aapm&r
American Academy of Physical Medicine and Rehabilitation

MIPS

IA Guide

Improvement Activities Guide

The Improvement Activities (IA) performance category assesses participation in activities that are designed to improve clinical practice. The IA category generally accounts for 15 percent of the MIPS composite score. You must attest to engaging in specific activities for a minimum of 90 days. How many activities you are required to report depends on many factors, including the size of your practice and whether your practice is in a rural or underserved area.

GENERAL REQUIREMENTS:

- **Most participants:** Attest that you completed two to four improvement activities, totaling 40 points, for a minimum of 90 days to receive full credit under this category.
  - » Medium-weighted activities receive credit for 10 points toward the total possible category score.
  - » High-weighted activities receive credit for 20 points toward the total possible category score.

SPECIAL ACCOMMODATIONS:

- **Participants in practices with 15 or fewer eligible clinicians or in TINs designated as being in a rural or health professional shortage area:** Attest that you completed one high-weighted improvement activity or two medium-weighted improvement activities for a minimum of 90 days to receive full credit. If participating in MIPS at the group level, more than 75 percent of the clinicians billing under your TIN must be located in a rural or health professional shortage area in order to receive this accommodation, or your practice must be designated as a small practice by CMS for the 2021 performance period.
- **Participants in certified patient-centered medical homes, comparable specialty practices, or an Alternative Payment Model (APM) designated as a Medical Home Model:** You will automatically earn full credit in the IA performance category. If participating in MIPS at the group level, at least 50 percent of the practice sites within your TIN must be recognized as a patient-centered medical home or comparable specialty practice in order to receive this accommodation.
- **Participants in APMs qualifying for special scoring under MIPS, such as the Shared Savings Program or Oncology Care Model:** If you are a participant in a MIPS APM, you may opt to participate in MIPS under the APM Performance Pathway (APP) at either the individual, group, or APM Entity level. If so, you will automatically be assigned full credit under the IA performance category, except in rare cases where the APM Entity failed to complete the required IAs and any associated corrective action plan. If you opt to report via traditional MIPS, you will automatically earn half credit under the IA performance category and may report additional activities to increase your score.
- **Participants in any other APM:** You will automatically earn half credit under the IA performance category and may report additional activities to increase your score.

Group-level reporting: Starting with performance year 2020, CMS updated the requirements for completion of improvement activities for a group to receive credit. In previous years, if a single MIPS eligible clinician completed an improvement activity for 90 consecutive days, the entire group could claim the improvement activity and receive credit. However, for 2020 onward, at least 50 percent of the clinicians billing under the TIN must complete the improvement activity for at least 90 consecutive days for the group to receive credit; individual clinicians in the group are not required to all complete the same improvement activity over the same 90-day period.

MIPS eligible clinicians can choose from an inventory of more than 100 CMS-approved improvement activities. Below is a list of activities that may be applicable to physiatrists. However, you are encouraged to review the entire inventory to see which activities are most relevant to your practice.

healthpolicy@aapmr.org

QPP IA ID NUMBER	WEIGHT	IMPROVEMENT ACTIVITIES THAT COULD BE APPLICABLE TO AAPM&R REGISTRY PARTICIPANTS	SUGGESTED DOCUMENTATION*
IA_PM_7	High	Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.	Participation in QCDR for population health, e.g., regular feedback reports provided by QCDR that summarize local practice patterns and treatment outcomes, including vulnerable populations.
IA_PM_15	Medium	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. Managing care intensively through new diagnoses, injuries and exacerbations of illness.	1) Follow-Up on Hospitalizations, ED or Other Visits and Medication Management - Routine and timely follow-up to hospitalizations, ED or other institutional visits, and medication reconciliation and management (e.g., documented in medical record or EHR); or 2) New diagnoses, Injuries and Exacerbations - Care management through new diagnoses, injuries and exacerbations of illness (medical record).
IA_PM_16	Medium	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; Conduct periodic, structured medication reviews.	1) Documented Medication Reviews or Reconciliation - Patient medical records demonstrating periodic structured medication reviews or reconciliation; or 2) Integrated Pharmacist - Evidence of pharmacist integrated into care team; or 3) Reconciliation Across Transitions - Reconciliation and coordination of mediations across transitions of care; or 4) Medication Management Improvement Plan - Report detailing medication management practice improvement plan and outcomes, if available.
IA_PM_17	Medium	Participation in federally- and/or privately-funded research that identifies interventions, tools, or processes that can improve a targeted patient population.	1) Documentation of participation in a federally and/or privately funded research initiative; and 2) Documentation of the interventions, tools, or processes used in the research; and 3) Documentation of the identified target population, and health outcomes targeted.
IA_CC_1	Medium	Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.	1) Specialist Reports to Referring Clinician - Sample of specialist reports reported to referring clinician or group (e.g., within EHR or medical record); or 2) Specialist Reports from Inquiries in Certified EHR - Specialist reports documented in inquiring clinicians certified EHR or medical records.
IA_CC_2	Medium	Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.	EHR reports or medical records demonstrating timely communication of abnormal test results to patient (capturing the communication rate and working toward improvement of that rate).

