Improvement Activities
Data Validation Criteria

Activity ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Validation	Suggested Documentation (inclusive of dates during the selected continuous 90-day or year long reporting period)
IA_EPA_1	Expanded Practice Access	Provide 24/7 access to eligible clinicians or groups 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	High	Functionality of 24/7 or expanded practice hours with access to medical records or ability to increase access through alternative access methods or same-day or next-day visits	1) Patient Record from EHR - A patient record from a certified EHR with date and timestamp indicating services provided outside of normal business hours for that clinician; or 2) Patient Encounter/Medical Record/Claim - Patient encounter/medical record claims indicating patient was seen or services provided outside of normal business hours for that clinician including use of alternative visits; or 3) Same or Next Day Patient Encounter/Medical Record/Claim - Patient encounter/medical record claims indicating patient was seen same-day or next-day to a consistent clinician for urgent or transitional care
IA_EPA_2	Expanded Practice Access	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.	Medium	Documented use of telehealth services and participation in data analysis assessing provision of quality care with those services	1) Use of Telehealth Services - Documented use of telehealth services through: a) claims adjudication (may use G codes to validate); b) certified EHR or c) other medical record document showing specific telehealth services, consults, or referrals performed for a patient; and 2) Analysis of Assessing Ability to Deliver Quality of Care - Participation in or performance of quality improvement analysis showing delivery of quality care to patients through the telehealth medium (e.g. Excel spreadsheet, Word document or others)
IA_EPA_3	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.	Medium	Development and use of access to care improvement plan based on collected patient experience and satisfaction data	1) Access to Care Patient Experience and Satisfaction Data - Patient experience and satisfaction data on access to care; and 2) Improvement plan - Access to care improvement plan
IA_EPA_4	Expanded Practice Access	Additional improvements in access as a result of QIN/QIO TA	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services (e.g., investment of on-site diabetes educator).	Medium	Implementation of additional processes, practices, resources or technology to improve access to services, as a result of receiving QIN/QIO technical assistance	1) Relationship with QIN/QIO Technical Assistance - Confirmation of technical assistance and documentation of relationship with QIN/QIO; and 2) Improvement Activities - Documentation of activities that improve access including support on additional services offered
IA_PM_1	Population Management	Participation in systematic anticoagulation program	Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, patient self-management program) for 60 percent of practice patients in the transition year and 75 percent of practice patients in year 2 who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors).	High	Documented participation of patients in a systematic anticoagulation program. Could be supported by claims.	1) Patients Receiving Anti-Coagulation Medications - Total number of patients receiving anti-coagulation medications; and 2) Percentage of that Total Participating in a Systematic Anticoagulation Program - Documented number of referrals to a coagulation/anti-coagulation clinic; number of patients performing patient self-reporting (PST); or number of patients participating in self-management (PSM).
IA_PM_2	Population Management	Anticoagulant management improvements	MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, in the first performance year, 60 percent or more of their ambulatory care patients receiving warfarin are being managed by one or more of these clinical practice improvement activities: Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care*, incorporating comprehensive patient education, systematic 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 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 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. The performance threshold will increase to 75 percent for the second performance year and onward. Clinicians would attest that, 60 percent for the transition year, or 75 percent for the second year, of their ambulatory care patients receiving warfarin participated in an anticoagulation management program for at least 90 days during the performance period.	High	Documented participation of patients being managed by one or more clinical practice improvement activities. Could be supported by claims.	1) Patients Receiving Anti-Coagulation Medications - Total number of outpatients prescribed oral Vitamin K antagonist therapy; and 2) Percentage of that Total Being Managed By a Clinical Practice Improvement Activity - Number of outpatients prescribed oral Vitamin K antagonist therapy and who are being managed by one or more of the four activities in the described in the activity description
IA_PM_3	Population Management	RHC, IHS or FQHC quality improvement activities	Participating in a Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center in ongoing engagement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality improvement and benchmarking improvement which will ultimately benefit patients. Participation in Indian Health Service, as an improvement activity, requires MIPS eligible clinicians and groups to deliver care to federally recognized American Indian and Alaska Native populations in the U.S. and in the course of that care implement continuous clinical practice improvement including reporting data on quality of services being provided and receiving feedback to make improvements over time.	High	Participation in RHC, HIS, or FQHC occurs and clinical quality improvement occurs	1) Name of RHC, HIS or FQHC - Identified name of RHC, IHS, or FQHC in which the practice participates in ongoing engagement activities; and 2) Continuous Quality Improvement Activities - Documented continuous quality improvement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality and benchmarking improvement that ultimately benefits patients
IA_PM_4	Population Management	Glycemic management services	For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance year, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Is reassessed at least annually. The performance threshold will increase to 75 percent for the second performance year and onward. Clinician would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.	High	Report listing patients who are diabetic and prescribed antidiabetic agents and have documented glycemic treatment goals based on patient-specific factors	1) Diabetic Patients Prescribed Antidiabetic Agents - Total number of outpatients who are diabetic and prescribed antidiabetic agents; and 2) Documented Percentage of Total with Glycemic Treatment Goals and Assessed at Least Annually - Number of outpatients, who are diabetic and prescribed antidiabetic agents, with documented glycemic treatment goals ; and the goals take into account patient-specific factors, including at least age, comorbidities, and risk for hypoglycemia; and are flagged for reassessment in following year.
