List of CMS Improvement Activities That Can Be Crosswalked to ASCO Quality Programs: 2020

Category of Improvement Activity (Subcategory Name)	**CMS ID** (Improvement Activity ID)	**Specifics on Activity** (Activity Description)	**ASCO Quality Program**
Patient Safety & Practice Assessment	IA_PSPA_7	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.	QCP QCDR SmartLinQ
Patient Safety & Practice Assessment	IA_PSPA_8	In order to receive credit for this activity, a MIPS eligible clinician must use tools that assist specialty practices in tracking specific measures that are meaningful to their practice. Some examples of tools that could satisfy this activity are: a surgical risk calculator; evidence based protocols, such as Enhanced Recovery After Surgery (ERAS) protocols; the Centers for Disease Control (CDC) Guide for Infection Prevention for Outpatient Settings predictive algorithms; and the opiate risk tool (ORT) or similar tool.	QCP
Patient Safety & Practice Assessment	IA_PSPA_19	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 multisource	QCP QTP

		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;- Participation in Bridges to Excellence;- Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.	SmartLinQ
Patient Safety & Practice Assessment	IA_PSPA_20	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.	QCP QTP
Behavioral & Mental Health	IA_BMH_4	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.	QCP
Beneficiary Engagement	IA_BE_15	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.	QCP
Beneficiary Engagement	IA_BE_21	Provide self-management materials at an appropriate literacy level and in an appropriate language.	QCP
Care Coordination	IA_CC_9	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	QCP

		beneficiary or caregiver(s). Individual care plans should include consideration of a patient's goals and priorities, as well as desired outcomes of care.	
Care Coordination	IA_CC_14	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 provide a guide to available community resources.- Including through the use of tools that facilitate electronic communication between settings;- Screen patients for health-harming legal needs;- Screen and assess patients for social needs using tools that are preferably health IT enabled and that include to any extent standards-based, coded question/field for the capture of data as is feasible and available as part of such tool; and/or- Provide a guide to available community resources.	QCP
Population Management	IA_PM_15	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.	QCP
Population Management	IA_PM_16	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.	QCP
Expanded Practice Access	IA_EPA_1	- 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	QCP

		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/orProvision 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.	