** Note that the suggested documentation reflects CMS guidance for 2020 that is available here.*

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IA_CC_8	Medium	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).	Documentation of the implementation of practices/processes that document care coordination activities, e.g., documented care coordination encounter that tracks clinical staff involved and communications from date patient is scheduled through day of procedure.
IA_CC_9	Medium	Implementation of practices/processes, including a discussion on care, to develop regularly-updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s). Individual care plans should include consideration of a patient's goals and priorities, as well as desired outcomes of care.	1) Individual Care Plans for At-Risk Patients - Documented practices/processes for developing regulary-updated individual care plans for at-risk patients, e.g., template care plan; and 2) Use of Care Plan with Beneficiary - Patient medical records demonstrating care plan being shared with beneficiary or caregiver, including consideration of a patient's goals and priorities, social risk factors, language and communication preferences, physical or cognitive limitations, as well as desired outcomes of care.
IA_CC_15	Medium	Participation in a Perioperative Surgical Home (PSH) that provides a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated patient care, which coordinates care from pre-procedure assessment through the acute care episode, recovery, and post-acute care. This activity allows for reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a PSH. The clinician must perform one or more of the following care coordination activities: • Coordinate with care managers/ navigators in preoperative clinic to plan and implementation comprehensive post discharge plan of care; • Deploy perioperative clinic and care processes to reduce post-operative visits to emergency rooms; • Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients; or • Implement processes to ensure effective communications and education of patients' post-discharge instructions.	1) Coordinate with care managers/navigators in preoperative clinic to plan and implement comprehensive post discharge plan of care that could take into account patients' post discharge environment and support system out of the hospital; and 2) Deploy perioperative clinic and care processes to reduce post -operative visits to emergency rooms; and 3) Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients; and 4) Implement processes to ensure effective communications and education of patients' post-discharge instructions, taking into account patients' literacy level, language and communication preferences, and cognitive or functional impairments.

** Note that the suggested documentation reflects CMS guidance for 2020 that is available here.*

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IA_CC_18	Medium	Participate in a minimum of eight hours of training on relationship-centered care tenets such as making effective open-ended inquiries; eliciting patient stories and perspectives; listening and responding with empathy; using the ART (ask, respond, tell) communication technique to engage patients, and developing a shared care plan. The training may be conducted in formats such as, but not limited to: interactive simulations practicing the skills above, or didactic instructions on how to implement improvement action plans; monitor progress; and promote stability around improved clinician communication.	1) MIPS eligible clinicians and groups must demonstrate a minimum of eight hours of training utilizing the ask, respond, tell (ART) communication technique and; 2) Provide documentation promoting relationship-centered care, open-ended inquiries, patient perspectives, and storytelling the emphasizes active listening, empathy, and patient engagement in the development of a shared plan of care.
IA_CC_19	High	Attest to reporting MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a minimum of a continuous 90-day period within the performance period. Reporting the PRC modifiers enables the identification of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service.	The MIPS eligible clinician or group must demonstrate with documentation that the provider implemented Patient Relationship Codes (PRC) applicable to HCPCS modifiers within their processes of care. Documentation could be captured in the patient chart or EHR note that the MIPS eligible clinician reported MACRA PRC using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a continuous 90-day minimum reporting period within the performance year.
IA_BE_4	Medium	Provide access to an enhanced patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange. The primary use of this portal should be clinical and not administrative. Examples of the use of such a portal include, but are not limited to: brief patient reevaluation by messaging; communication about test results and follow up; communication about medication adherence, side effects, and refills; blood pressure management for a patient with hypertension; blood sugar management for a patient with diabetes; or any relevant acute or chronic disease management.	Documentation through screenshots or reports of an enhanced patient portal, e.g., portal functions that provide up-to-date information related to chronic disease health or blood pressure control, interactive features allowing patients to enter health and demographic information (e.g., race/ethnicity, sexual orientation, sex, gender identity, disability), and/or bidirectional communication about medication changes and adherence.
IA_BE_6	High	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.	1) Follow-Up on Patient Experience and Satisfaction - Documentation of collection and follow-up on patient experience and satisfaction (e.g., survey results) which must be administered by a third-party survey administrator/vendor; and 2) Patient Experience and Satisfaction Improvement Plan - Documented patient experience and satisfaction improvement plan.