IA_PM_5	Population Management	Engagement of community for health status improvement	Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist MIPS eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	Medium	Activity to improve specific chronic condition within the community is being undertaken	1) Documentation of Partnership in the Community - Screenshot of website or other correspondence identifying key partners and stakeholders and relevant initiative including specific chronic condition; and 2) Steps for Improving Community Health Status - Report detailing steps being taken to satisfy the activity including, e.g., timeline, purpose, and outcome that is in compliance with the local QIO
IA_PM_6	Population Management	Use of toolsets or other resources to close healthcare disparities across communities	Take steps to improve healthcare disparities, such as Population Health Toolkit or other resources identified by CMS, the Learning and Action Network, Quality Innovation Network, or National Coordinating Center. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	Medium	Activity to improve health disparities	1) Resources Used to Improve Disparities - Resources used, e.g., Population Health Toolkit; and 2) Documentation of Steps - Report detailing activity as outlined by the local QIO
IA_PM_7	Population Management	Use of QCDR for feedback reports that incorporate population health	Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.	High	Involvement with a QCDR to generate local practice patterns and outcomes reports including vulnerable populations	Participation in QCDR for population health, e.g., regular feedback reports provided by QCDR that summarize local practice patterns and treatment outcomes, including vulnerable populations

IA_PM_8	Population Management	Participation in CMMI models such as Million Hearts Campaign	Participation in CMMI models such as the Million Hearts Cardiovascular Risk Reduction Model	Medium	Involvement in a CMMI model including acceptance and model participation. (Could be obtained from CMMI)	CMMI documents confirming participation in model and submission of requested data
IA_PM_9	Population Management	Participation in population health research	Participation in research that identifies interventions, tools or processes that can improve a targeted patient population.	Medium	Involvement in research to improve targeted patient population	Documentation confirming participation in research that identifies interventions, tools or processes that can improve a targeted patient population, e.g. email, correspondence, shared data, or research reports
IA_PM_10	Population Management	Use of QCDR data for quality improvement such as comparative analysis reports across patient populations	Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).	Medium	Participation and use of QCDR, clinical data or other registries to improve quality of care	Participation in QCDR for quality improvement across patient populations, e.g., regular feedback reports provided by QCDR using data for quality improvement such as comparative analysis reports across patient populations
IA_PM_11	Population Management	Regular review practices in place on targeted patient population needs	Implementation of regular reviews of targeted patient population needs which includes access to reports that show unique characteristics of eligible professional'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.	Medium	Participation in reviews of targeted patient population needs including access to reports and community resources	1) Targeted Patient Population Identification - Documentation of method for identification and ongoing monitoring/review for a targeted patient population; and 2) Report with Unique Characteristics - Reports that show unique characteristics of patient population and identification of vulnerable patients; and 3) Tailored Clinical Treatments - Medical records demonstrating ways clinical treatment needs are being tailored to meet unique needs including additional community resources, if necessary
IA_PM_12	Population Management	Population empanelment	Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team. Empanelment is a series of processes that assign each active patient to a MIPS eligible clinician or group and/or care team, confirm assignment with patients and clinicians, and use the resultant patient panels as a foundation for individual patient and population health management. Empanelment identifies the patients and population for whom the MIPS eligible clinician or group and/or care team is responsible and is the foundation for the relationship continuity between patient and MIPS eligible clinician or group /care team that is at the heart of comprehensive primary care. Effective empanelment requires identification of the "active population" of the practice: those patients who identify and use your practice as a source for primary care. There are many ways to define "active patients" operationally, but generally, the definition of "active patients" includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal acute or preventive health care.	Medium	Functionality of patient population empanelment including use of panels for health management	1) Active Population Empanelment - Identification of "active population" of the practice with empanelment and assignment confirmation linking patients to MIPS eligible clinician or care team; and 2) Process for Updating Panel - Process for review and update of panel assignments
