Documented use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or telemedicine visits that assess ability to deliver quality care to patients.

Medium

Use of telehealth services and participation in data analysis assessing provision of quality care with these services.

High

Use of telehealth services and coordination with other health systems in the local community.

Medium

Use of telehealth services and participation in data analysis assessing provision of quality care with these services.

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Use of telehealth services and participation in data analysis assessing provision of quality care with these services.

Medium

Use of telehealth services and coordination with other health systems in the local community.

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Use of telehealth services and participation in data analysis assessing provision of quality care with these services.

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Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or telemedicine visits that assess ability to deliver quality care to patients.

Medium

Use of telehealth services and coordination with other health systems in the local community.

High

Use of telehealth services and participation in data analysis assessing provision of quality care with these services.

High

Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or telemedicine visits that assess ability to deliver quality care to patients.

Medium

Use of telehealth services for feedback and improvement activities.

High

Use of telehealth services for feedback and improvement activities.

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Use of telehealth services for feedback and improvement activities.

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Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or telemedicine visits that assess ability to deliver quality care to patients.

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Use of telehealth services and coordination with other health systems in the local community.

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Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or telemedicine visits that assess ability to deliver quality care to patients.

High

Use of telehealth services and coordination with other health systems in the local community.

High

Use of telehealth services and participation in data analysis assessing provision of quality care with these services.
Population Management

- Participation in population health research
- Medication reconciliation and management for high-risk patients
- Routine medication reconciliation
- Use of reminders and outreach to alert and educate patients about services due; and/or
- Use of routine medication reconciliation

- Documentation of implemented regular care coordination training within practice, e.g., training materials with follow-up.
- Training materials, face-to-face, or virtual meetings demonstrating timely communication of abnormal test results to patient

- Implementation of additional activity as a result of TF for improving care coordination
- Implementation of care management that coordinate care to improve communication of clinical results
- Use of CMS to provide clinical decision support, tools, and processes for improving care in coordination
- Participation in the MIPS transforming clinical practice initiative
- Use of CMS to provide clinical decision support, tools, and processes for improving care in coordination
- High active participation in the MIPS transforming clinical practice initiative

- Improved communication of lab results identified as timely identification of abnormal test results with follow-up.
- MIPS reports, face-to-face, or virtual meetings demonstrating timely communication of abnormal test results to patient

- Medication management improvement plans to identify and use resources
- Use of reminders and outreach to alert and educate patients about services due; and/or
- Use of routine medication reconciliation

- Use of reminders and outreach to alert and educate patients about services due; and/or
- Use of routine medication reconciliation

- Documentation of implemented regular care coordination training within practice, e.g., training materials with follow-up.
- Training materials, face-to-face, or virtual meetings demonstrating timely communication of abnormal test results to patient

- Implementation of at least one recommended QIN-improvement initiative
- Participation in one or more of the following:
  - Care management through new diagnoses, injuries, and exacerbations of illness
  - Use of reminders and outreach to alert and educate patients about services due; and/or
  - Use of routine medication reconciliation

- Participation in one or more of the following:
  - Care management through new diagnoses, injuries, and exacerbations of illness
  - Use of reminders and outreach to alert and educate patients about services due; and/or
  - Use of routine medication reconciliation

- Use of reminders and outreach to alert and educate patients about services due; and/or
- Use of routine medication reconciliation

- Participation in one or more of the following:
  - Care management through new diagnoses, injuries, and exacerbations of illness
  - Use of reminders and outreach to alert and educate patients about services due; and/or
  - Use of routine medication reconciliation

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Care Coordination

Implementation of care coordination programs for developing regular registered care plans

- Establishing of patient-oriented processes that ensure non-overlapping and effective coordination of care, as specific to the patient, and communication with local settings via telemedicine or who are involved with the patient's care coordination.

- Implementation of care coordination programs for developing regular registered care plans: Establishing of patient-oriented processes that ensure non-overlapping and effective coordination of care, which are patient-centered, care transition action plans for is.

- Use of QCDR that shows performance of activities.

- Part of an individual care plan, which promotes collaborative learning network opportunities that are structured to achieve understanding, recognition, and support.

- Development of regular individual care plans for improvement.

- Participation in an HIE.

- Referral information integrated into the plan of care.

- Participation in an HIE.

- Referral information integrated into the plan of care.

Beneficiary Engagement

Use of certified e-value capture patient reported outcomes.

- Support for improving patient access, performing additional activities that enable consumers to self-manage their health conditions, e.g., patient education, in particular through implementation of patient-centered action plans (e.g., home-based programs target blood pressure or blood glucose, food diaries, risk factors such as tobacco or alcohol use, etc.) or health information exchange.

