

2025 Improvement Activities for Optometry

Below is a summary of those IA that an Optometrist might want to consider for 2025. Providers, if in a small practice or utilizing MVP only need to choose one IA for 2025.

The complete listing of IA and the requirements can be found [here](#).

2025 Improvement Activities List

| Activity Name | Activity Description | Activity ID | Subcategory Name |
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| Use of telehealth services that expand practice access | Create and implement a standardized process for providing telehealth services to expand access to care. | IA_EPA_2 | Expanded Practice Access |
| 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. | IA_EPA_3 | Expanded Practice Access |
| Create and Implement a Language Access Plan | Create and implement a language access plan to address communication barriers for individuals with limited English proficiency. The language access plan must align with standards for communication and language assistance defined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (https://thinkculturalhealth.hhs.gov/clas). | IA_EPA_6 | Expanded Practice Access |
| Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities | Address inequities in health outcomes by using population health data analysis tools to identify health inequities in the community and practice and assess options for effective and relevant interventions such as Population Health Toolkit or other resources identified by the clinician, practice, or by CMS. Based on this information, create, refine, and implement an action plan to address and close inequities in health outcomes and/or health care access, quality, and safety. | IA_PM_6 | Population Management |
| Regular review practices in place on targeted patient population needs | Implement regular reviews of targeted patient population needs, such as structured clinical case reviews, which include access to reports that show unique characteristics of MIPS eligible clinician's patient population, identification of underserved 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. The review should consider how structural inequities, such as racism, are influencing patterns of care and consider changes to acknowledge and address them. Reviews should stratify patient data by demographic characteristics and health related social needs to appropriately identify differences among unique populations and assess the drivers of gaps and disparities and identify interventions appropriate for the needs of the sub-populations. | IA_PM_11 | Population Management |
| 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 individual MIPS eligible clinician or group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology. | IA_CC_1 | Care Coordination |
| 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. | IA_CC_2 | Care Coordination |
| Regular training in care coordination | Implementation of regular care coordination training. | IA_CC_7 | Care Coordination |
| Implementation of documentation improvements for practice/process improvements | 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). | IA_CC_8 | Care Coordination |
| Implementation of practices/processes for developing regular individual care plans | 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. | IA_CC_9 | Care Coordination |

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| Care coordination agreements that promote improvements in patient tracking across settings | Establish effective care coordination and active referral management that could include one or more of the following: <ul style="list-style-type: none"> • Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings. Provide patients with information that sets their expectations consistently with the care coordination agreements; • Track patients referred to specialist through the entire process; and/or • Systematically integrate information from referrals into the plan of care. | IA_CC_12 | Care Coordination |
| Relationship-Centered Communication | In order to receive credit for this activity, MIPS eligible clinicians must 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. | IA_CC_18 | Care Coordination |
| Engagement of patients through implementation of improvements in patient portal | To receive credit for this activity, MIPS eligible clinicians must 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. | IA_BE_4 | Beneficiary Engagement |
| Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities | Enhancements and ongoing regular updates and use of websites/tools that include consideration for compliance with section 508 of the Rehabilitation Act of 1973 or for improved design for patients with cognitive disabilities. Refer to the CMS website on Section 508 of the Rehabilitation Act https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/Section508/index.html?redirect=/InfoTechGenInfo/07_Section508.asp that requires that institutions receiving federal funds solicit, procure, maintain and use all electronic and information technology (EIT) so that equal or alternate/comparable access is given to members of the public with and without disabilities. For example, this includes designing a patient portal or website that is compliant with section 508 of the Rehabilitation Act of 1973. | IA_BE_5 | Beneficiary Engagement |
| Regularly Assess Patient Experience of Care and Follow Up on Findings | Collect and follow up on patient experience and satisfaction data. This activity also requires follow-up on findings of assessments, including the development and implementation of improvement plans. To fulfill the requirements of this activity, MIPS eligible clinicians can use surveys (e.g., Consumer Assessment of Healthcare Providers and Systems Survey), advisory councils, or other mechanisms. MIPS eligible clinicians may consider implementing patient surveys in multiple languages, based on the needs of their patient population. | IA_BE_6 | Beneficiary Engagement |
| Use evidence-based decision aids to support shared decision-making. | Use evidence-based decision aids to support shared decision-making. | IA_BE_12 | Beneficiary Engagement |
| 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. | IA_BE_15 | Beneficiary Engagement |
| Drug Cost Transparency | Provide counseling to patients and/or their caregivers regarding: costs of medications using 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. | IA_BE_25 | Beneficiary Engagement |