IA_PM_13	Population Management	Chronic care and preventative care management for empaneled patients	Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning; Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target; Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions; Use panel support tools (registry functionality) to identify services due; Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or Routine medication reconciliation.	Medium	Management of empaneled patients' chronic and preventive care needs (could use EHR or medical records)	1) Individualized Plan of Care - Annual opportunity for development and/or adjustment of an individualized plan of care appropriate to age and health status; or 2) Condition-Specific Pathways - Use of condition-specific pathways for chronic conditions with evidence-based protocols, or 3) Pre-visit Planning - Use of pre-visit planning to optimize preventive care and team management; or 4) Panel Support Tools - Use of panel support tools to identify services that are due; or 5) Reminders and Outreach - Use of reminders and outreach to alert and educate patients about services due; or 6) Medication Reconciliation - Use of routine medication reconciliation
IA_PM_14	Population Management	Implementation of methodologies for improvements in longitudinal care management for high risk patients	Provide longitudinal care management to patients at high risk for adverse health outcome or harm that could include one or more of the following: Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.	Medium	Longitudinal care management to patients at high risk for adverse health outcome or harm	1) High Risk Patients - Identification of patients at high risk for adverse health outcome or harm; and 2) Use of Longitudinal Care Management - Documented use of longitudinal care management methods including at least one of the following: a) empaneled patient risk assignment and risk stratification into actionable risk cohorts; or b) personalized care plans for patients at high risk for adverse health outcome or harm; or c) evidence of use of on-site practice based or shared care managers to monitor and coordinate care for highest risk cohort
IA_PM_15	Population Management	Implementation of episodic care management practice improvements	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.	Medium	Provision of episodic care management practice improvements (could use medical records or claims)	1) Follow-Up on Hospitalizations, ED or Other Visits and Medication Management - Routine and timely follow-up to hospitalizations, ED or other institutional visits, and medication reconciliation and management (e.g. documented in medical record or EHR); or 2) New diagnoses, Injuries and Exacerbations - Care management through new diagnoses, injuries and exacerbations of illness (medical record)
IA_PM_16	Population Management	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.	Medium	Inclusion of medication management practice improvements	1) Documented Medication Reviews or Reconciliation - Patient medical records demonstrating periodic structured medication reviews or reconciliation; or 2) Integrated Pharmacist - Evidence of pharmacist integrated into care team; or 3) Reconciliation Across Transitions - Reconciliation and coordination of mediations across transitions of care; or 4) Medication Management Improvement Plan - Report detailing medication management practice improvement plan and outcomes, if available
IA_CC_1	Care Coordination	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 certified EHR technology.	Medium	Functionality of providing information by specialist to referring clinician or inquiring clinician receives and documents specialist report	1) Specialist Reports to Referring Clinician - Sample of specialist reports reported to referring clinician or group (e.g. within EHR or medical record); or 2) Specialist Reports from Inquiries in Certified EHR - Specialist reports documented in inquiring clinicians certified EHR or medical records
IA_CC_2	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.	Medium	Functionality of reporting abnormal test results in a timely basis with follow-up.	EHR reports, from certified EHR, or medical records demonstrating timely communication of abnormal test results to patient
IA_CC_3	Care Coordination	Implementation of additional activity as a result of TA for improving care coordination	Implementation of at least one additional recommended activity from the Quality Innovation Network-Quality Improvement Organization after technical assistance has been provided related to improving care coordination.	Medium	Implementation of at least one recommended QIN-QIO activity related to care coordination	1) QIN/QIO Technical Assistance - Documentation of Quality Innovation Network- Quality Improvement Organization technical assistance; and 2) Activity Implementation - Documentation that at least one recommended care coordination activity has been implemented (e.g. report detailing activity, patients cohort, results)
IA_CC_4	Care Coordination	TCPI participation	Participation in the CMS Transforming Clinical Practice Initiative.	High	Active participation in TCP Initiative	Confirmation of participation in the TCP Initiative for that year (e.g. CMS confirmation email)
IA_CC_5	Care Coordination	CMS partner in Patients Hospital Engagement Network	Membership and participation in a CMS Partnership for Patients Hospital Engagement Network.	Medium	Active participation in Partnership for Patients Hospital Engagement Network (HEN) initiative	Confirmation of participation in the Partnership for Patients Hospital Engagement Network (HEN) initiative for that year (e.g. CMS confirmation email)