- Implementation of practices/processes for care transition that include

  - Patient reported outcomes.

- Implementation of care coordination practices to engage community resources to improve patient health outcomes.

- Follow-up on patient experience and satisfaction data for beneficiaries who are beneficiaries of care coordination agreements with frequently used consultants that set expectations for documented flow of information and provide patients with patient reported outcomes.

- Documentation from QIN-QIO of eligible clinician or group's engagement and use of services for clinician recognition and review (e.g. within a report or a screenshot).

- Use of MIPS Data Validation Criteria.

- Implementation of care coordination practices to engage community resources to improve patient health outcomes.

- Follow-up on patient experience and satisfaction data for beneficiaries who are beneficiaries of care coordination agreements with frequently used consultants that set expectations for documented flow of information and provide patients with patient reported outcomes.

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- Use of MIPS Data Validation Criteria.
Patient Safety & Practice Assessment

Participation in an AHRQ-listed patient safety culture assessment.

Methodology
- Participation in an AHRQ-listed patient safety culture assessment.

Documentation of use of patient safety tools, e.g., surgical risk calculator, that assist meaningful patient safety and practice assessment.

Methodology
- Participation in an AHRQ-listed patient safety culture assessment.

Use of tools to support patient self-management.

Methodology
- Documentation of the use of patient safety tools, e.g., surgical risk calculator, that assist meaningful patient safety and practice assessment.

Use of QCDR data for ongoing practice assessment.

Methodology
- Use of tools to support patient self-management.

Inclusion of patients, family and caregivers in developing a plan of care.

Methodology
- Use of QCDR data for ongoing practice assessment.

Conduct of regular assessments of patient care delivery.

Methodology
- Inclusion of patients, family and caregivers in developing a plan of care.

Documentation in patient record or EHR showing use of Patient Activation Measure, How’s My Practice?

Methodology
- Conduct of regular assessments of patient care delivery.

Patient Safety & Practice Assessment

Participation in MOC Part IV including a local, regional or national outcomes registry or quality assessment program.

Methodology
- Use of tools to support patient self-management.

Annual registration by eligible clinician or group in the prescription drug monitoring program.

Methodology
- Participation in MOC Part IV including a local, regional or national outcomes registry or quality assessment program.

Use of tools to support patient self-management.

Methodology
- Annual registration by eligible clinician or group in the prescription drug monitoring program.

Use of evidence-based decision aids to support shared decision-making.

Methodology
- Use of tools to support patient self-management.

Engage patients and families in improving the system of care.

Methodology
- Use of evidence-based decision aids to support shared decision-making.

Pre-visit agenda shared with patient.

Methodology
- Engage patients and families in improving the system of care.

Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or other similar activity.

Methodology
- Pre-visit agenda shared with patient.

Use of condition-specific chronic disease self-management support programs or coaching or link to those programs in the community.

Methodology
- Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or other similar activity.

Inclusion of patients, family and caregivers in developing a plan of care.

Methodology
- Use of condition-specific chronic disease self-management support programs or coaching or link to those programs in the community.

Documentation in patient record or EHR showing use of Patient Activation Measure, How’s My Practice?

Methodology
- Inclusion of patients, family and caregivers in developing a plan of care.

Use of tools to support patient self-management.

Methodology
- Documentation in patient record or EHR showing use of Patient Activation Measure, How’s My Practice?

Use of condition-specific chronic disease self-management support programs or coaching or link to those programs in the community.

Methodology
- Use of tools to support patient self-management.

Inclusion of patients, family and caregivers in developing a plan of care.

Methodology
- Use of condition-specific chronic disease self-management support programs or coaching or link to those programs in the community.

Conduct of regular assessments of patient care delivery.

Methodology
- Inclusion of patients, family and caregivers in developing a plan of care.

Documentation in patient record or EHR showing use of Patient Activation Measure, How’s My Practice?

Methodology
- Conduct of regular assessments of patient care delivery.

Patient Safety & Practice Assessment

Participation of eligible professionals in re-certification or re-certification of the Prescription Drug Monitoring Program.

Methodology
- Documentation in patient record or EHR showing use of Patient Activation Measure, How’s My Practice?

Use of patient safety tools.

Methodology
- Participation of eligible professionals in re-certification or re-certification of the Prescription Drug Monitoring Program.

Use of condition-specific chronic disease self-management support programs or coaching or link to those programs in the community.

Methodology
- Use of patient safety tools.

Inclusion of patients, family and caregivers in developing a plan of care.

Methodology
- Use of condition-specific chronic disease self-management support programs or coaching or link to those programs in the community.

