HHSM-500-T0001, to convene a technical expert panel (TEP) around the effectiveness and accuracy of the improvement activities (IAs) included in the Transition Year of the Quality Payment Program (QPP) under the Merit-based Incentive Payment System's (MIPS) IA performance category. HealthInsight, through its subcontract with GDIT, prepared and convened this TEP. This report summarizes the feedback and recommendations received from the TEP members during TEP meeting pre-work, the TEP virtual meeting, and post-TEP follow-up with members.

HealthInsight is a private, nonprofit, community-based organization with four decades of quality improvement experience, dedicated to improving health and health care in the states we serve across the west and in our national contracts.

IA TEP Objectives and Purpose

The members of the Improvement Activities Technical Expert Panel (IA TEP) reviewed a list of 20 selected IAs, which were a combination of those the members rated as important to discuss, and those for which the QPP Service Center has been receiving the most comments and questions. The purpose of this review is to: engage users in the design of the IAs, solicit feedback on the IAs with those using them in the real world, and to ensure that IAs are valid, weighted correctly, and sensible.

IA TEP Members

In alignment with the CMS Measures Management System (MMS), and under the guidance of CMS, HealthInsight held a 30-day public call for nominations and convened a TEP for the review of Transition Year IAs. Potential TEP members were solicited via emails to individuals and organizations, as well as email communication sent through CMS' established physician and hospital email Listservs, and through a posting on the CMS website. The TEP was composed of 12 members, listed in Table 1.

Table 1. TEP Member Name, Affiliation and Location

Name, Credentials	Professional Role	Organizational Affiliation, City, State
Amy Aronsky, D.O., FCCP, FAASM	Senior Medical Director	CareCentrix, Inc., Hartford, CT
Patrick Vance Bailey, MD, MLS, FACS, FAAP	Medical Director of Advocacy, Division of Advocacy and Health Policy	American College of Surgeons, Washington, DC
Sara Berger, MBA	Project Manager, External Metrics and Quality Reporting	Memorial Sloan Kettering Cancer Center, New York, NY
Karen R. Clark, MBA, CPHIMS, FHIMSS	Chief Information Officer	OrthoTennessee, Knoxville, TN
Jeremy Collins, MD	Chair of Performance and Quality Improvement Division	Society of Interventional Radiology, Chicago, IL
Cathy Costello, JD, CPHIMS	Director, CliniSyncPLUS Services	Ohio Health Information Partnership, Hilliard, OH
Stephen L. Davidow, MBA-HCM, CPHQ, APR	Director, Quality Improvement	PCPI Foundation, Chicago, IL
Erin C. DeLoreto, MPAP	AVP Value Based Programs	CareAllies, Piscataway, NJ

Name, Credentials	Professional Role	Organizational Affiliation, City, State
Tamarah Duperval-Brownlee MD, MPH, MBA, FAAFP	Vice President, Care Excellence	Ascension, St. Louis, MO
Amy Mullins, MD, CPE, FAAFP	Medical Director, Quality Improvement	American Academy of Family Physicians, Leawood, KS
Sheila Roman, MD, MPH	Endocrinologist	Independent Healthcare Quality Consultant, Baltimore, MD
Ted Rooney RN, MPH	Consumer	Volunteer Board member of Maine Assn. Of Area Agencies on Aging, Part-time HealthDoer Ambassador for Network for Regional Health Improvement, Brunswick, ME

Pre-Work and Assessment Collection

The MIPS IA performance category evaluates how much providers/practices participate in activities that improve clinical practice. Under this performance category, practices can choose from a variety of activities to demonstrate their performance, and includes incentives that help drive participation in certified patient-centered medical homes (PCMHs) and Advanced Alternative Payment Models (APMs)[i]. The Transition Year IA inventory is divided into nine subcategories:

1. Expanded Practice Access
2. Population Management
3. Care Coordination
4. Beneficiary Engagement
5. Patient Safety and Practice Assessment
6. Participation in an APM
7. Achieving Health Equity
8. Integrating Behavioral and Mental Health
9. Emergency Preparedness and Response

Prior to the IA TEP meeting, IA TEP members were asked to review, prioritize, and provide feedback on the 92 IAs included in the Transition Year so that the conversation could be better informed and targeted to specific issues of importance identified by the IA TEP. The first pre-work assessment was emailed to IA TEP members with supporting materials, completion time estimate, and response deadline. The response rate was 100 percent.

The results of the first pre-work assessment were compared to the IAs for which the QPP Service Center had received the most feedback and questions. The IA TEP members were not provided with a list of the QPP Service Center's IAs, yet their rankings of IAs that were most important to discuss were aligned closely with those generated from the QPP Service Center. A final list of 20 prioritized IAs was comprised of the IAs that had the highest prioritization from both sources.

Based on the pre-work assessment, IA TEP members thought that the objective of the TEP aligned with what they identified as the most important discussion points for the IAs – mainly burden on providers/practices, weighting, clarification, and alignment. The 20 prioritized IAs were used to get a deeper level of feedback regarding these discussion points in a second pre-work assessment. The second pre-work assessment specifically asked about each of the 20 prioritized IAs regarding: weighting, burden

on providers/practices, whether the activity fit easily into practices' workflows, whether practices were already performing these activities, if the activity was relevant and important to patients, if the IA fit into the subcategory in which it was placed, and if it was clear and understandable. This second assessment was also emailed to IA TEP members with support materials, completion time estimate, and a response deadline. The response rate was 67 percent.

Details from the results of the first and second pre-work assessment can be found in Appendix A. The results of the second pre-work assessment shaped the final agenda and questions asked at the virtual IA TEP meeting.

IA TEP Virtual Meeting

The IA TEP meeting was scheduled based on best availability for TEP members. This meeting was set as a two-hour virtual meeting, held on February 21, 2018 (see Appendix B for the TEP meeting materials packet). All IA TEP members were in attendance. The following subsections follow the TEP meeting agenda, and review both the feedback from the second pre-work assessment (henceforth referred to as "the assessment") and from the TEP members during the TEP meeting. Detailed minutes from the IA TEP meeting can be found in Appendix C.

Relevance to Patients/Caregivers

The feedback of patients and non-medical caregivers is a priority of CMS, and the IA TEP included members that specifically were chosen to represent the patient/consumer/non-medical caregiver perspective. The IA TEP members were asked in the assessment if they felt the 20 prioritized IAs were relevant and important to patients. Most of the 20 prioritized IAs were rated as at least somewhat important to patients and non-medical caregivers, with the following IAs being rated "Very Relevant/Important":

- IA_CC_10: Care transition documentation practice improvements,
- IA_CC_2: Implementation of improvements that contribute to more timely communication of test results, and
- IA_EPA_1: Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record.

These most patient and caregiver relevant IAs were discussed in more depth at the virtual TEP meeting. For IA_CC_10: Care transition documentation practice improvements, IA TEP members thought that including patient input about how the patient thought the service was conducted, as well as proper provider documentation is critical. If a process is not well-documented, it cannot be improved. IA TEP members thought that this is as much a measure of patient safety as a care transition measure. It is important to assess if the patient feels that their follow-up directions are understandable, and the specific recommended next steps are clear. IA TEP members emphasized that patient input is important, and that this can sometimes be a shift, from a cultural and resource perspective, to look at accountability for patient care. It was pointed out that this IA is related to reducing hospital admissions and re-admissions, which is extremely important.

IA TEP members thought that IA_CC_2: Implementation of improvements that contribute to more timely communication of test results is crucial to any practice, to keep patients informed and avoid missing necessary follow-up to abnormal test results. They thought that many practices poorly coordinate with the patient about test results and next steps, such as specialist referrals. IA TEP members pointed out that some patients and family members may experience different communication barriers, and the burden of trying to comprehend the information coming from multiple sources/providers should not be

overlooked. An IA TEP member expressed that some patients may not press their providers for additional clarification when they do not understand because they perceive it to be a burden or an interruption, and this can lead to dangerous miscommunication or lack of follow-through. Anything that clarifies or improves the reporting of test results would be beneficial to both patients and providers. The IA TEP members thought that if the goal is to incentivize practices to improve in this way, it should be weighted as High.

Finally, IA TEP members felt strongly that IA_EPA_1: Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record is key to the idea of practice transformation and that practices should be incentivized to provide the services outlined in this activity. IA TEP members felt this IA is a core tenet of Patient-Centered care, but that most practices are not currently providing 24/7 access. This was not made clear in the assessment results but was highlighted at the TEP meeting.