IA_CC_6	Care Coordination	Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination	Participation in a Qualified Clinical Data Registry, demonstrating performance of activities that promote use of standard practices, tools and processes for quality improvement (e.g., documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups).	Medium	Active participation in QCDR to promote standard practices, tools and processes for quality improvement	Participation in QCDR demonstrating promotion of standard practices, tools and processes for quality improvement, e.g., regular feedback reports provided by QCDR that demonstrate the use of QCDR data to promote use of standard practices, tools, and processes for quality improvement, including, e.g., preventative screenings

IA_CC_7	Care Coordination	Regular training in care coordination	Implementation of regular care coordination training.	Medium	Inclusion of regular care coordination training in practice	Documentation of implemented regular care coordination training within practice, e.g., availability of care coordination training curriculum/training materials and attendance or training certification registers/documents
IA_CC_8	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).	Medium	Processes and practices are implemented to improve care coordination	Documentation of the implementation of practices/processes that document care coordination activities, e.g., documented care coordination encounter that tracks clinical staff involved and communications from date patient is scheduled through day of procedure
IA_CC_9	Care Coordination	Implementation of practices/processes for developing regular individual care plans	Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s).	Medium	Individual care coordination plans are regularly developed and updated for at-risk patients and shared with beneficiary or caregiver	1) Individual Care Plans for At-Risk Patients - Documented practices/processes for developing regularly individual care plans for at-risk patients, e.g., template care plan; and 2) Use of Care Plan with Beneficiary - Patient medical records demonstrating care plan being shared with beneficiary or caregiver
IA_CC_10	Care Coordination	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.).	Medium	Patient-centered, care transition action plan for is carried out for first 30 days following a discharge	Documentation of care transition practices/processes including a patient-centered action plan for first 30 days following a discharge
IA_CC_11	Care Coordination	Care transition standard operational improvements	Establish standard operations to manage transitions of care that could include one or more of the following: Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or Partner with community or hospital-based transitional care services.	Medium	Functionality of information flow during transitions of care to ensure seamless transitions	1) Communication Lines with Local Settings - Documentation of formal lines of communication to manage transitions of care with local settings (e.g. community or hospital-based transitional care services) in which empaneled patients receive care to ensure documented flow of information and seamless transitions; or 2) Partnership with Community or Hospital-Based Transitional Care Services - Documentation showing partnership with community or hospital-based transitional care services
IA_CC_12	Care Coordination	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: 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.	Medium	Functionality of effective care coordination and referral management	1) Care Coordination Agreements - Sample of care coordination agreements with frequently used consultant that establish documented flow of information and provides patients with information to set consistent expectations; or 2) Tracking of Patient Referrals to Specialists - Medical record or EHR documentation demonstrating tracking of patients referred to specialists through the entire process; or 3) Referral Information Integrated into the Plan of Care - Samples of specialist referral information systematically integrated into the plan of care
IA_CC_13	Care Coordination	Practice improvements for bilateral exchange of patient information	Ensure that there is bilateral exchange of necessary patient information to guide patient care that could include one or more of the following: Participate in a Health Information Exchange if available; and/or Use structured referral notes.	Medium	Functionality of bilateral exchange of patient information to guide patient care	1) Participation in an HIE - Confirmation of participation in a health information exchange (e.g. email confirmation, screen shots demonstrating active engagement with Health Information Exchange; or 2) Structured Referral Notes - Sample of patient medical records including structured referral notes
IA_CC_14	Care Coordination	Practice improvements that engage community resources to support patient health goals	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/or Provide a guide to available community resources.	Medium	Availability of formal links to community-based health and wellness programs potentially including availability of resource guides	1) Community-Based Chronic Disease Self-Management Programs - Documentation of community-based chronic disease self-management support programs, exercise programs, and other wellness resources (including specific names) with which practices have formal referral links and have potential bidirectional flow of information; or 2) Provision of Community Resource Guides - Medical record demonstrating provision of a guide to community resources