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| Implementation of formal quality improvement methods, practice changes, or other practice improvement processes | <p>Adopt a formal model for quality improvement and create a culture in which all staff, including leadership, actively participates in improvement activities that could include one or more of the following, such as:</p> <ul style="list-style-type: none"> • Participation in multisource 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. | IA_PSPA_19 | Patient Safety and Practice Assessment |
| 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). | IA_PSPA_21 | Patient Safety and Practice Assessment |
| 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 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score. | IA_PSPA_22 | Patient Safety and Practice Assessment |
| Completion of CDC Training on Antibiotic Stewardship | Completion of all modules of the Centers for Disease Control and Prevention antibiotic stewardship course. Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score. | IA_PSPA_23 | Patient Safety and Practice Assessment |
| Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event | A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75 percent of case visits that result from a clinically significant adverse drug event, the MIPS eligible clinician provides information, including through the use of health IT to the patient's primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, suprathreshold effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization. | IA_PSPA_26 | Patient Safety and Practice Assessment |
| Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support | 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. | IA_PSPA_32 | Patient Safety and Practice Assessment |
| Enhance Engagement of Medicaid and Other Underserved Populations | To improve responsiveness of care for Medicaid and other underserved patients: use time-to-treat data (i.e., data measuring the time between clinician identifying a need for an appointment and the patient having a scheduled appointment) to identify patterns by which care or engagement with Medicaid patients or other groups of underserved patients has not achieved standard practice guidelines; and with this information, create, implement, and monitor an approach for improvement. This approach may include screening for patient barriers to treatment, especially transportation barriers, and providing resources to improve engagement (e.g., state Medicaid non-emergency medical transportation benefit). | IA_AHE_1 | Achieving Health Equity |

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| 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. | IA_AHE_6 | Achieving Health Equity |
| Comprehensive Eye Exams | <p>To receive credit for this activity, MIPS eligible clinicians must promote the importance of a comprehensive eye exam, which may be accomplished by any one or more of the following:</p> <ul style="list-style-type: none"> • providing literature, • facilitating a conversation about this topic using resources such as the “Think About Your Eyes” campaign, • referring patients to resources providing no-cost eye exams, such as the American Academy of Ophthalmology’s EyeCare America and the American Optometric Association’s VISION USA, or • promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment. <p>This activity is intended for:</p> <ul style="list-style-type: none"> • Non-ophthalmologists / optometrists who refer patients to an ophthalmologist/optometrist; • Ophthalmologists/optometrists caring for underserved patients at no cost; or • Any clinician providing literature and/or resources on this topic. <p>This activity must be targeted at underserved and/or high-risk populations that would benefit from engagement regarding their eye health with the aim of improving their access to comprehensive eye exams or vision rehabilitation services.</p> | IA_AHE_7 | Achieving Health Equity |
| Create and Implement an Anti-Racism Plan | <p>Create and implement an anti-racism plan using the CMS Disparities Impact Statement or other anti-racism planning tools. The plan should include a clinic-wide review of existing tools and policies, such as value statements or clinical practice guidelines, to ensure that they include and are aligned with a commitment to anti-racism and an understanding of race as a political and social construct, not a physiological one.</p> <p>The plan should also identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones for addressing prioritized issues and gaps. This may also include an assessment and drafting of an organization’s plan to prevent and address racism and/or improve language access and accessibility to ensure services are accessible and understandable for those seeking care. MIPS eligible clinician or practice can also consider including in their plan ongoing training on anti-racism and/or other processes to support identifying explicit and implicit biases in patient care and addressing historic health inequities experienced by people of color. More information about elements of the CMS Disparities Impact Statement is detailed in the template and action plan document at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf.</p> | IA_AHE_8 | Achieving Health Equity |
| | <p>through meaningful linkages to community resources.</p> <p>Drivers of health (also referred to as social determinants of health [SDOH] or health-related social needs [HSRN]) prioritized by the practice might include, but are not limited to, the following: food security; housing stability; transportation accessibility; interpersonal safety; legal challenges; and environmental exposures.</p> | | |
| Participation on Disaster Medical Assistance Team, registered for 6 months. | Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of 6 months as a volunteer for disaster or emergency response. | IA_ERP_1 | Emergency Response And Preparedness |
| Participation in a 60-day or greater effort to support domestic or international humanitarian needs. | Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater. | IA_ERP_2 | Emergency Response And Preparedness |