Clarity

Clarity is an important aspect of the IAs, as clear IAs ensure that providers can confidently attest to these IAs and fully meet the intent of the IAs in their practices. The IA TEP members were asked in the assessment if the 20 prioritized IAs were clear and understandable to practices and providers, and the majority of assessment respondents felt that they were. There were some notable exceptions discussed at the TEP meeting where IA TEP members thought that a change in the language would make the IA more understandable. These are described below:

IA_CC_13: Practice improvements for bilateral exchange of patient information

Some of the IA TEP members thought this was an IA that might be improved by being separated into two activities: 1) the ability to send messaging, and 2) how many times a practice successfully executed this. IA TEP members suggested separating the activity because practices are only in control of their ability to send messages. One IA TEP member illustrated that while they have a system they regularly use to exchange patient information, there is mixed utility amongst the practices they communicate with. The TEP member noted that the receiving provider opening and then using the information is out of their locus of control. If the IA was separated into two activities, it may lessen the perceived burden.

IA_BE_14: Engage patients and families to guide improvement in the system of care

IA TEP members thought this IA needed additional clarity, and a possible revision to the language. IA TEP members recommended additional clarity by specifically calling out patient advisory councils in the specifications to provide examples of what this should look like, without being too prescriptive. It was suggested that the wording be modified to: “Engage patients and families to guide improvement in the process of delivering care.” This language would make this IA less structured and encourage practices to innovate and create engagement opportunities that would work for them rather than adopting a model that may have worked for others.

IA_CC_10: Care transition documentation practice improvements

Some IA TEP members recommend a language change to: “Implementation of processes for transitional care management (TCM) that include documentation of how a clinician or group carries out a patient-specific action plan for the first 30 days following discharge (e.g., document patient/staff engagement including phone calls, contacts for follow-up actions with other providers or agencies, and scheduled office visits or home health care).” Practices understand TCM, but the wording for this IA is confusing and could be better defined through naming examples of activities that are part of TCM.

IA_EPA_2: Use of telehealth services that expand practice access

TEP members suggested that this IA could be changed to "Use of telehealth services, such as participation in remote specialty care consult, for delivering quality care to patients." This was recommended so the IA called out and prioritized the use of technology, since physicians are using this as a tool to enhance their capabilities and provide patients with improved access to resources outside their clinics.

IA_BE_1: Use of certified electronic health information technology (CEHRT) to capture patient reported outcomes

An IA TEP member suggested changing the language to state, "Use of certified EHR and/or nationally-accredited instrument to capture patient reported outcomes." This would allow for technological flexibility, which is needed to capture patient reported outcomes, according to IA TEP members. This desire for more flexibility in selection of technology used is a part of a larger discussion, which is outlined further in the section on Burden, Workflow and Implementation below.

An IA TEP member also suggested that the language for an IA outside of the 20 prioritized IAs could be improved. IA_BE_4: Engagement of patients through implementation of improvements in patient portal, was suggested to be changed to: "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, such as: allowing patients to enter health information, or enabling bidirectional communication about medication changes and adherence."

Burden, Workflow and Implementation

The burden that IAs can put on practices and providers is a very important issue for CMS and was highlighted by IA TEP members as the most important aspect of IAs to discuss. Fifteen of the 20 prioritized IAs were rated by more than half of the IA TEP assessment respondents to be burdensome in some way to providers and practices:

- IA_CC_10: Care transition documentation practice improvements
- IA_AHE_2: Leveraging a QCDR to standardize processes for screening
- IA_BE_1: Use of certified EHR to capture patient reported outcomes
- IA_BE_17: Use of tools to assist patient self-management
- IA_BE_12: Use evidence-based decision aids to support shared decision-making
- IA_CC_13: Practice improvements for bilateral exchange of patient information
- IA_AHE_3: Leveraging a QCDR to promote use of patient-reported outcome tools
- IA_AHE_1: Engagement of new Medicaid patients and follow-up
- IA_BE_6: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
- IA_CC_2: Implementation of improvements that contribute to more timely communication of test results
- IA_EPA_1: Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record
- IA_PSPA_7: Use of QCDR data for ongoing practice assessment and improvements
- IA_BE_13: Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms
- IA_BE_15: Engagement of patients, family and caregivers in developing a plan of care
- IA_BE_7: Participation in a QCDR, that promotes use of patient engagement tools

IA TEP members acknowledged that new activities are always burdensome to practices who are implementing them for the first time but thought that these IAs were especially so. IA TEP members felt that as practices get used to implementing these actions in their workflows, it would become increasingly easier, but that the initial switch in workflow and the disruption of implementation is very burdensome to clinics.

IA TEP members were asked if the 20 prioritized IAs fit easily into practices' workflows to address the idea of undue burden on practices. It may not seem burdensome to ask a clinic to perform a particular IA, but if the activity runs counter to the current organization of their practice workflow then implementation can easily become an unforeseen burden. There were nine IAs that respondents thought would not easily fit into the average clinic's existing workflows:

- IA_CC_10: Care transition documentation practice improvements
- IA_AHE_2: Leveraging a QCDR to standardize processes for screening
- IA_EPA_2: Use of telehealth services that expand practice access
- IA_BE_1: Use of certified EHR to capture patient reported outcomes
- IA_BE_15: Engagement of patients, family and caregivers in developing a plan of care
- IA_PSPA_7: Use of QCDR data for ongoing practice assessment and improvements
- IA_BE_14: Engage patients and families to guide improvement in the system of care
- IA_AHE_3: Leveraging a QCDR to promote use of patient-reported outcome tools
- IA_BE_7: Participation in a QCDR, that promotes use of patient engagement tools

Fitting into workflow is something that IA TEP members thought could be re-examined as practices continue to improve and have had the chance to adapt to these IAs, in conjunction with other practice improvements. Again, the IA TEP indicated that what is initially difficult will be increasingly easier to manage with repetition.

Similarly, assessment respondents were asked for their impression of whether these 20 prioritized IAs were currently being performed in practices. While not every IA TEP respondent felt qualified to speak to this, those who responded gave the impression that most of these IAs were in some way currently being performed, with two notable exceptions. First, as previously discussed, some IA TEP members voiced the opinion that IA_EPA_1: Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record was not being performed in many clinics. Secondly, the exception in the assessment was IA_AHE_1: Engagement of new Medicaid patients and follow-up. IA TEP members reasoned that because there are many providers who do not take Medicaid patients, there is an increased burden on those patients to find a physician. An IA TEP member pointed out that there are state-specific Medicaid laws that impact providers and may explain why some physicians choose to not accept Medicaid. Many TEP members thought that there should be incentives for physicians to see special populations of patients in markets where there is heavily managed care.

During the IA TEP meeting, members discussed some of the IAs that the majority had rated as burdensome and expanded on their feedback. IA_CC_10: Care transition documentation practice improvements was discussed again, as many IA TEP members wished to reiterate that this was a large lift for practices in terms of both time and resources and should be weighted as High. The relationship to TCM was again highlighted, as an IA TEP member stated that attention should be paid to those patients that get re-admitted to the hospital within 30 days, and beyond. There is nothing that precludes

readmission better than a robust TCM program that allows you to identify patients that will need additional care.

IA_BE_1, the use of CEHRT to capture patient reported outcomes is particularly burdensome because of the technology required, and practices have to work with their vendors to establish a suitable workflow. It was observed that patient reported outcomes are incredibly important to capture but are extremely challenging to get into the CEHRT. Many of the IA TEP members stated that their practices use third-party vendors that utilize nationally recognized instruments to gather patient feedback. These have a much higher response rate because they are more adaptable with current technological platforms (iPads, mobile devices, etc.). These tools cannot be used to attest to this IA because they are not capturing data in a CEHRT, but IA TEP members stressed that patients were more likely to engage with these tools, and that was the ultimate goal. The majority of IA TEP members want to see more flexibility in this area; as one TEP member stated, the more CMS can make this easier the better, because this is a measure that truly matters to patients and family members.

IA_AHE_2: Leveraging a QCDR to standardize processes for screening was felt to be burdensome for a few different reasons. One IA TEP member noticed overlap with other QCDR IAs, and another pointed out that if practices had standardized these processes without leveraging a QCDR, then adding one would be very burdensome. It was agreed that this IA was an important measure, and IA TEP members noted that QCDR IAs should be incentivized since they are designed to drive improvement. However, these IAs may be confusing because some seem to be specialty-specific and more appropriate for some organizations than others. It was suggested that QCDR IAs be grouped together or linked in a more meaningful way.