IA_BE_1	Beneficiary Engagement	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.	Medium	Functionality of patient reported outcomes in certified EHR	1) Patient Reported Outcomes in EHR - Report from the certified EHR, showing the capture of PROs or the patient activation measures performed; or 2) Separate Queue for Recognition and Review - Documentation showing the call out of this data for clinician recognition and review (e.g. within a report or a screen-shot)
IA_BE_2	Beneficiary Engagement	Use of QCDR to support clinical decision making	Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision making capabilities.	Medium	Use of QCDR that shows performance of activities promoting shared clinical decision making capabilities	Participation in QCDR to support clinical decision making, e.g., regular feedback reports provided by QCDR that document performance of activities promoting shared clinical decision-making capabilities
IA_BE_3	Beneficiary Engagement	Engagement with QIN-QIO to implement self-management training programs	Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs such as diabetes.	Medium	Use of QIN-QIO to implement self-management training programs	Documentation from QIN-QIO of eligible clinician or group's engagement and use of services to assist with, e.g., self management training program(s) such as diabetes
IA_BE_4	Beneficiary Engagement	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.	Medium	Functionality of patient portal that includes patient interactive features	Documentation through screenshots or reports of an enhanced patient portal, e.g. portal functions that provide up to date information related to chronic disease health or blood pressure control, interactive features allowing patients to enter health information, and/or bidirectional communication about medication changes and adherence
IA_BE_5	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	Medium	Practice website/tools are regularly updated and enhanced and are Section 508 compliant	1) Regular Updates and Section 508 Compliance Process - Documentation of regular updates and Section 508 compliance process for the clinician's patient portal or website; and 2) Compliant Website/Tools - Screenshots or hard copies of the practice's website/tools showing enhancements and regular updates in compliance with section 508 of the Rehabilitation Act of 1973
IA_BE_6	Beneficiary Engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.	High	Patient experience and satisfaction data on beneficiary engagement is collected and follow up occurs through an improvement plan	1) Follow-Up on Patient Experience and Satisfaction - Documentation of collection and follow-up on patient experience and satisfaction (e.g. survey results) which should be administered by a third party survey administrator/vendor; and 2) Patient Experience and Satisfaction Improvement Plan - Documented patient experience and satisfaction improvement plan
IA_BE_7	Beneficiary Engagement	Participation in a QCDR, that promotes use of patient engagement tools.	Participation in a QCDR, that promotes use of patient engagement tools.	Medium	Participation in QCDR promoting use of engagement tools	Participation in QCDR that promotes use of patient engagement tools, e.g., regular feedback reports provided by the QCDR detailing activities promoting the use of patient engagement tools
IA_BE_8	Beneficiary Engagement	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.	Medium	Participation in QCDR promoting collaborative learning network interactive opportunities	Participation in QCDR that promotes interactive collaborative learning network opportunities, e.g., regular feedback reports provided by the QCDR that promote interactive collaborative learning networks
IA_BE_9	Beneficiary Engagement	Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.	Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.	Medium	Use of patient experience data from the QCDR to inform and advance improvements in beneficiary engagement	Participation in QCDR to inform and advance improvements in beneficiary engagement , e.g., regular feedback reports provided by the QCDR that show participation in the use of patient experience measures/activities in informing and advancing beneficiary engagement

IA_BE_10	Beneficiary Engagement	Participation in a QCDR, that promotes implementation of patient self-action plans.	Participation in a QCDR, that promotes implementation of patient self-action plans.	Medium	Participation in a QCDR to promote implementation of patient self-action plans	Participation in QCDR that promotes implementation of patient self-action plans, e.g., regular feedback reports provided by the QCDR that show the promotion and use of patient self action plans
IA_BE_11	Beneficiary Engagement	Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan.	Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan.	Medium	Participation in a QCDR to promote use of processes and tools to engage patients to adhere to treatment plans	Participation in QCDR promoting engagement of patients for adherence to treatment plans, e.g., regular feedback reports provided by the QCDR showing the promotion of processes and tools that engage patients for adherence to treatment plans
