IMPROVEMENT ACTIVITIES

AMERICAN ACADEMY OF NEUROLOGY®

Suggestions for Neurologists to Consider Implementing

Under CMS' Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS), eligible providers will earn one overall composite score for their performance across the four domains: quality, cost, promoting interoperability, and improvement activities. This tip sheet provides you with an overview of reporting requirements and improvement activities reporting options. Clinicians may achieve a maximum score of 40 points for improvement activities. For more information on quality, cost, and promoting interoperability requirements you can visit *AAN.com/qpp* or email *practice@aan.com*.

You can find the complete list of over 100 Improvement Activities for the current year on the Quality Payment Program website in the *Resource Library*.

To meet the requirement

Groups with more than 15 clinicians must report:

- Two high-weighted activities for a minimum of 90 consecutive days, or
- One high-weighted activity and two medium-weighted activities for a minimum of 90 consecutive days, or
- Up to four medium-weighted activities for a minimum of 90 consecutive days.

Groups with 15 or fewer clinicians, non-patient facing clinicians and/or clinicians located in rural area or HPSA must report:

- One high-weighted activity for a minimum of 90 consecutive days, or
- Two medium-weighted activities for a minimum of 90 consecutive days.

Non-MIPS Alternative Payment Models (APMs):

- Participants will receive full credit for improvement activities if they are in a Patient Centered Medical Home (PCMH).

MIPS APM participants:

- Participants will get half the full score (20 points).
- Participants may choose from these additional activities to increase the score.

High Impact

Title	Activity	MIPS Measures (meet the quality component)	Special Tips & Resources for Neurologists
Provide 24/7 Access to MIPS Eligible Clinicians or Group 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.	QPP 321: CAHPS for MIPs Clinician/Group Survey	*Delivery Models: PCMH*
Consultation of the Prescription Drug Monitoring Program	Clinicians would attest to reviewing the patients' history of controlled substance prescription using state prescription drug monitoring program (PDMP) data prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription lasting longer than three days. For the transition year, clinicals would attest to 60 percent review of applicable patient's history. For the Quality Payment Program Year 2 and future years, clinicians would attest to 75 percent review of applicable patient's history performance.	QPP 131: Pain Assessment and Follow-up	*CDC PDMP Website*
Implementation of Integrated Patient Centered Behavioral Health Model	Offer integrated behavioral health services to support patients with behavioral health needs who also have conditions such as dementia or poorly controlled chronic illnesses. The services 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 health information technology functionality to support active care management and outreach to patients in treatment; • Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible; and/or • Participate in the National Partnership to Improve Dementia Care Initiative, which promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training, and revised surveyor guidance.	QPP 283: Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management QPP 371: Depression Utilization of the PHQ-9 Tool QPP 134: Screening for Depression and Follow-up Plan	*PHQ-9 Instructional Video*

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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. A timely manner is defined as within 10 business days for this activity.	QPP 321: CAHPS for MIPs Clinician/Group Survey	
Anticoagulant Management Improvements	Individual MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, for 60 percent of practice patients in the transition year and 75 percent of practice patients in Quality Payment Program Year 2 and future years, their ambulatory care patients receiving warfarin are being managed by one or more of the following improvement activities: • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-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 PT-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 PT-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.		
Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients	Individual MIPS eligible clinicians or groups must regularly engage in integrated prevention and treatment interventions, including screening and brief counseling (for example: NQF #2152) for patients with co-occurring conditions of mental health and substance abuse. MIPS eligible clinicians would attest that 60 percent for the CY 2018 Quality Payment Program performance period, and 75 percent beginning in the 2019 performance period, of their ambulatory care patients are screened for unhealthy alcohol use.	QPP 367: Appraisal for Alcohol or Chemical Substance Use	