IA_BE_17: Use of tools to assist patient self-management was ranked burdensome by many IA TEP members because of the work it took to implement the tools in practice workflows. It was stated that this was a shift for some of the older workforce, and training or re-training makes this burdensome. Without training on how to use patient self-management tools within the practice workflow, practices must employ someone to analyze the data, which is potentially financially burdensome. It was suggested and agreed upon by most of the IA TEP that this IA be expanded to include referral to accredited self-management programs, as this would allow for providers to use the tools and workflows that make sense to their patients and practice. Most IA TEP members agreed with this, and felt it makes sense to allow for flexibility for practices to use tools that work for their patients.

Weighting

The issue of whether or not the IAs were weighted appropriately was raised throughout the TEP meeting. During the assessment, IA TEP members were asked if the 20 prioritized IAs had been weighted correctly, and respondents felt that the majority of the IAs were. Most of assessment respondents indicated that there were three IAs that were not weighted correctly:

- IA_CC_13: Practice improvements for bilateral exchange of patient information
- IA_CC_10: Care transition documentation practice improvements
- IA_EPA_2: Use of telehealth services that expand practice access

Respondents wanted all three of these IAs weighted High instead of Medium because of the level of effort and investment required by practices to attest to those IAs.

There were four IAs that IA TEP respondents were evenly split on in terms of their weight needing adjustment:

- IA_BE_6: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
- IA_CC_1: Implementation of use of specialist reports back to referring clinician or group to close referral loop
- IA_BE_15: Engagement of patients, family and caregivers in developing a plan of care
- IA_AHE_2: Leveraging a QCDR to standardize processes for screening

One respondent felt IA_AHE_2 should be removed, while one felt it was less important than other incorrect weightings, and another felt it was the "new frontier" and should be weighted High. Two respondents thought IA_BE_6 should be weighted Medium and not High, and another stated that it may overlap with other IAs.

During the TEP, there was an overwhelming consensus among IA TEP members about the need for the following IAS to be weighted High instead of Medium, based on their analysis of the burden/benefit ratio on providers and practices:

- IA_CC_10: Care transition documentation practice improvements
- IA_EPA_2: Use of telehealth services that expand practice access
- IA_BE_1: Use of certified EHR to capture patient reported outcomes
- IA_BE_17: Use of tools to assist patient self-management

IA_EPA_2: Use of telehealth services that expand practice access was especially highlighted during IA TEP discussions, as many members saw this as an important but very disruptive activity. Adopting telehealth in a practice means a major disruption to a clinic's workflow and carries a different level of risk because providers must learn to practice outside of a traditional, face-to-face visit. It is a very different way to practice medicine but can be very beneficial to patients.

Many IA TEP members thought that an additional IA outside of the 20 prioritized IAs - IA_PSPA_10: Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments - should be weighted High to incentivize its implementation, considering the current national opioid crisis. Overall, IA TEP members stated they encouraged CMS to look carefully at their weighting process to ensure that complexity and burden is being considered as a key factor in determining the weight of IAs.

Other IA Considerations

During the assessment, IA TEP members were asked to indicate if any of the IAs were duplicative. While there were some answers given, there was no consensus. IA TEP members were also asked for feedback on the subcategories, specifically if the IAs fit into the subcategory in which they were placed. There were a few who felt that that certain IAs did not fit, and suggested where they may fit better, but there was no consensus on any IA. The majority felt they were subcategorized correctly, and so this was not discussed during the TEP meeting.

Near the end of the IA TEP meeting, IA TEP members were given time for more general feedback on IA intent, duplication, alignment with other MIPS categories, etc. The IA TEP members felt that the IAs generally met their intent, and there were IAs to which both specialists and primary care providers could attest. There was no sense of real duplication in the IAs, although some thought that the IAs seemed to overlap in many areas, especially surrounding QCDR measures. Some IA TEP members voiced the opinion that the IAs were too broad, and a few thought the list of IAs may be too long. Others disagreed with this assessment, stating that the wide breadth of IAs was needed to encompass practices with

different levels of available support and resources for practice transformation, and that the long list of IAs was important for meeting practices where they are.
Many IA TEP members voiced their approval of CMS' alignment of IAs with the Advancing Care Information (ACI) through bonus points for some IAs. They mentioned that this added incentive was helpful for providers to see the connection between the programs and the push for quality CEHRT adoption. They encouraged that this be continued long-term.

IA TEP members generally thought that the 90-day period for performance of IAs was appropriate, but some encouraged CMS to consider lengthening the period in the future to encourage practices to sustain the practice transformation within their clinics. IA TEP members were asked whether or not any of the IAs seemed too simple, or were at the top edge of their improvement in the sense that the great majority of providers already incorporated the activity in their practices, etc. This was a difficult concept to apply to IAs, as there is not a standard way of measuring IA performance the way that there is for quality measures. It was suggested that before CMS removes any IA, the length of attestation be lengthened.

Post-TEP Interviews

Since the TEP meeting was structured to make the most of the available time, PIMMS wanted to ensure that IA TEP members had an outlet for additional feedback and deeper dives into the feedback they were able to give during the meeting. IA TEP members were offered individual post-TEP interview time in the weeks following the IA TEP meeting, and 66 percent of IA TEP members accepted. These post-TEP interviews highlighted some reflection from the IA TEP members, and a few additions to the IA feedback.

IA TEP members voiced a general agreement with many of the thoughts expressed during the TEP meeting and the pre-work. The majority of IA TEP members reiterated the need for IA_CC_10: Care transition documentation practice improvements, IA_EPA_2: Use of telehealth services that expand practice access, IA_BE_1: Use of certified EHR to capture patient reported outcomes, and IA_BE_17: Use of tools to assist patient self-management to be changed from Medium to High weight to properly capture the effort required by practices to implement these correctly and sustain their practice. Many again expressed the desire to have CMS thoughtfully consider burden and cost of implementation in future IA weighting. Some expressed a desire to add a "Low" weighting so that practices could gauge the complexity of IAs more accurately when choosing what to attest to.

The majority of the IA TEP members that expressed during the meeting that the 92 Transition Year IAs were too broad or numerous had changed their minds during follow-up. Many expressed that after discussion at the meeting, they now saw the long list of IAs as necessary since there are so many clinics still in the early stages of practice transformation that may not have access to the resources that the larger systems have. However, these IA TEP members thought that there seemed to be a lot of overlap to those not considering the context of these IAs, and that they were organized in a way that is confusing to busy practices.

To this point, many IA TEP members agreed that providers tend to be detail-oriented and would benefit from further documentation and guidance around what attestation to the different IAs require. While IA TEP members appreciated that documentation is an area where practices can be more innovative with how they achieve these activities, many stated that additional examples and clarification in plain English would help providers narrow down which IAs to focus on and attest to, which may lead practices in better implementation of practice transformation. If a practice was as advanced as a PCMH, they would

just be able to attest to that and get full credit. However, IAs are for the practices that are working on components of transformation, and this makes additional guidance very handy, as it may help them to know which IAs fit together. One IA TEP member stressed the importance of more clarity around group participation requirements (i.e.: how many in group have to be performing the activity in order to attest to it).

Nearly all of the IA TEP members thought that the IAs would benefit from additional organization; however, they were split on what this should entail. Some felt it would be best to have a tiered structure that guided practices through practice transformation based more on where they are at without being too pejorative. Others felt that further subcategories, or ways to group the IAs that would guide practices towards exact IAs would be helpful, such as QCDR or patient engagement IAs. This would allow practices to search for more specific IAs that apply to them.

There was consensus around the need for technological flexibility to reduce barriers for data collection. IA TEP members pointed out again that there are many ways to collect patient-reported outcomes, and that practices need flexibility to find what works for them. Most of the technology that IA TEP members mentioned using does not qualify for IA credit as it does not work with their CEHRT. Many providers are not satisfied with the flexibility of their CEHRT and wish to be able to get credit for finding technology that works for their patients and their workflow.