Conduct of regular assessments of patient care delivery.

Methodology
- Inclusion of patients, family and caregivers in developing a plan of care.

Documentation in patient record or EHR showing use of Patient Activation Measure, How’s My Practice?

Methodology
- Conduct of regular assessments of patient care delivery.
Participation in a QCDR, demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status.

Participation in QIAP and demonstrated performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status.

Participation in a QCDR demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status.

Participation in a QCDR, documenting use of patient-reported outcomes (PRO) tools and corresponding collection of PRO data (e.g., use of PHQ-2 for depression and PROMIS outcomes).

Participation in a QCDR demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status.

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Behavioral and Mental Health

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 #0508) for patients with co-occurring conditions of behavioral or mental health and at risk for tobacco dependence.

Impact from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice of tobacco screening for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.

Unhealthy Alcohol Use

- Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including unhealthy alcohol use screening and follow-up plan (refer to NQF #0611) for patients with co-occurring conditions of behavioral or mental health and at risk for unhealthy alcohol use.

Impact from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice for unhealthy alcohol use screening for patients with co-occurring conditions of behavioral or mental health.

Depression Screening and Follow-up Plan

- Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicidal risk assessment (refer to NQF #0990) for mental health patients with co-occurring conditions of behavioral or mental health.

Impact from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice for depression screening and follow-up plan for these patients with co-occurrences of behavioral or mental health.

Unhealthy Alcohol Use

- Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including unhealthy alcohol use screening and follow-up plan (refer to NQF #0611) for patients with co-occurring conditions of behavioral or mental health.

Impact from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice for unhealthy alcohol use screening for patients with co-occurring conditions of behavioral or mental health.

Major Depressive Disorder

- Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicidal risk assessment (refer to NQF #0990) for mental health patients with co-occurring conditions of behavioral or mental health.

Impact from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice for depression screening and follow-up plan for these patients with co-occurrences of behavioral or mental health.

Provision of 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 care 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 certified EHRs, QCDRs, clinical registries, or documentation from medical charts showing regular practice of tobacco screening and cessation interventions for these patients with co-occurring conditions of behavioral or mental health.

Impact from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice of tobacco screening and cessation interventions for these patients with co-occurring conditions of behavioral or mental health.

Implementation of Co-located PCP and BMH Services

- Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicidal risk assessment (refer to NQF #0990) for mental health patients with co-occurring conditions of behavioral or mental health.

Implementation of co-located PCP and BMH services in primary and/or non-primary clinical care settings, e.g., 70% to 99% that participate in a behavioral health specialist, mental health clinician or primary care clinician in co-located setting or patient claims showing mental health and substance use disorders services collocated in primary and/or non-primary clinical settings.

Implementation of 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 care 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 certified EHRs, QCDRs, clinical registries, or documentation from medical charts showing regular practice of tobacco screening and cessation interventions for these patients with co-occurring conditions of behavioral or mental health.

Impact from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice of tobacco screening and cessation interventions for these patients with co-occurring conditions of behavioral or mental health.

Implementation of the Patient-Centered Medical Home model

- Use of certified EHR and/or certified health information technology functionality to support action plan management and outreach in patients treatment, e.g., clinical registries that support electronic tracking and facilitation integration through co-location of services when feasible.

Assessment of integration and promotion of the utilization of mental health and substance use disorders services primary and/or non-primary care settings, e.g., use of certified EHRs, QCDRs, clinical registries, or documentation from medical charts showing regular practice of tobacco screening and cessation interventions for these patients with co-occurring conditions of behavioral or mental health.

Assessment of integrated behavioral health services with at least one of the conditions described in the activity description.

Implementation of the Patient-Centered Medical Home model

- Use of certified EHR and/or certified health information technology functionality to support action plan management and outreach in patients treatment, e.g., clinical registries that support electronic tracking and facilitation integration through co-location of services when feasible.

Assessment of integration and promotion of the utilization of mental health and substance use disorders services primary and/or non-primary care settings, e.g., use of certified EHRs, QCDRs, clinical registries, or documentation from medical charts showing regular practice of tobacco screening and cessation interventions for these patients with co-occurring conditions of behavioral or mental health.

Implementation of Co-located PCP and BMH Services

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Impact from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice of tobacco screening and cessation interventions for these patients with co-occurring conditions of behavioral or mental health.

Provision of 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 care 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 certified EHRs, QCDRs, clinical registries, or documentation from medical charts showing regular practice of tobacco screening and cessation interventions for these patients with co-occurring conditions of behavioral or mental health.

Impact from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice of tobacco screening and cessation interventions for these patients with co-occurring conditions of behavioral or mental health.