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| Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data | Use security labeling services available in certified Health Information Technology (IT) for electronic health record (EHR) data to facilitate data segmentation. Certification criteria for security tags may be found in the ONC Health IT Certification Program at 45 CFR 170.315(b)(7) and (b)(8). | IA_AHE_1 0 | Achieving Health Equity |
| Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients | Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patients by understanding and addressing health disparities for this population. The plan may include an analysis of sexual orientation and gender identity (SO/GI) data to identify disparities in care for LGBTQ+ patients. Actions to implement this activity may also include identifying focused goals for addressing disparities in care, collecting and using patients' pronouns and chosen names, training clinicians and staff on SO/GI terminology (including as supported by certified health IT and the Office of the National Coordinator for Health Information Technology US Core Data for Interoperability [USCDI]), identifying risk factors or behaviors specific to LGBTQ+ individuals, communicating SO/GI data security and privacy practices with patients, and/or utilizing anatomical inventories when documenting patient health histories. | IA_AHE_1 1 | Achieving Health Equity |
| Practice Improvements that Engage Community Resources to Address Drivers of Health | Select and screen for drivers of health that are relevant for the eligible clinician's population using evidence-based tools. If possible, use a screening tool that is health IT-enabled and includes standards-based, coded questions/fields for the capture of data. After screening, address identified drivers of health through at least one of the following: <ul style="list-style-type: none"> • Develop and maintain formal relationships with community-based organizations to strengthen the community service referral process, implementing closed-loop referrals where feasible; or • Work with community partners to provide and/or update a community resource guide for to patients who are found to have and/or be at risk in one or more areas of drivers of health; or • Record findings of screening and follow up within the electronic health record (EHR); identify screened patients with one or more needs associated with drivers of health and implement approaches to better serve their holistic needs through meaningful linkages to community resources. <p>Drivers of health (also referred to as social determinants of health [SDOH] or health-related social needs [HSRN]) prioritized by the practice might include, but are not limited to, the following: food security; housing stability; transportation accessibility; interpersonal safety; legal challenges; and environmental exposures.</p> | IA_AHE_1 2 | Achieving Health Equity |
| Participation on Disaster Medical Assistance Team, registered for 6 months. | Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of 6 months as a volunteer for disaster or emergency response. | IA_ERP_1 | Emergency Response And Preparedness |
| Participation in a 60-day or greater effort to support domestic or international humanitarian needs. | Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater. | IA_ERP_2 | Emergency Response And Preparedness |
| Tobacco use | 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. | IA_BMH_2 | Behavioral And Mental Health |
| Promoting Clinician Well-Being | Develop and implement programs to support clinician well-being and resilience—for example, through relationship-building opportunities, leadership development plans, or creation of a team within a practice to address clinician well-being—using one of the following approaches: <ul style="list-style-type: none"> • Completion of clinician survey on clinician well-being with subsequent implementation of an improvement plan based on the results of the survey. • Completion of training regarding clinician well-being with subsequent implementation of a plan for improvement. | IA_BMH_1 2 | Behavioral And Mental Health |