There was further discussion into how the IAs should signal real change within practices, and how many providers see the IA requirement as more of another regulatory hurdle than as driving change. All of the IA TEP members felt positively about the IAs and their intent, but many highlighted the need for more engagement from CMS with providers. Many mentioned that practices and providers they work with need to understand the intent of these IAs to fully embrace them. A few mentioned that the points structure seemed needlessly confusing and expressed confusion around why the requirement was 40 points instead of a more intuitive point system (5 points each, for example). There was concern expressed around CMS' intentions for growing this program in the future without it feeling too overwhelming. Many expressed the desire to continue to engage with CMS on design and guidance for IAs in the future. Moreover, they encouraged CMS to engage with practices so that the process did not feel as prescriptive, or that practices were "waiting to be told" what to do.

Discussion and Recommendations

Most IA TEP members thought that the IAs fulfill their intent and are broad and applicable to many practices and providers. The feedback seems to point out that there is a broad enough range of IAs that is appropriate to a large country where many practices are in a continuum of improvement. In the future IA TEP members hope to see changes that further incentivize difficult activities that have the most benefit to patients and that add or maintain the flexibility to make improvements that work for evolving technology.

Based on IA TEP feedback, HealthInsight recommends the language change for IA_BE_1 to "Use of certified EHR and/or nationally-accredited instrument to capture patient reported outcomes" to capture the use of technology that expands data collection. HealthInsight also recommends changing the language for IA_BE_14 to "Engage patients and families to guide improvement in the process of delivering care" to lessen the emphasis on "system of care", which is a confusing term for this IA.

In addition, HealthInsight recommends the change in weighting for the IAs the IA TEP members highlighted (IA_CC_10, IA_BE_1, IA_BE_17, and IA_EPA_2), as the identified burden and cost involved in

implementing these IAs, as well as the overall benefit to patients because of their implementation, seems to warrant their higher weighting.

The organization of the IAs came up frequently during IA TEP member discussions, but there is no clear consensus around what should be done to help clarify their organization. One IA TEP member mentioned creating a future attestation category that would be a "catch-all" – where providers could submit their activity and CMS could approve it for credit or not. This seems problematic, as it may be difficult for CMS to set parameters that were clear enough as to what would and would not qualify. It would, at a minimum, be helpful for CMS to design multiple ways to search for IAs so that providers can easily find IAs that pertain to their practices. The current IA subcategories do not seem to be intuitive or helpful to guiding providers, and many IA TEP members mentioned the need to have groupings based on type of activity.

The overwhelming sentiment was more guidance was needed, and it is recommended that CMS develop more robust documentation on activities providers and practices can perform to meet the criteria for each IA. Based on IA TEP feedback, HealthInsight recommends that this includes specific examples that lay out the desired outcomes, goals and/or intention of each IA so that providers are able to connect the IA to a specific positive patient outcome or change in practice. This would lessen the feeling that IAs are just a regulatory function, or "box-checking". Providers are used to more robust levels of information for other QPP areas, such as the quality measures, and while IA TEP members stressed the need to not be too prescriptive, additional information about the IAs would help clarify their intent and guide providers that may be having difficulty.

The IA TEP members stated that CMS should be commended for developing IAs, since these activities encourage improvement. IA TEP members expressed the hope that CMS would continue to stay focused on encouraging that trend.

Appendix A: Assessment Results

Summary of the First Pre-Work Assessment

Assessment Topic	Responses
Please rate each IA based on your interest in a more in-depth discussion: (***note:*** *these differ slightly from the 20 selected IAs as they were then weighted with the QPP Service Center analysis of IAs that received the most questions and comments*)	Top rated IAs (in order from highest to lowest): • IA_CC_10 - Care transition documentation practice improvements • IA_EPA_2 - Use of telehealth services that expand practice access • IA_PSPA_7 - Use of QCDR data for ongoing practice assessment and improvements • IA_AHE_1 - Engagement of new Medicaid patients and follow-up • IA_BE_1 - Use of certified EHR to capture patient reported outcomes • IA_BE_12 - Use evidence-based decision aids to support shared decision-making • IA_BE_14 - Engage patients and families to guide improvement in the system of care • IA_BE_6 - Collection and follow-up on patient experience and satisfaction data on beneficiary engagement • IA_CC_1 - Implementation of use of specialist reports back to referring clinician or group to close referral loop • IA_CC_13 - Practice improvements for bilateral exchange of patient information • IA_BE_15 - Engagement of patients, family and caregivers in developing a plan of care • IA_PSPA_16 - Use of decision support and standardized treatment protocols • IA_AHE_2 - Leveraging a QCDR to standardize processes for screening • IA_BE_13 - Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms • IA_CC_2 - Implementation of improvements that contribute to more timely communication of test results • IA_BE_7 - Participation in a QCDR, that promotes use of patient engagement tools • IA_PM_10 - Use of QCDR data for quality improvement such as comparative analysis reports across patient populations • IA_CC_6 - Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination • IA_EPA_1 - Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record • IA_AHE_3 - Leveraging a QCDR to promote use of patient-reported outcome tools • IA_BE_17 - Use of tools to assist patient self-management
For the TEP meeting, we intend to discuss various issues impacting these IAs - burden, weighting, etc. What discussion topics related to the IAs we discuss are you most interested in, and why?	Answers (listed most frequent to least): 1) Burden 2) Weighting 3) Clarity 4) Quality Improvement/performance improvement 5) Flexibility and alignment

Summary of the Second Pre-Work Assessment
(regarding the 20 prioritized IAs)

Question: Has CMS weighted this activity correctly?

Individual IA:	No	Yes
Practice improvements for bilateral exchange of patient information. (IA_CC_13)	6	2
Care transition documentation practice improvements. (IA_CC_10)	5	3
Use of telehealth services that expand practice access. (IA_EPA_2)	5	3
Collection and follow-up on patient experience and satisfaction data on beneficiary engagement. (IA_BE_6)	4	4
Implementation of use of specialist reports back to referring clinician or group to close referral loop. (IA_CC_1)	4	4
Engagement of patients, family and caregivers in developing a plan of care. (IA_BE_15)	4	4
Leveraging a QCDR to standardize processes for screening. (IA_AHE_2)	4	4
Engage patients and families to guide improvement in the system of care. (IA_BE_14)	3	5
Use evidence-based decision aids to support shared decision-making. (IA_BE_12)	3	5
Implementation of improvements that contribute to more timely communication of test results. (IA_CC_2)	3	5
Use of QCDR data for ongoing practice assessment and improvements. (IA_PSPA_7)	2	6
Use of decision support and standardized treatment protocols. (IA_PSPA_16)	2	6
Use of QCDR data for quality improvement such as comparative analysis reports across patient populations. (IA_PM_10)	2	6
Use of tools to assist patient self-management. (IA_BE_17)	2	6
Engagement of new Medicaid patients and follow-up. (IA_AHE_1)	1	7
Leveraging a QCDR to promote use of patient-reported outcome tools. (IA_AHE_3)	1	7
Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms. (IA_BE_13)	1	7
Participation in a QCDR, that promotes use of patient engagement tools. (IA_BE_7)	1	7
Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record. (IA_EPA_1)	0	8
Use of certified EHR to capture patient reported outcomes. (IA_BE_1)	0	8

Question: Do you feel this activity is burdensome to providers/practices?

Individual IA:	No	Yes
Care transition documentation practice improvements. (IA_CC_10)	0	8
Leveraging a QCDR to standardize processes for screening. (IA_AHE_2)	0	8
Use of certified EHR to capture patient reported outcomes. (IA_BE_1)	1	7
Use of tools to assist patient self-management. (IA_BE_17)	1	7
Use evidence-based decision aids to support shared decision-making. (IA_BE_12)	2	6
Practice improvements for bilateral exchange of patient information. (IA_CC_13)	2	6
Leveraging a QCDR to promote use of patient-reported outcome tools. (IA_AHE_3)	2	6
Engagement of new Medicaid patients and follow-up. (IA_AHE_1)	2	6
Collection and follow-up on patient experience and satisfaction data on beneficiary engagement. (IA_BE_6)	2	6
Implementation of improvements that contribute to more timely communication of test results. (IA_CC_2)	3	5
Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record. (IA_EPA_1)	3	5

Individual IA:	No	Yes
Use of QCDR data for ongoing practice assessment and improvements. (IA_PSPA_7)	3	5
Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms. (IA_BE_13)	3	5
Engagement of patients, family and caregivers in developing a plan of care. (IA_BE_15)	3	5
Participation in a QCDR, that promotes use of patient engagement tools. (IA_BE_7)	3	5
Engage patients and families to guide improvement in the system of care. (IA_BE_14)	4	4
Use of decision support and standardized treatment protocols. (IA_PSPA_16)	4	4
Use of QCDR data for quality improvement such as comparative analysis reports across patient populations. (IA_PM_10)	4	4
Implementation of use of specialist reports back to referring clinician or group to close referral loop. (IA_CC_1)	5	3
Use of telehealth services that expand practice access. (IA_EPA_2)	6	2

Question: From your experience, does this activity fit easily into practices' workflows?