IA_BE_12	Beneficiary Engagement	Use evidence-based decision aids to support shared decision-making.	Use evidence-based decision aids to support shared decision-making.	Medium	Use of evidence based decision aids to support shared decision-making with beneficiary	Documentation (e.g. checklist, algorithms, tools, screenshots) showing the use of evidence-based decision aids to support shared decision-making with beneficiary
IA_BE_13	Beneficiary Engagement	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.	Medium	Conduct of regular assessments of patient care experience	Documentation (e.g. survey results, advisory council notes and/or other methods) showing regular assessments of the patient care experience to improve the experience; surveys should be administered by a third party survey administrator/vendor independently to the best extent possible
IA_BE_14	Beneficiary Engagement	Engage patients and families to guide improvement in the system of care.	Engage patients and families to guide improvement in the system of care.	Medium	Functionality of methods to engage patients and families in improving the system of care	Documentation showing patient and family engagement, e.g. meeting agendas and summaries where patients families have been engaged, survey results from patients and/or families; and improvements made in the system of care; surveys should be administered by a third party survey administrator/vendor independently to the best extent possible
IA_BE_15	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 certified EHR technology.	Medium	Inclusion of patients, family and caregivers in plan of care and prioritizing goals for action, as documented in certified EHR.	Report from the certified EHR, showing the plan of care and prioritized goals for action with engagement of the patient, family and caregivers, if applicable
IA_BE_16	Beneficiary Engagement	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.	Medium	Functionality of evidence based techniques to promote self-management into usual care	Documented evidence-based techniques to promote self-management into usual care; and evidence of the use of the techniques (e.g. clinicians' completed office visit checklist, EHR report of completed checklist)
IA_BE_17	Beneficiary Engagement	Use of tools to assist patient self-management	Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's My Health).	Medium	Use of tools to assist patient self-management	Documentation in patient record or EHR showing use of Patient Activation Measure, How's My Health, or similar tools to assess patients need for support for self-management
IA_BE_18	Beneficiary Engagement	Provide peer-led support for self-management.	Provide peer-led support for self-management.	Medium	Use of peer-led self-management	Documentation in medical record or EHR of peer-led self-management program
IA_BE_19	Beneficiary Engagement	Use group visits for common chronic conditions (e.g., diabetes).	Use group visits for common chronic conditions (e.g., diabetes).	Medium	Use of group visits for chronic conditions. Could be supported by claims.	Medical claims or referrals showing group visit and chronic condition codes in conjunction with care provided
IA_BE_20	Beneficiary Engagement	Implementation of condition-specific chronic disease self-management support programs	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.	Medium	Use of condition-specific chronic disease self-management programs or coaching or link to community programs	1) Chronic Disease Self-Management Support Program - Documentation from medical record or EHR showing condition specific chronic disease self-management support program or coaching; or 2) Community Chronic Disease Self-Management Support Program - Documentation of referral/link of patients to condition specific chronic disease self-management support
IA_BE_21	Beneficiary Engagement	Improved practices that disseminate appropriate self-management materials	Provide self-management materials at an appropriate literacy level and in an appropriate language.	Medium	Provision of self-management materials appropriate for literacy level and language	Documented provision in EHR or medical record of self-management materials, e.g., pamphlet, discharge summary language, or other materials that include self management materials appropriate for the patient's literacy and language
IA_BE_22	Beneficiary Engagement	Improved practices that engage patients pre-visit	Provide a pre-visit development of a shared visit agenda with the patient.	Medium	Pre-visit agenda shared with patient	Documentation of a letter, email, portal screenshot, etc. that shows a pre-visit agenda was shared with patient
IA_BE_23	Beneficiary Engagement	Integration of patient coaching practices between visits	Provide coaching between visits with follow-up on care plan and goals.	Medium	Use of coaching between visits with follow-up on care plan and goals. Could be supported by claims.	Documentation of: 1) Use of Coaching Codes - Medical claims with codes for coaching provided between visits; or 2) Coaching Plan and Goals - Copy of documentation provided to patients (e.g. letter, email, portal screenshot) that includes coaching on care plan and goals
IA_PSPA_1	Patient Safety & Practice Assessment	Participation in an AHRQ-listed patient safety organization.	Participation in an AHRQ-listed patient safety organization.	Medium	Participation in an AHRQ-listed patient safety organization	Documentation from an AHRQ-listed patient safety organization (PSO) confirming the eligible clinician or group's participation with the PSO. PSOs listed by AHRQ are here: http://www.pso.ahrq.gov/listed
