OEIS National Registry 2021 Recommended Improvement Activities

Activity Name	Activity Description	Activity ID	Subcategory Name	Activity Weighting	Objective & Validation Documentation
Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: • Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); • Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or • Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.	IA_EPA_1	Expanded Practice Access	High	Objective: Increase patient access to eligible clinicians who work in an outpatient setting with the goal of reducing unnecessary emergency room visits. Validation Documentation: Evidence of demonstrated patient care provided outside of normal business hours through expanded practice hours and by eligible clinicians with real-time access to patient's electronic health record (EHR), or that patients received needed urgent or transitional care in a timely way. Expanded Business Hours are defined as hours that are outside of a practice's standard business hours of operation. Include at least one of the following elements: 1) **Patient record from EHR** – A patient record from an EHR with date and timestamp indicating services provided outside of the practice's normal business hours for that eligible clinician (a certified EHR may be used for documentation purposes, but is not required unless attesting for the Promoting Interoperability bonus); OR 2) **Patient encounter/medical record/claim** – Patient encounter/medical record/claim indicating patient was seen or services provided outside of the practice's normal business hours for that eligible clinician including use of telehealth visits; OR 3) **Same or next-day patient encounter/medical record/claim** – Patient encounter/medical record/claim indicating patient was seen same-day or next-day by the eligible clinician or practice initially contacted for urgent or transitional care.
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.	IA_PM_7	Population Management	High	Objective: Increase knowledge of practice patterns and treatment outcomes to better serve patients, including vulnerable populations. Validation Documentation: Evidence of use of qualified clinical data registry (QCDR) data and support to identify local/geographical practice patterns and clinical outcomes, particularly among underserved, vulnerable, and special-needs populations. By vulnerable populations/patients, CMS is referring to racial and ethnic minorities, refugees, those who are elderly, financially disadvantaged, or without health insurance, and those who have a disability or medical condition which are associated with disparities in outcomes across populations. Include at least one of the following elements: 1) **QCDR agreement** – Documented arrangement with a QCDR to generate feedback reports summarizing local practice patterns and treatment outcomes, including for vulnerable populations; OR 2) **Feedback reports** – Copies of feedback reports provided by a QCDR that summarize local practice patterns and treatment outcomes with focus on vulnerable populations.
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.	IA_BE_1	Beneficiary Engagement	Medium	Objective: Improve patient engagement through patient/clinician review of patient collected information or through assessment of a patient's understanding, confidence, and ability to perform self-care. Validation Documentation: Evidence of patient reported data and/or outcomes in the electronic health record (EHR). Include the following element: 1) **Patient reported outcomes/self-management** – Documentation demonstrating use of a tool that assesses a patient's understanding, confidence, and ability to care for one's self. Examples of a tool may include Patient Activation Measures, HowsYourHealth.org, HealthConfidence.org, and MedicareHealthAssess.org. The eligible clinician should incorporate the results of the assessment into the patient's overall plan of care, as deemed most appropriate for their population. As necessary or helpful, also include patient's data in the certified EHR.
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.	IA_BE_6	Beneficiary Engagement	High	Objective: Improve patients' experience of and satisfaction with care by gathering and applying learnings from relevant data. Validation Documentation: Evidence that patient experience and satisfaction data are collected and that follow-up occurs through an improvement plan. Include at least two of the following elements: 1) **Report of patient experience and satisfaction** – Report including collected data on patient experience and satisfaction (e.g., survey results). The eligible clinician or practice must use a third-party administrator; AND/OR 2) **Follow-up on patient experience and satisfaction** – Documentation of follow-up on patient experience and satisfaction (e.g., specific improvements made to practices/processes in response to survey results); AND/OR 3) **Patient experience and satisfaction improvement plan** – Documentation of a patient experience and satisfaction improvement plan. Example/Information: • A third-party administrator offers patients of the practice the option to fill out a questionnaire after their visit. A) The practice finds that a consistent complaint is the long wait times and that the practice is losing patients as a result. The practice develops a plan to address wait times. B) The practice finds that there are multiple complaints about a single eligible clinician that include poor listening skills and a tendency to rush in and out of the room so fast that questions are not answered. The practice creates an education plan for the eligible clinician and also identifies and addresses environmental issues that lead the eligible clinician to feel pressure to rush through patient visits. • Available surveys: https://www.rand.org/health-care/surveys_tools/psq.html.
Use of QCDR data for ongoing practice assessment and improvements	Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including: • Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups); • Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment); • Use of standardized processes for screening for social determinants of health such as food security, employment, and housing; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology; or • Use of QCDR data for quality improvement such as comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes.	IA_PSPA_7	Patient Safety and Practice Assessment	Medium	Objective: Use qualified clinical data registry (QCDR) data for practice assessment and improvement with primary goal of addressing patient safety for targeted populations. Validation Documentation: Documented use of QCDR data for ongoing practice assessment and improvements in patient safety. Include both of the following elements: 1) **Use of QCDR for assessment** – Feedback reports provided by the QCDR that demonstrate ongoing practice assessments in patient safety; AND 2) **Use of QCDR for improvement** – Documentation of how the practice is using QCDR data and documentation of intended improvements in patient safety for the specific populations targeted (e.g., documentation of standard tools, processes for screening, use of standard questionnaires, or use of QCDR data that are used for quality improvement, such as population-level analysis to assess for adverse outcomes). Example: An anesthesia group is supported by a QCDR for quality improvement and MIPS reporting. The QCDR provides routine data feedback reports to the eligible clinicians as part of the engagement. In one of the areas of review, the anesthesiologists realize, through the provided data, that they are inconsistently providing appropriately timed dosing of neuromuscular blocker recovery medication. This creates significant potential for complications at the time of extubation following the procedure. As a result, the anesthesiology group develops a plan that includes checklists to prevent this problem moving forward and they successfully eliminate the safety risk.