Individual IA:	No	Yes
Care transition documentation practice improvements. (IA_CC_10)	7	1
Leveraging a QCDR to standardize processes for screening. (IA_AHE_2)	6	2
Use of telehealth services that expand practice access. (IA_EPA_2)	6	2
Use of certified EHR to capture patient reported outcomes. (IA_BE_1)	5	3
Engagement of patients, family and caregivers in developing a plan of care. (IA_BE_15)	5	3
Use of QCDR data for ongoing practice assessment and improvements. (IA_PSPA_7)	5	3
Engage patients and families to guide improvement in the system of care. (IA_BE_14)	5	3
Leveraging a QCDR to promote use of patient-reported outcome tools. (IA_AHE_3)	5	3
Participation in a QCDR, that promotes use of patient engagement tools. (IA_BE_7)	5	3
Engagement of new Medicaid patients and follow-up. (IA_AHE_1)	4	4
Implementation of improvements that contribute to more timely communication of test results. (IA_CC_2)	4	4
Collection and follow-up on patient experience and satisfaction data on beneficiary engagement. (IA_BE_6)	4	4
Practice improvements for bilateral exchange of patient information. (IA_CC_13)	4	4
Use evidence-based decision aids to support shared decision-making. (IA_BE_12)	4	4
Use of tools to assist patient self-management. (IA_BE_17)	3	5
Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms. (IA_BE_13)	3	5
Use of QCDR data for quality improvement such as comparative analysis reports across patient populations. (IA_PM_10)	3	5
Implementation of use of specialist reports back to referring clinician or group to close referral loop. (IA_CC_1)	3	5
Use of decision support and standardized treatment protocols. (IA_PSPA_16)	2	6
Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record. (IA_EPA_1)	2	6

Question: From your experience, is this an activity that practices are already doing?

Individual IA:	No	Yes	N/A
Use of certified EHR to capture patient reported outcomes. (IA_BE_1)	0	5	3
Leveraging a QCDR to standardize processes for screening. (IA_AHE_2)	0	5	3
Leveraging a QCDR to promote use of patient-reported outcome tools. (IA_AHE_3)	1	5	2
Participation in a QCDR, that promotes use of patient engagement tools. (IA_BE_7)	1	5	2
Use of telehealth services that expand practice access. (IA_EPA_2)	1	4	3
Use of tools to assist patient self-management. (IA_BE_17)	0	4	4
Use of QCDR data for ongoing practice assessment and improvements. (IA_PSPA_7)	2	3	3
Practice improvements for bilateral exchange of patient information. (IA_CC_13)	1	3	4
Use of QCDR data for quality improvement such as comparative analysis reports across patient populations. (IA_PM_10)	2	3	3
Implementation of use of specialist reports back to referring clinician or group to close referral loop. (IA_CC_1)	1	3	4
Use of decision support and standardized treatment protocols. (IA_PSPA_16)	1	3	4
Engagement of patients, family and caregivers in developing a plan of care. (IA_BE_15)	1	3	4
Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record. (IA_EPA_1)	0	3	5
Implementation of improvements that contribute to more timely communication of test results. (IA_CC_2)	0	2	6
Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms. (IA_BE_13)	0	2	6
Collection and follow-up on patient experience and satisfaction data on beneficiary engagement. (IA_BE_6)	1	2	5
Engagement of new Medicaid patients and follow-up. (IA_AHE_1)	4	2	2
Engage patients and families to guide improvement in the system of care. (IA_BE_14)	1	2	5
Care transition documentation practice improvements. (IA_CC_10)	0	2	6
Use evidence-based decision aids to support shared decision-making. (IA_BE_12)	2	1	5

Question: Is this activity relevant and important to patients?

Individual IA:	Not at all	Less	Some-what	More	Very
Engage patients and families to guide improvement in the system of care. (IA_BE_14)	1		1	4	2
Use of QCDR data for ongoing practice assessment and improvements. (IA_PSPA_7)	1		3	3	1
Care transition documentation practice improvements. (IA_CC_10)	1	1		1	6
Use of telehealth services that expand practice access. (IA_EPA_2)			2	2	5
Use of certified EHR to capture patient reported outcomes. (IA_BE_1)			3	2	3
Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms. (IA_BE_13)			4	1	3
Engagement of patients, family and caregivers in developing a plan of care. (IA_BE_15)				3	5
Collection and follow-up on patient experience and satisfaction data on beneficiary engagement. (IA_BE_6)		1	2	3	2
Implementation of improvements that contribute to more timely communication of test results. (IA_CC_2)			1	1	6
Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record. (IA_EPA_1)			1	1	6

Individual IA:	Not at all	Less	Some-what	More	Very
Implementation of use of specialist reports back to referring clinician or group to close referral loop. (IA_CC_1)				4	4
Use evidence-based decision aids to support shared decision-making. (IA_BE_12)			3	1	4
Leveraging a QCDR to promote use of patient-reported outcome tools. (IA_AHE_3)		1	3		4
Use of decision support and standardized treatment protocols. (IA_PSPA_16)			2	2	4
Leveraging a QCDR to standardize processes for screening. (IA_AHE_2)		1	3	1	3
Use of QCDR data for quality improvement such as comparative analysis reports across patient populations. (IA_PM_10)		1	3	1	3
Use of tools to assist patient self-management. (IA_BE_17)			4	1	3
Engagement of new Medicaid patients and follow-up. (IA_AHE_1)		1	1	1	5
Practice improvements for bilateral exchange of patient information. (IA_CC_13)		1	2	2	3
Participation in a QCDR, that promotes use of patient engagement tools. (IA_BE_7)			4	1	3

Question: Does this activity fit into the subcategory in which it has been placed?

Individual IA:	No	Yes
Leveraging a QCDR to promote use of patient-reported outcome tools. (IA_AHE_3)	4	4
Leveraging a QCDR to standardize processes for screening. (IA_AHE_2)	3	5
Use of certified EHR to capture patient reported outcomes. (IA_BE_1)	2	6
Collection and follow-up on patient experience and satisfaction data on beneficiary engagement. (IA_BE_6)	2	6
Use evidence-based decision aids to support shared decision-making. (IA_BE_12)	1	7
Use of QCDR data for ongoing practice assessment and improvements. (IA_PSPA_7)	1	7
Implementation of improvements that contribute to more timely communication of test results. (IA_CC_2)	1	7
Engage patients and families to guide improvement in the system of care. (IA_BE_14)	1	7
Use of telehealth services that expand practice access. (IA_EPA_2)	1	8
Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms. (IA_BE_13)	1	7
Care transition documentation practice improvements. (IA_CC_10)	1	8
Practice improvements for bilateral exchange of patient information. (IA_CC_13)	0	8
Use of tools to assist patient self-management. (IA_BE_17)	0	8
Use of decision support and standardized treatment protocols. (IA_PSPA_16)	0	8
Implementation of use of specialist reports back to referring clinician or group to close referral loop. (IA_CC_1)	0	8
Use of QCDR data for quality improvement such as comparative analysis reports across patient populations. (IA_PM_10)	0	8
Engagement of patients, family and caregivers in developing a plan of care. (IA_BE_15)	0	8
Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record. (IA_EPA_1)	0	8
Engagement of new Medicaid patients and follow-up. (IA_AHE_1)	0	8
Participation in a QCDR, that promotes use of patient engagement tools. (IA_BE_7)	0	8

Question: Is this activity clear and understandable?