IA_PSPA_2	Patient Safety & Practice Assessment	Participation in MOC Part IV	Participation in Maintenance of Certification (MOC) Part IV for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program. Performance of monthly activities across practice to regularly assess performance in practice, by reviewing outcomes addressing identified areas for improvement and evaluating the results.	Medium	Participation in MOC Part IV including a local, regional, or national outcomes registry or quality assessment program and performance of monthly activities to assess and address practice performance	1) Participation in Maintenance of Certification from ABMS Member Board - Documentation of participation in Maintenance of Certification (MOC) Part IV from an ABMS member board including participation in a local, regional or national outcomes registry or quality assessment program; and 2) Monthly Activities to Assess Performance - Documented performance of monthly activities across practice to assess performance in practice by reviewing outcomes, addressing areas of improvement, and evaluating the results
IA_PSPA_3	Patient Safety & Practice Assessment	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or other similar activity.	For eligible professionals not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS®	Medium	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or other similar activity.	Certificate or letter of participation from an IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or other similar activity, for eligible clinicians or groups not participating in MOC Part IV
IA_PSPA_4	Patient Safety & Practice Assessment	Administration of the AHRQ Survey of Patient Safety Culture	Administration of the AHRQ Survey of Patient Safety Culture and submission of data to the comparative database (refer to AHRQ Survey of Patient Safety Culture website http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html)	Medium	Administration of the AHRQ survey of Patient Safety Culture and submission of data to the comparative database	Survey results from the AHRQ Survey of Patient Safety Culture, including proof of administration and submission
IA_PSPA_5	Patient Safety & Practice Assessment	Annual registration in the Prescription Drug Monitoring Program	Annual registration by eligible clinician or group in the prescription drug monitoring program of the state where they practice. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups must participate for a minimum of 6 months.	Medium	Annual registration in the prescription drug monitoring program of the state and participation for a minimum of 6 months	1) Activation/Registration of an PDMP Account - Documentation evidencing activation/registration of an PDMP account (e.g. an email), and 2) Participation in PDMP - Evidence of participating in the PDMP, i.e., accessing/consulting (e.g. copies of patient reports created, with the PHI masked)
IA_PSPA_6	Patient Safety & Practice Assessment	Consultation of the Prescription Drug Monitoring program	Clinicians would attest that, 60 percent for the transition year, or 75 percent for the second year, of consultation of prescription drug monitoring program prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription that lasts for longer than 3 days.	High	Provision of consulting with PDMP before issuance of a controlled substance schedule II opioid prescription that lasts longer than 3 days	1) Number of Issuances of CSII Prescription - Total number of issuances of a CSII prescription that lasts longer than 3 days over the same time period as those consulted; and 2) Documentation of Consulting the PDMP - Total number of patients for which there is evidence of consulting the PDMP prior to issuing an CSII prescription (e.g. copies of patient reports created, with the PHI masked)
IA_PSPA_7	Patient Safety & Practice Assessment	Use of QCDR data for ongoing practice assessment and improvements	Use of QCDR data, for ongoing practice assessment and improvements in patient safety.	Medium	Use of QCDR data for ongoing practice assessment and improvements in patient safety	Participation in QCDR that promotes ongoing improvements in patient safety, e.g., regular feedback reports provided by the QCDR that promote ongoing practice assessment and improvements in patient safety
IA_PSPA_8	Patient Safety & Practice Assessment	Use of patient safety tools	Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of the Surgical Risk Calculator.	Medium	Use of tools by specialty practices in tracking specific meaningful patient safety and practice assessment measures	Documentation of the use of patient safety tools, e.g. surgical risk calculator, that assist specialty practices in tracking specific patient safety measures meaningful to their practice

IA_PSPA_9	Patient Safety & Practice Assessment	Completion of the AMA STEPS Forward program	Completion of the American Medical Association's STEPS Forward program.	Medium	Completion of AMA STEPS Forward program	Certificate of completion from AMA's STEPS Forward program
IA_PSPA_10	Patient Safety & Practice Assessment	Completion of training and receipt of approved waiver for provision of opioid medication-assisted treatments	Completion of training and obtaining an approved waiver for provision of medication -assisted treatment of opioid use disorders using buprenorphine.	Medium	Completion of training and obtaining approved waiver for provision of medication assisted treatment of opioid use disorders using buprenorphine	1) Waiver - SAMHSA letter confirming waiver and physician prescribing ID number; and 2) Training - Certificate of completion of training to prescribe and dispense buprenorphine dated during the selected reporting period