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CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain	Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course "Applying CDC's Guideline for Prescribing Opioids" that reviews the 2016 "Guideline for Prescribing Opioids for Chronic Pain." Note: This activity may be selected once every four years, to avoid duplicative information given that some of the modules may change on a year by year basis but over four years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.		*Applying CDC's Guideline for Prescribing Opioids*
Promote Use of Patient-Reported Outcome Tools	Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data such as the use of PQH-2 or PHQ-9, PROMIS instruments, patient reported Wound-Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening.	QPP 371: Depression Utilization of the PHQ-9 Tool	*Patient Reported Outcome Tools*
Provide Education Opportunities for New Clinicians	MIPS eligible clinicians acting as a preceptor for clinicians-in-training (such as medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved, or rural areas.		*AAN Program Director Resources*
COVID-19 Clinical Data Reporting with or without Clinical Trial	To receive credit for this improvement activity, a MIPS eligible clinician or group must: (1) participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study; or (2) 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. Data would be submitted to the extent permitted by applicable privacy and security laws.		*US National Library of Medicine Clinical Trials Page Clinical Data Registries*

Medium Impact

Title	Activity	MIPS Measures (meet the quality component)	Special Tips & Resources for Neurologists
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.	QPP 226: Tobacco Use: Screening and Cessation Intervention QPP 402: Tobacco Use and Help with Quitting Among Adolescents	
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.	QPP 130: Documentation of Current Medications in the Medical Record QPP 046: Medication Reconciliation Post-discharge	*IHI Toolkit on Medication Reconciliation to Prevent Adverse Drug Events*
***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 EHR technology.	QPP 374: Closing the Referral Loop: Receipt of Specialist Report	*PCPI and The Wright Center joint initiative*
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.		
Advance Care Planning	Implementation of practices/processes to develop advance care planning that includes: documenting the advance care plan or living will within the medical record, educating clinicians about advance care planning motivating them to address advance care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the health care policy side of advance care planning	QPP 047: Care Plan	
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.		
Use Group Visits for Common Chronic Conditions	Use group visits for common chronic conditions (e.g., diabetes).		

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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.		*AAN Quality Improvement Toolkit*
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).	QPP 155: Falls Plan of Care QPP 154: Falls Risk Assessment QPP 318: Falls Screening for Future Risk	*AAN Quality Improvement Toolkit*
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.	QPP 371: Depression Utilization of the PHQ-9 Tool QPP 134: Screening for Depression and Follow-up Plan QPP 290: Psychiatric Symptoms Assessment for Patients with Parkinson's Disease QPP 283: Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management	*SAMHSA Depression Management Toolkit*
Improved Practices that Engage Patients Pre-visit	Implementation of workflow changes that engage patients prior to the visit, such as a pre-visit development of a shared visit agenda with the patient, or targeted pre-visit laboratory testing that will be resulted and available to the MIPS eligible clinician to review and discuss during the patient's appointment.		*AAN Quality Improvement Toolkit*
Improved Practices that Disseminate Appropriate Self-management Materials	Provide self-management materials at an appropriate literacy level and in an appropriate language.		*AAN Patient Handouts*
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 electronic health record (EHR) technology.	QPP 047: Care Plan	

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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.		*Patient Reported Outcomes*
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.).		*AAN Quality Improvement Toolkit*
Participation in Population Health Research	Participation in federally and/or privately funded research that identifies interventions, tools, or processes that can improve a targeted patient population.		
Regular Review Practices in Place on Targeted Patient Population Needs	Implementation of regular reviews of targeted patient population needs, such as structured clinical case reviews, which includes access to reports that show unique characteristics of eligible clinician's patient population, identification of vulnerable patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources.		
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.	QPP 321: CAHPS for MIPS Clinician/Group Survey	
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.		*AAN Telemedicine and Remote Care* *AAN Quality Improvement Toolkit*
Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients	The primary care and behavioral health practices use the same electronic health record system for shared patients or have an established bidirectional flow of primary care and behavioral health records.		
Use Evidence-based Decision Aids to Support Shared Decision-making	Use evidence-based decision aids to support shared decision-making.		*AAN Shared Decision Making Tools*
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		*AAN Quality Improvement Toolkit*

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Cost Display for Laboratory and Radiographic Orders	Implementation of a cost display for laboratory and radiographic orders, such as costs that can be obtained through the Medicare clinical laboratory fee schedule.		
Completion of an Accredited Safety or Quality Improvement Program	Completion of an accredited performance improvement continuing medical education 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.		