Individual IA:	No	Yes
Practice improvements for bilateral exchange of patient information. (IA_CC_13)	5	3
Collection and follow-up on patient experience and satisfaction data on beneficiary engagement. (IA_BE_6)	4	4
Engage patients and families to guide improvement in the system of care. (IA_BE_14)	4	4
Use of QCDR data for ongoing practice assessment and improvements. (IA_PSPA_7)	3	5
Use evidence-based decision aids to support shared decision-making. (IA_BE_12)	3	5
Care transition documentation practice improvements. (IA_CC_10)	3	6
Use of telehealth services that expand practice access. (IA_EPA_2)	3	6
Leveraging a QCDR to standardize processes for screening. (IA_AHE_2)	3	5
Participation in a QCDR, that promotes use of patient engagement tools. (IA_BE_7)	3	5
Leveraging a QCDR to promote use of patient-reported outcome tools. (IA_AHE_3)	2	6
Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms. (IA_BE_13)	2	6
Use of tools to assist patient self-management. (IA_BE_17)	2	6
Implementation of improvements that contribute to more timely communication of test results. (IA_CC_2)	2	6
Use of certified EHR to capture patient reported outcomes. (IA_BE_1)	2	6
Implementation of use of specialist reports back to referring clinician or group to close referral loop. (IA_CC_1)	1	7
Engagement of patients, family and caregivers in developing a plan of care. (IA_BE_15)	1	7
Use of decision support and standardized treatment protocols. (IA_PSPA_16)	0	8
Engagement of new Medicaid patients and follow-up. (IA_AHE_1)	0	8
Use of QCDR data for quality improvement such as comparative analysis reports across patient populations. (IA_PM_10)	0	8
Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record. (IA_EPA_1)	0	8

Of all of the 92 Year 1 IAs, are there any that seem to be duplicative? If so, please list them here:

- I would say overlapping. I think they should be grouped more in overarching categories than they already are. From my perspective, many fall into process or quality improvement as an overarching theme and now in the subcategories. QI and process improvement is problem solving and needs to be about giving clinicians additional tools to make improvements themselves and not be prescriptive. This is where IAs become burdensome.
- Participation in an AHRQ-listed patient safety organization (IA_PSPA_1) and Membership and participation in a CMS Partnership for Patients Hospital Engagement Network (IA_CC_5).
- IA_BE_13 and IA_BE_14 and IA_BE_6; all the QCDR IAs
- Those on QCDRs are redundant and also not familiar to many physicians.

GENERAL DYNAMICS Information Technology

HealthInsight

Merit-based Incentive Payment System (MIPS)
Improvement Activities (IA) Technical Expert Panel (TEP)

Wednesday, February 21, 2018
12:00 – 2:00 pm Pacific Standard Time

Agenda Items	Discussion Lead	Estimated Time	Objective
Welcome and Introductions	Natalya Seibel	10 minutes	Know who is on the TEP
Review of TEP Purpose and Charter • Affirm Charter with Co-Chairs	Meredith Roberts Tomasi	10 minutes	Affirm the TEP Charter Know why we are here
Relevance to Patients/Caregivers • Are the activities relevant and important to patients/caregivers?	Natalya Seibel	15 minutes	Provide actionable feedback on what is most relevant to patients/caregivers
Discussion on IA Clarity • Are the IAs understandable?	Natalya Seibel	15 minutes	Provide actionable feedback to CMS on IA clarity
Discussion on IA Burden • Are providers/clinics able to work IAs into their workflow? • Is there enough flexibility for MIPS providers to use innovative methods and technology?	Meredith Roberts Tomasi	30 minutes	Provide actionable feedback to CMS on IA burden to providers/clinics
Discussion on IA Weighting • Are the IAs weighted appropriately?	Natalya Seibel	15 minutes	Provide actionable feedback to CMS on IA weighting
Other IA Issues • In general, are the IAs fulfilling their intent? • Are there specific rules that need to be made and why? • Are there duplicative IAs? • Are there IAs that seem to be near the top edge of their improvement? • Alignment with other MIPS programs, such as ACI credit for some IAs	Meredith Roberts Tomasi	20 minutes	Provide actionable feedback on important issues for CMS to consider for IAs
Wrap-Up • Thank you for all your feedback! • This information will be included in a final report that will be posted with this TEP's information on CMS.gov • You may be called upon for further feedback in the coming week	Natalya Seibel	5 minutes	Thank TEP members and let them know there may be follow-up

Merit-based Incentive Payment System (MIPS) Improvement Activities (IA) Technical Expert Panel (TEP) Member Roster

Name, Credentials, and Professional Role	Organizational Affiliation, City, State
Amy Aronsky, D.O., FCCP, FAASM, Senior Medical Director	CareCentrix, Inc., Hartford, CT
Patrick Vance Bailey, MD, MLS, FACS, FAAP, Medical Director of Advocacy, Division of Advocacy and Health Policy	American College of Surgeons, Washington, DC
Sara Berger, MBA, Project Manager, External Metrics and Quality Reporting	Memorial Sloan Kettering Cancer Center, New York, NY
Karen R. Clark, MBA, CPHIMS, FHIMSS, Chief Information Officer	OrthoTennessee, Knoxville, TN
Jeremy Collins, MD, Chair of Performance and Quality Improvement Division	Society of Interventional Radiology, Chicago, IL
Cathy Costello, JD, CPHIMS, Director, CliniSyncPLUS Services	Ohio Health Information Partnership, Hilliard, OH
Stephen L. Davidow, MBA-HCM, CPHQ, APR, Director, Quality Improvement	PCPI Foundation, Chicago, IL
Erin C. DeLoreto, MPAP, AVP Value Based Programs	CareAllies, Piscataway, NJ
Tamarah Duperval-Brownlee MD, MPH, MBA, FAAFP, Vice President, Care Excellence	Ascension, St. Louis, MO
Amy Mullins, MD, CPE, FAAFP, Medical Director, Quality Improvement	American Academy of Family Physicians, Leawood, KS
Sheila Roman, MD, MPH, Endocrinologist	Independent Healthcare Quality Consultant, Baltimore, MD
Ted Rooney RN, MPH	Consumer, Volunteer Board member of Maine Assn. Of Area Agencies on Aging, Part-time HealthDoer Ambassador for Network for Regional Health Improvement, Brunswick, ME

Meeting Facilitators:
Meredith Roberts Tomasi, MPH, Senior Program Director, HealthInsight Oregon
Natalya Seibel, MPA, Project Manager, HealthInsight Oregon

TECHNICAL EXPERT PANEL (TEP) CHARTER

Project Title: Merit-based Incentive Payment System (MIPS) Improvement Activities (IA) Technical Expert Panel (TEP)

Date:

February 21, 2018

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with General Dynamics Information Technology (GDIT), through the Practice Improvement and Measures Management Support (PIMMS) – HHSM-500-2013-13008I, to convene a technical expert panel (TEP) around the effectiveness and accuracy of the improvement activities (IAs) included in year 1 of the Quality Payment Program under the Merit-based Incentive Payment System's (MIPS) Improvement Activities performance category. HealthInsight is the sub-contractor for this aspect of the project.

As part of its IA development process, CMS is convening a group of stakeholders and experts to contribute direction and provide thoughtful input for the improvement activity developers during improvement activity development and maintenance.

Project Objectives:

HealthInsight, through its contract with GDIT and CMS, will convene a TEP around the effectiveness and accuracy of the IAs included in year 1 of the Quality Payment Program under the MIPS Improvement Activities performance category.

TEP Objectives:

The TEP will perform a review of selected IAs, especially those about which the Quality Payment Program Service Center has been receiving comments and questions. The purpose of this review is to:

- Engage users in the design of the IAs;
- Solicit feedback on the IAs with those using them in the real world; and
- Ensure that IAs are valid, weighted correctly, and that their qualifications/criteria make sense.

Scope of Responsibilities:

The role of each TEP member is to provide advisory input to HealthInsight on IAs.

The TEP is comprised of approximately 12 clinicians and individuals with the following perspectives and areas of expertise:

- Subject matter/clinical expertise with IAs
- Consumer/patient/family (non-medical caregiver) voice
- Healthcare disparities
- Performance measurement
- Quality improvement

Duties and Role of TEP Chair/Co-Chairs: TEP Chairs will be responsible for initiating/finalizing any votes (if scheduled/called) and potentially reviewing the adjudication of any declared or identified conflicts of interest.

Duties and Role of TEP members: According to the CMS Measure Management System Blueprint, TEPs are advisory to the improvement activity contractor. In this advisory role, the primary duty of the TEP is to help prioritize and review the existing IAs, and provide input as to the validity, weighting and criteria of IAs. TEP members are expected to attend the virtual meeting, and be available for additional pre- and post-meeting activities as needed in order to support the TEP work.

The TEP will review the charter prior to the meeting, provide edits (if necessary), and affirm a final charter.