** Note that the suggested documentation reflects CMS guidance for 2020 that is available here.*

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IA_BE_13	Medium	Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms.	Documentation (e.g., survey results, advisory council notes and/or other methods) showing regular assessments of the patient care experience to improve the experience, taking into account specific populations served and including them in this assessment, such as identified vulnerable populations. Surveys should be administered independently to the best extent possible.
IA_BE_15	Medium	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the EHR technology.	Report from the certified EHR, showing the plan of care and prioritized goals for action with engagement of the patient, family and caregivers, if applicable.
IA_BE_16	Medium	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.	Documented evidence-based techniques to promote self-management into usual care; and evidence of the use of the techniques (e.g., clinicians' completed office visit checklist, EHR report of completed checklist, copies of goal setting tools or techniques, motivational interviewing script/questions, action planning tool with patient feedback).
IA_BE_25	High	Attest that the practice provides counseling to patients and/or their caregivers about the costs of drugs and the patients' out-of-pocket costs for the drugs. If appropriate, also explore with patients the availability of alternative drugs and patients' eligibility for patient assistance programs that provide free medications to people who cannot afford to buy their medicine. One source of information for pricing of pharmaceuticals could be a real-time benefit tool (RTBT), which provides to the prescriber, real-time patient specific formulary and benefit information for drugs, including cost-sharing for a beneficiary.	1) Documentation could include an EHR note that the MIPS eligible clinician provided counseling to patients and/or caregivers about the costs of drugs including the patient's out-of-pocket costs for the drugs; and/or 2) The MIPS eligible clinician or group must demonstrate with documentation within the RTBT or EHR that a discussion/counseling regarding the availability of alternative drugs, and (when applicable) a patient's eligibility for patient assistance programs that provide free medications for patients occurred. NOTE: For the purposes of this IA, patient assistance programs pertain to financially needy patients that require assistance to purchase necessary medications, i.e., www.rxassist.org/providers. Additional information pertaining to real-time benefit checks and its impact on patient care can be reviewed here.

** Note that the suggested documentation reflects CMS guidance for 2020 that is available here.*

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IA_PSPA_2	Medium	Participate in Maintenance of Certification® (MOC) Part IV. MOC Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results. Some examples of activities that can be completed to receive MOC Part IV credit are: the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program; specialty-specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules.	1) Documentation of participation in Maintenance of Certification® (MOC) Part IV from an American Board of Medical Specialties (ABMS) member board such as the American Board of Internal Medicine (ABIM) Approved Quality improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, including participation in a local, regional or national outcomes registry or quality assessment program; and specialty-specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules; and 2) Monthly Activities to Assess Performance - Documented performance of monthly activities across practice to assess performance in practice by reviewing outcomes, addressing areas of improvement, and evaluating the results.
IA_PSPA_6	High	Consultation of the Prescription Drug Monitoring Program (PDMP). Clinicians would attest to reviewing the patients' history of controlled substance prescription using state PDMP data prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription lasting longer than 3 days. For the Quality Payment Program Year 2 and future years, clinicians would attest to 75 percent review of applicable patient's history performance.	1) Number of Issuances of CSII Prescription - Total number of issuances of a CSII prescription that lasts longer than 3 days over the same time period as those consulted; and 2) Documentation of Consulting the PDMP - Total number of patients for which there is evidence of consulting the PDMP prior to issuing an CSII prescription (e.g., copies of patient reports created, with the PHI masked).

