Subcategory: Implementation of additional processes, practices, and systems

Documented participation of patients in a systematic anticoagulation program

Activity: Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care clinics or telehealth clinics that assess access to clinical data and use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care clinics or telehealth clinics that assess access to clinical data.

Outcome: Use of telehealth services and participation in data analysis assessing provision of quality care to patients.

TA: Technical Assistance - Confirmation of technical assistance and implementation of improvement strategies.

Suggested Documentation (inclusive of dates during the selected continuous 90-day or year transition year)

Participation in a Rural Health Clinic (RHC), Indian Health Service Medium Care Center (FQHC) occurs and clinical functionality of 24/7 or expanded practice hours with access to patient records.

Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care clinics or telehealth clinics that assess access to clinical data.

Activity: Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care clinics or telehealth clinics that assess access to clinical data.

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TA: Technical Assistance - Confirmation of technical assistance and implementation of improvement strategies.

Suggested Documentation (inclusive of dates during the selected continuous 90-day or year transition year)

Participation in a Rural Health Clinic (RHC), Indian Health Service Medium Care Center (FQHC) occurs and clinical functionality of 24/7 or expanded practice hours with access to patient records.
Involvement in research to improve targeted patient population

Functionality of reporting abnormal test results in a timely manner.

Coordination of care for the highest risk cohort of patients.

Provide episodic care management, including management across transitions and care coordination for the highest risk cohort of patients.

- Use a consistent method to assign and adjust global risk status for all empaneled patients.
- Use a personalized plan of care for patients at high risk for adverse health outcome or harm.
- Use panel support tools to identify services due; or
- Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, and heart failure) with evidence-based protocols to guide treatment to target.
- Use previsit planning to optimize preventive care and transitional management of patients with chronic conditions.

- Use panel support tools to identify services due; or
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Participation in QCDR promoting collaborative care coordination activities, e.g., documentation of regular updates and use of websites/tools that guide to community resources; or

Structured Referral Notes

- Medical record or EHR documentation of formal lines of communication (e.g., regular feedback reports provided by the QCDR detailing activities promoting the use of patient engagement tools, e.g., regular feedback reports provided by the QCDR showing the promotion of processes and Partnerships with Community or Hospital-Based Transitional Care Services

- Documentation supporting performance with or without hospital-based transitional care services.

Follow-Up on Patient Experience and Satisfaction

- Documentation of regular updates and use of websites/tools that guide to community resources; or

Rehabilitation Act of 1973 or for improved design for patients with cognitive disabilities. Refer to the

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enhancements and ongoing regular updates and use of websites/tools that include documentation for conformance with section 11 of the Rehabilitation Act of 1973 for improved design for patients with cognitive disabilities. Refer to the

Enhancements and ongoing regular updates and use of websites/tools that include documentation for conformance with section 11 of the Rehabilitation Act of 1973 for improved design for patients with cognitive disabilities. Refer to the

EDs in the article referenced above in Section 508 compliant

Participation in QCDR promoting collaborative care coordination activities, e.g., documentation of regular updates and use of websites/tools that guide to community resources; or

Participation in QCDR promoting clinical decision making capabilities

- Medical record or EHR documentation of formal lines of communication (e.g., regular feedback reports provided by the QCDR showing the promotion of processes and Partnerships with Community or Hospital-Based Transitional Care Services

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- Documentation supporting performance with or without hospital-based transitional care services.
Use evidence-based decision aids to support shared decision-making.

Documented evidence-based techniques to promote self-management into usual care or an evidence of the use of the techniques (e.g., clinicians’ completed off-line checklist, EHR report of completed checklist).

Incorporate evidence-based techniques to prevent self-management into usual care, using techniques such as goal setting with a follow-up, teach back, written planning, and motivational interviewing.

Incorporate evidence-based techniques to promote self-management into usual care.

Use group visits for common chronic conditions. Could be supported by claims.

Provide coaching between visits with follow-up on care plan and goals. Could be supported by claims.

Provide peer-led self-management support programs or coaching or link patients to those programs in the community.

Use evidence-based techniques to promote self-management into usual care.

Provide coaching between visits and follow-up on care plan and goals. Could be supported by claims.

Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with a follow-up, teach back, written planning, and motivational interviewing.

Use of tools to assist patient self-management.

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

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

Use of patient safety tools.

Provide peer-led self-management support programs or coaching or link to those programs in the community.

Provide peer-led self-management support programs or coaching or link to those programs in the community.

Documented evidence-based techniques to promote self-management into usual care or an evidence of the use of the techniques (e.g., clinicians’ completed off-line checklist, EHR report of completed checklist).

Use of tools to assist patient self-management.

Recorded-based techniques to prevent self-management into usual care.

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

Use of coaching codes.

Recorded-based techniques to prevent self-management into usual care.

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Participation in patient safety events.

Participation in the Vermont Quality Improvement Organization (VQIO) Forum on Medication-Specific Safety Observations (MSSOs), or other supplemental patient safety questionnaire items, e.g., submitted information on health information technology tool sets.

Participation in patient safety education programs for health care providers or department leaders at the practice.

Participation in department-specific or practice-specific disaster and emergency preparedness events.

Participation in disaster or emergency preparedness drills.

Participation in a 60-day or longer period of a continuous 60 days or greater.

Participation on Disaster Medical Assistance Teams, or Community Emergency Response Teams, for a minimum of 6 months as a volunteer for disaster or emergency response.