Guiding Principles:

HealthInsight will use the following criteria to assess the IAs under review:

- Burden on providers/practices
- Relevance and importance to patients
- Program appropriateness
- Appropriate weighting of IA activity
- Evidence of importance and opportunity for improvement
- Clarity
- Duplication or other issues
- Flexibility for MIPS providers to use innovative methods and technology

The TEP will engage users in the review of these IAs, solicit feedback from those using them in the real world, and ensure that the IAs are valid and weighted correctly, and that their qualifications/criteria make sense. The project team will consider the TEP's recommendations, follow up with TEP members as needed to get a full sense of the feedback given, and will convey feedback and recommendations to CMS. The project team will complete a summary

report of TEP proceedings following the meeting to highlight discussions and document recommendations.

Potential TEP members must be aware that participation on the TEP is voluntary. As such, individuals wishing to participate on the TEP should understand that their input would be recorded in the meeting minutes. Proceedings of the TEP will be summarized in a report that is disclosed to the public. If a participant has disclosed private, personal data by his or her own choice, then that material and those communications are deemed not to be covered by HIPAA confidentiality restrictions. If potential patient participants wish to keep their names confidential, that request can be accommodated. Any questions about confidentiality will be answered by HealthInsight.

*All potential TEP members must disclose any significant financial interest or other relationships that may influence their perceptions or judgment. It is unethical to conceal (or fail to disclose) conflicts of interest. However, the disclosure requirement is not intended to prevent individuals with particular perspectives or strong points of view from serving on the TEP. The intent of full disclosure is to inform the improvement activity developer, other TEP members, and CMS about the source of TEP members' perspectives and how that might affect discussions or recommendations.

Estimated Number and Frequency of Meetings:

The TEP meeting will be conducted virtually via teleconference/virtual meeting platform.

As this TEP will inform the rulemaking process, it will be conducted annually. A new TEP will be selected each year.

The length of this meeting is approximately 120 minutes. Self-directed meeting preparation time could run approximately 3-4 hours. Time for follow-up feedback may also be required.

TEP members will be asked to review meeting materials prior to the meeting. Additionally, TEP members may be called upon to review information and provide comments after the meeting.

Date Approved by TEP:

February 21, 2018

TEP Membership:

Amy Aronsky, D.O., FCCP, FAASM, Senior Medical Director

Patrick Vance Bailey, MD, MLS, FACS, FAAP, Medical Director of Advocacy, Division of Advocacy and Health Policy

Sara Berger, MBA, Project Manager, External Metrics and Quality Reporting

Karen R. Clark, MBA, CPHIMS, FHIMSS, Chief Information Officer

Jeremy Collins, MD, Chair of Performance and Quality Improvement Division; TEP Co-Chair

Cathy Costello, JD, CPHIMS, Director, CliniSyncPLUS Services

Stephen L. Davidow, MBA-HCM, CPHQ, APR, Director, Quality Improvement

Erin C. DeLoreto, MPAP, AVP Value Based Programs

Tamarah Duperval-Brownlee MD, MPH, MBA, FAAFP, Vice President, Care Excellence

Amy Mullins, MD, CPE, FAAFP, Medical Director, Quality Improvement

Sheila Roman, MD, MPH, Endocrinologist, Independent Healthcare Consultant; TEP Co-Chair

Ted Rooney RN, MPH, Consumer

Transition Year Improvement Activities (IAs) with Prioritized TEP IAs

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_CC_10 (TEP IA)	Care transition documentation practice improvements.	Implementation of practices/processes for care transition that include documentation of how a MIPS eligible clinician or group carried out a patient-centered action plan for first 30 days following a discharge (e.g., staff involved, phone calls conducted in support of transition, accompaniments, navigation actions, home visits, patient information access, etc.).	Care Coordination	Medium
IA_EPA_2 (TEP IA)	Use of telehealth services that expand practice access.	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleaudiology pilots that assess ability to still deliver quality care to patients.	Expanded Practice Access	Medium
IA_PSPA_7 (TEP IA)	Use of QCDR data for ongoing practice assessment and improvements.	Use of QCDR data, for ongoing practice assessment and improvements in patient safety.	Patient Safety and Practice Assessment	Medium
IA_BE_1 (TEP IA)	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.	Beneficiary Engagement	Medium
IA_BE_12 (TEP IA)	Use evidence-based decision aids to support shared decision-making.	Use evidence-based decision aids to support shared decision-making.	Beneficiary Engagement	Medium
IA_BE_14 (TEP IA)	Engage patients and families to guide improvement in the system of care.	Engage patients and families to guide improvement in the system of care.	Beneficiary Engagement	Medium
IA_BE_6 (TEP IA)	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.	Beneficiary Engagement	High
IA_CC_1 (TEP IA)	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.	Care Coordination	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_CC_13 (TEP IA)	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.	Care Coordination	Medium
IA_BE_15 (TEP IA)	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.	Beneficiary Engagement	Medium
IA_PSPA_16 (TEP IA)	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.	Patient Safety and Practice Assessment	Medium
IA_BE_7 (TEP IA)	Participation in a QCDR, that promotes use of patient engagement tools.	Participation in a QCDR, that promotes use of patient engagement tools.	Beneficiary Engagement	Medium
IA_PM_10 (TEP IA)	Use of QCDR data for quality improvement such as comparative analysis reports across patient populations.	Participation in a QCDR, clinical data registries, 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).	Population Management	Medium
IA_AHE_3 (TEP IA)	Leveraging a QCDR to promote use of patient-reported outcome tools.	Participation in a QCDR, demonstrating performance of activities for promoting use of patient-reported outcome (PRO) tools and corresponding collection of PRO data (e.g., use of PQH-2 or PHQ-9 and PROMIS instruments).	Achieving Health Equity	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_EPA_1 (TEP IA)	Provide 24/7 access to 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 and emergent care (e.g., 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 consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.	Expanded Practice Access	High
IA_AHE_1 (TEP IA)	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.	Achieving Health Equity	High
IA_BE_13 (TEP IA)	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.	Beneficiary Engagement	Medium
IA_BE_17 (TEP IA)	Use of tools to assist patient self-management.	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).	Beneficiary Engagement	Medium
IA_CC_2 (TEP IA)	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.	Care Coordination	Medium
IA_AHE_2 (TEP IA)	Leveraging a QCDR to standardize processes for screening.	Participation in a QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health such as food security, employment and housing. Use of supporting tools that can be incorporated into the certified EHR technology is also suggested.	Achieving Health Equity	Medium
IA_AHE_4	Leveraging a QCDR for use of standard questionnaires.	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).	Achieving Health Equity	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_BE_10	Participation in a QCDR, that promotes implementation of patient self-action plans.	Participation in a QCDR, that promotes implementation of patient self-action plans.	Beneficiary Engagement	Medium
IA_BE_11	Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan.	Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan.	Beneficiary Engagement	Medium
IA_BE_16	Evidenced-based techniques to promote self-management into usual care.	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.	Beneficiary Engagement	Medium
IA_BE_18	Provide peer-led support for self-management.	Provide peer-led support for self-management.	Beneficiary Engagement	Medium
IA_BE_19	Use group visits for common chronic conditions (e.g., diabetes).	Use group visits for common chronic conditions (e.g., diabetes).	Beneficiary Engagement	Medium
IA_BE_2	Use of QCDR to support clinical decision making.	Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision-making capabilities.	Beneficiary Engagement	Medium
IA_BE_20	Implementation of condition-specific chronic disease self-management support programs.	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.	Beneficiary Engagement	Medium
IA_BE_21	Improved practices that disseminate appropriate self-management materials.	Provide self-management materials at an appropriate literacy level and in an appropriate language.	Beneficiary Engagement	Medium
IA_BE_22	Improved practices that engage patients pre-visit.	Provide a pre-visit development of a shared visit agenda with the patient.	Beneficiary Engagement	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_BE_23	Integration of patient coaching practices between visits.	Provide coaching between visits with follow-up on care plan and goals.	Beneficiary Engagement	Medium
IA_BE_3	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.	Beneficiary Engagement	Medium
IA_BE_4	Engagement of patients through implementation of improvements in patient portal.	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.	Beneficiary Engagement	Medium
IA_BE_5	Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities.	Enhancements and ongoing regular updates and use of websites/tools that include consideration for compliance 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.	Beneficiary Engagement	Medium
IA_BE_8	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.	Beneficiary Engagement	Medium
IA_BE_9	Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.	Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.	Beneficiary Engagement	Medium
IA_BMH_1	Diabetes screening.	Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.	Behavioral and Mental Health	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
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 NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at-risk factors for tobacco dependence.	Behavioral and Mental Health	Medium
IA_BMH_3	Unhealthy alcohol use.	Unhealthy alcohol use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including screening and brief counseling (refer to NQF #2152) for patients with co-occurring conditions of behavioral or mental health conditions.	Behavioral and Mental Health	Medium
IA_BMH_4	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.	Behavioral and Mental Health	Medium
IA_BMH_5	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.	Behavioral and Mental Health	Medium
IA_BMH_6	Implementation of co-location PCP and MH services.	Integration facilitation, and promotion of the colocation of mental health services in primary and/or non-primary clinical care settings.	Behavioral and Mental Health	High
IA_BMH_7	Implementation of integrated PCBH model.	Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions that 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 services; Ensure regular communication and coordinated workflows between 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 certified health information technology functionality to support active care management and outreach to patients in treatment; and/or Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.	Behavioral and Mental Health	High