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IA_PSPA_19	Medium	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following such as: Participation in Multi-Source Feedback; Train all staff in quality improvement methods; Integrate practice change/ quality improvement into staff duties; Engage all staff in identifying and testing practices changes; Designate regular team meetings to review data and plan improvement cycles; Promote transparency and accelerate improvement by sharing practice level and panel level quality-of-care, patient experience and utilization data with staff; Promote transparency and engage patients and families by sharing practice level quality-of-care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data; Participate in Bridges to Excellence; and/or Participate in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.	1) Adopt Formal Quality Improvement Model and Create Culture of Improvement - Documentation of adoption of a formal model for quality improvement and creation of a culture in which staff actively participate in improvement activities; and 2) Staff Participation - Documentation of staff participation in one or more of the six identified; including, training, integration into staff duties, identifying and testing practice changes, regular team meetings to review data and plan improvement cycles, share practice and panel level quality-of-care, patient experience and utilization data with staff, or share practice level quality-of-care, patient experience and utilization data with patients and families.
IA_PSPA_20	Medium	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 Incorporate population health, quality and patient experience metrics in regular reviews of practice performance.	1) Clinical and Administrative Leadership Role Descriptions - Documentation of clinical and administrative leadership role descriptions include responsibility for practice improvement change (e.g., position description); or; 2) Time for Leadership in Improvement Activities - Documentation of allocated time for clinical and administrative leadership participating in improvement efforts, e.g., regular team meeting agendas and post meeting summary; or; 3) Population Health, Quality, and Health Experience Incorporated into Performance Reviews - Documentation of population health, quality and health experience metrics incorporated into regular practice performance reviews, e.g., reports, agendas, analytics, meeting notes.
IA_PSPA_21	Medium	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).	1) Implementation of a Falls Screening and Assessment Program - Implementation of a falls screening and assessment program that uses valid and reliable tools to identify patients at risk for falls and address modifiable risk factors, for example, the STEADI program for identification of falls risk; and 2) Implementation Progress- Documentation of progress made on falls screening and assessment after implementation of tool.

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IA_PSPA_28	Medium	Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information.	Documentation that the activity addresses a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements and provide participant completion information.
IA_PSPA_31	High	In order to receive credit for this activity, MIPS eligible clinicians must provide both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use for patients who are prescribed both benzodiazepines and opioids. Education must be completed for at least 75 percent of qualifying patients and occur: (1) at the time of initial co-prescribing and again following greater than 6 months of co-prescribing of benzodiazepines and opioids, or (2) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.	Education must be completed for at least 75 percent of qualifying patients and occur as follows: 1) at the time of initial co-prescribing and again following greater than 6 months of co-prescribing of benzodiazepines and opioids, or 2) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.
IA_PSPA_32	High	In order to receive credit for this activity, MIPS eligible clinicians must utilize the Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain via clinical decision support (CDS). For CDS to be most effective, it needs to be built directly into the clinician workflow and support decision-making on a specific patient at the point-of-care. Specific examples of how the guideline could be incorporated into a CDS workflow include, but are not limited to: electronic health record (EHR)-based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.	1) Eligible clinicians or groups utilizing CDS must build the capability directly into the clinician workflow and document the support decision making on patients during the 90 day or year-long attestation period at the point of care; and 2) Document specific examples of how the guideline is incorporated into a CDS workflow. This may include, but is not limited to: electronic health record (EHR)-based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.

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IA_BMH_2	Medium	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.	Report from EHR, QCDR, clinical registry or documentation from medical charts showing regular practice of tobacco screening for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.
IA_BMH_4	Medium	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.	Report from EHR, QCDR, clinical registry or documentation from medical charts showing regular practice for depression screening and follow-up plan for these patients with co-conditions of behavioral or mental health.
IA_ERP_3	High	Participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report findings through a clinical data repository or clinical data registry for the duration of the study; OR participate in the care of patients diagnosed with COVID-19 and simultaneously submit relevant clinical data to a clinical data registry for ongoing or future COVID-19 research. Additional requirements apply.	A screenshot capture of the MIPS eligible clinician or group's submission to the participating clinical data repository/registry.

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