Composition of staff participation in one or more of the six identified; e.g., regular team meetings to review data and plan improvement cycles, team practice and patient panel level quality of care, patient experience and satisfaction with care, patients, and family.

Use available data regularly to analyze opportunities to reduce cost through improved care.

Ensure full engagement of clinical and administrative leadership in practice improvement activities.

Allocate time for clinical and administrative leadership through participation in regular team meetings; and/or

Allocate time for clinical and administrative leadership through participation in one or more improvement activities.

Participation in a 60-day or longer period of a continuous 60 days or greater.

Participation in self-directed improvement activities.

Participation in quality improvement programs for health care providers or department leaders at the practice.

Participation in self-directed improvement activities.

Participation in practice event.

Participation in the Vermont Quality Improvement Organization (VQIO) Forum on Medication-Specific Safety Observations (MSSOs), or other supplemental patient safety questionnaire items, e.g., submitted information on health information technology tool sets.

Participation in department-specific or practice-specific disaster and emergency preparedness events.

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Participation in department-specific or practice-specific disaster and emergency preparedness events.

Participation in disaster or emergency preparedness drills.

Participation in a 60-day or longer period of a continuous 60 days or greater.

Participation on Disaster Medical Assistance Teams, or Community Emergency Response Teams, for a minimum of 6 months as a volunteer for disaster or emergency response.

Composition of staff participation in one or more of the six identified; e.g., regular team meetings to review data and plan improvement cycles, team practice and patient panel level quality of care, patient experience and satisfaction with care, patients, and family.

Use available data regularly to analyze opportunities to reduce cost through improved care.

Ensure full engagement of clinical and administrative leadership in practice improvement activities.

Allocate time for clinical and administrative leadership through participation in regular team meetings; and/or

Allocate time for clinical and administrative leadership through participation in one or more improvement activities.

Participation in a 60-day or longer period of a continuous 60 days or greater.

Participation in self-directed improvement activities.

Participation in quality improvement programs for health care providers or department leaders at the practice.

Participation in quality improvement programs for health care providers or department leaders at the practice.

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Improvement Activities Data Validation Criteria

**IA_BMH_3** Behavioral and Mental Health
Tobacco use

Tobacco use: Regular engagement of APMs eligible clinicians on groups in integrated prevention and treatment interventions, including tobacco use screening and intervention strategies (refer to NQF #0106) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.

**IA_BMH_4** Behavioral and Mental Health
Unhealthy alcohol use

Unhealthy alcohol use: Regular engagement of APMs eligible clinicians on groups in integrated prevention and treatment interventions, including screening and brief intervention strategies (refer to NQF #0295) for patients with co-occurring conditions of behavioral or mental health and at risk factors for unhealthy alcohol use.

**IA_BMH_4** Behavioral and Mental Health
Depression screening

Depression screening and follow-up plan: Regular engagement of eligible clinicians on groups in integrated prevention and treatment interventions, including suicide screening and follow-up plan (refer to NQF #0059) for patients with co-occurring conditions of behavioral or mental health.

**IA_BMH_5** Behavioral and Mental Health
Mental Health Centered Medical Home model

**IA_BMH_6** Behavioral and Mental Health
Enhancements for BH data

Enhancements for electronic health record to capture additional data on behavioral health populations and use that data for additional decision-making.

**IA_BMH_7** Behavioral and Mental Health
Implementation of integrated (PMH) tools

Integration of 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: 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 work flow 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; and use information technology for support of care management and outreach to patients in treatment, along with care coordination between behavioral health and medical care providers and facilitate integration through co-location of services when feasible.

**IA_BMH_8** Behavioral and Mental Health
Enhancements Health IT and enhancements for Asteroids capture

Enhancements to an electronic health record to capture additional data on behavioral health conditions and use that data for additional decision-making purposes (e.g., capture of additional data on tobacco use screening for at risk patient not previously identified).

**US** US

Implementation of Patient Centered Medical Home metrics

Implementation of the patient centered medical home metrics to continually improve comprehensive care coordination and accountability within the primary care setting. This may include implementing a variety of strategies and patient centered around care coordination, patient centered care models, care programs, and transitions of care, among others.

**Measure** Performance of regular engagement in integrated prevention and treatment interventions including screening and brief intervention strategies (refer to NQF #0106) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.

**Impact** 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.

**Measure** Performance of regular engagement in integrated prevention and treatment interventions for patients with co-occurring conditions of behavioral or mental health and at risk factors for unhealthy alcohol use.

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

**Measure** Performance of regular engagement in integrated prevention and treatment interventions for patients with co-occurring conditions of behavioral or mental health and at risk factors for unhealthy alcohol use.

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

**Measure** Performance of regular engagement in integrated prevention and treatment interventions for patients with co-occurring conditions of behavioral or mental health and at risk factors for unhealthy alcohol use.

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

**Measure** Performance of regular engagement in integrated prevention and treatment interventions for patients with co-occurring conditions of behavioral or mental health and at risk factors for unhealthy alcohol use.

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

**Measure** Performance of regular engagement in integrated prevention and treatment interventions for patients with co-occurring conditions of behavioral or mental health and at risk factors for unhealthy alcohol use.

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

**Measure** Performance of regular engagement in integrated prevention and treatment interventions for patients with co-occurring conditions of behavioral or mental health and at risk factors for unhealthy alcohol use.

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

**Measure** Performance of regular engagement in integrated prevention and treatment interventions for patients with co-occurring conditions of behavioral or mental health and at risk factors for unhealthy alcohol use.

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