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_BMH_8	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).	Behavioral and Mental Health	Medium
IA_CC_11	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.	Care Coordination	Medium
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.	Care Coordination	Medium
IA_CC_14	Practice improvements that engage community resources to support patient health goals.	Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following: Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; and/or Provide a guide to available community resources.	Care Coordination	Medium
IA_CC_3	Implementation of additional activity as a result of TA for improving care coordination.	Implementation of at least one additional recommended activity from the Quality Innovation Network-Quality Improvement Organization after technical assistance has been provided related to improving care coordination.	Care Coordination	Medium
IA_CC_4	TCPI participation.	Participation in the CMS Transforming Clinical Practice Initiative.	Care Coordination	High

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_CC_5	CMS partner in Patients Hospital Improvement Innovation Networks.	Membership and participation in a CMS Partnership for Patients Hospital Improvement Innovation Network.	Care Coordination	Medium
IA_CC_6	Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination.	Participation in a Qualified Clinical Data Registry, 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).	Care Coordination	Medium
IA_CC_7	Regular training in care coordination.	Implementation of regular care coordination training.	Care Coordination	Medium
IA_CC_8	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).	Care Coordination	Medium
IA_CC_9	Implementation of practices/processes for developing regular individual care plans.	Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s).	Care Coordination	Medium
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.	Expanded Practice Access	Medium
IA_EPA_4	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 (e.g., investment of on-site diabetes educator).	Expanded Practice Access	Medium
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.	Emergency Response and Preparedness	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
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 attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater.	Emergency Response and Preparedness	High
IA_PM_1	Participation in systematic anticoagulation program.	Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, patient self-management program) for 60 percent of practice patients in year 1 and 75 percent of practice patients in year 2 who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors).	Population Management	High
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 professional'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.	Population Management	Medium
IA_PM_12	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.	Population Management	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_PM_13	Chronic care and preventative care management for empaneled patients.	Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: 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; plan of care for chronic conditions; and advance care planning; Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target; Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions; Use panel support tools (registry functionality) to identify services due; 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.	Population Management	Medium
IA_PM_14	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.	Population Management	Medium
IA_PM_15	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.	Population Management	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_PM_16	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.	Population Management	Medium
IA_PM_2	Anticoagulant management improvements.	MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, in the first performance year, 60 percent or more of their ambulatory care patients receiving warfarin are being managed by one or more of these clinical practice improvement activities: Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care*, incorporating comprehensive patient education, systematic 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 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 INR testing, tracking, follow-up, and patient communication of results and dosing decisions; and/or For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program. The performance threshold will increase to 75 percent for the second performance year and onward. Clinicians would attest that, 60 percent for first year, or 75 percent for the second year, of their ambulatory care patients receiving warfarin participated in an anticoagulation management program for at least 90 days during the performance period.	Population Management	High

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_PM_3	RHC, IHS or FQHC quality improvement activities.	Participating in a Rural Health Clinic (RHC), Indian Health Service (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.	Population Management	High
IA_PM_4	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 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.	Population Management	High
IA_PM_5	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 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.	Population Management	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_PM_6	Use of toolsets or other resources to close healthcare disparities across communities.	Take steps to improve healthcare disparities, such as Population Health Toolkit or other resources identified by CMS, the Learning and Action Network, Quality Innovation Network, or National Coordinating Center. 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 select from for satisfying this activity. QIOs work under the direction of CMS to assist eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	Population Management	Medium
IA_PM_7	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.	Population Management	High
IA_PM_8	Participation in CMMI models such as Million Hearts Campaign.	Participation in CMMI models such as the Million Hearts Cardiovascular Risk Reduction Model.	Population Management	Medium
IA_PM_9	Participation in population health research.	Participation in research that identifies interventions, tools or processes that can improve a targeted patient population.	Population Management	Medium
IA_PSPA_1	Participation in an AHRQ-listed patient safety organization.	Participation in an AHRQ-listed patient safety organization.	Patient Safety and Practice Assessment	Medium
IA_PSPA_10	Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments.	Completion of training and obtaining an approved waiver for provision of medication-assisted treatment of opioid use disorders using buprenorphine.	Patient Safety and Practice Assessment	Medium
IA_PSPA_11	Participation in CAHPS or other supplemental questionnaire.	Participation in the Consumer Assessment of Healthcare Providers and Systems Survey or other supplemental questionnaire items (e.g., Cultural Competence or Health Information Technology supplemental item sets).	Patient Safety and Practice Assessment	High
IA_PSPA_12	Participation in private payer CPIA.	Participation in designated private payer clinical practice improvement activities.	Patient Safety and Practice Assessment	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_PSPA_13	Participation in Joint Commission Evaluation Initiative.	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative.	Patient Safety and Practice Assessment	Medium
IA_PSPA_14	Participation in Bridges to Excellence or other similar program.	Participation in other quality improvement programs such as Bridges to Excellence.	Patient Safety and Practice Assessment	Medium
IA_PSPA_15	Implementation of antibiotic stewardship program.	Implementation of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions (URI Rx in children, diagnosis of pharyngitis, Bronchitis Rx in adults) according to clinical guidelines for diagnostics and therapeutics.	Patient Safety and Practice Assessment	Medium
IA_PSPA_17	Implementation of analytic capabilities to manage total cost of care for practice population.	Build the analytic capability required to manage total cost of care for the practice population that could include one or more of the following: Train appropriate staff on interpretation of cost and utilization information; and/or Use available data regularly to analyze opportunities to reduce cost through improved care.	Patient Safety and Practice Assessment	Medium
IA_PSPA_18	Measurement and improvement at the practice and panel level	Measure and improve quality at the practice and panel level 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.	Patient Safety and Practice Assessment	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
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.	Patient Safety and Practice Assessment	Medium
IA_PSPA_2	Participation in MOC Part IV.	Participation in Maintenance of Certification (MOC) Part IV for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program. Performance of monthly activities across practice to regularly assess performance in practice, by reviewing outcomes addressing identified areas for improvement and evaluating the results.	Patient Safety and Practice Assessment	Medium
IA_PSPA_20	Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes.	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.	Patient Safety and Practice Assessment	Medium
IA_PSPA_21	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).	Patient Safety and Practice Assessment	Medium

ACTIVITY ID	ACTIVITY NAME	ACTIVITY DESCRIPTION	SUBCATEGORY NAME	WEIGHT
IA_PSPA_3	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS(R) or other similar activity.	For eligible professionals not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS®.	Patient Safety and Practice Assessment	Medium
IA_PSPA_4	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).	Patient Safety and Practice Assessment	Medium
IA_PSPA_5	Annual registration in the Prescription Drug Monitoring Program.	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 6 months.	Patient Safety and Practice Assessment	Medium
IA_PSPA_6	Consultation of the Prescription Drug Monitoring program.	Clinicians would attest that, 60 percent for first year, or 75 percent for the second year, of consultation of prescription drug monitoring program prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription that lasts for longer than 3 days.	Patient Safety and Practice Assessment	High
IA_PSPA_8	Use of patient safety tools.	Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of the Surgical Risk Calculator.	Patient Safety and Practice Assessment	Medium
IA_PSPA_9	Completion of the AMA STEPS Forward program.	Completion of the American Medical Association's STEPS Forward program.	Patient Safety and Practice Assessment	Medium