IA_PSPA_11	Patient Safety & Practice Assessment	Participation in CAHPS or other supplemental questionnaire	Participation in the Consumer Assessment of Healthcare Providers and Systems Survey or other supplemental questionnaire items (e.g., Cultural Competence or Health Information Technology supplemental item sets).	High	Participation in CAHPS or other supplemental questionnaire	1) CAHPS - CAHPS participation report; or 2) Other Patient Supplemental Questionnaire Items - Other supplemental patient safety questionnaire items, e.g., cultural competence or health information technology item sets, must be administered by a third party survey administrator/vendor
IA_PSPA_12	Patient Safety & Practice Assessment	Participation in private payer CPIA	Participation in designated private payer clinical practice improvement activities.	Medium	Participation in private payer clinical practice improvement activities	Documents showing participation in private payer clinical practice improvement activities
IA_PSPA_13	Patient Safety & Practice Assessment	Participation in Joint Commission Evaluation Initiative	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative	Medium	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative	Practice documents that show participation in Joint Commission's Ongoing Professional Practice Evaluation initiative
IA_PSPA_14	Patient Safety and Practice Assessment	Participation in Bridges to Excellence or other similar program	Participation in other quality improvement programs such as Bridges to Excellence	Medium	Participation in other quality improvement programs such as Bridges to Excellence	Documentation from Bridges to Excellence or other similar program confirming participation in its improvement program(s)
IA_PSPA_15	Patient Safety and Practice Assessment	Implementation of antibiotic stewardship program	Implementation of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions (URI Rx in children, diagnosis of pharyngitis, Bronchitis Rx in adults) according to clinical guidelines for diagnostics and therapeutics	Medium	Functionality of an antibiotic stewardship program	Documentation of implementation of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions according to clinical guidelines for diagnostics and therapeutics and identifies improvement actions
IA_PSPA_16	Patient Safety and Practice Assessment	Use of decision support and standardized treatment protocols	Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	Medium	Use of decision support and treatment protocols to manage workflow in the team to meet patient needs	Documentation (e.g. checklist, algorithm, screenshot) showing use of decision support and standardized treatment protocols to manage workflow in the team to meet patient needs
IA_PSPA_17	Patient Safety and Practice Assessment	Implementation of analytic capabilities to manage total cost of care for practice population	Build the analytic capability required to manage total cost of care for the practice population that could include one or more of the following: Train appropriate staff on interpretation of cost and utilization information; and/or Use available data regularly to analyze opportunities to reduce cost through improved care.	Medium	Use of analytic capabilities to manage total cost of care for practice population	1) Staff Training - Documentation of staff training on interpretation of cost and utilization information (e.g. training certificate); or 2) Cost/Resource Use Data - Availability of cost/resource use data for the practice population that is used regularly to analyze opportunities to reduce cost
IA_PSPA_18	Patient Safety and Practice Assessment	Measurement and improvement at the practice and panel level	Measure and improve quality at the practice and panel level that could include one or more of the following: Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or MIPS eligible clinician or group(panel); and/or Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.	Medium	Measure and improve quality at the practice and panel level	1) Quality Improvement Program/Plan at Practice and Panel Level - Copy of a quality improvement program/plan or review of quality, utilization, patient satisfaction (surveys should be administered by a third party survey administrator/vendor) and other measures to improve one or more elements of this activity; or 2) Review of and Progress on Measures - Report showing progress on selected measures, including benchmarks and goals for performance using relevant data sources at the practice and panel level
IA_PSPA_19	Patient Safety and Practice Assessment	Implementation of formal quality improvement methods, practice changes or other practice improvement processes	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: 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; and/or Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.	Medium	Implementation of a formal model for quality improvement and creation of a culture in which staff actively participates in one or more improvement activities	1) Adopt Formal Quality Improvement Model and Create Culture of Improvement - Documentation of adoption of a formal model for quality improvement and creation of a culture in which staff actively participate in improvement activities; and 2) Staff Participation - Documentation of staff participation in one or more of the six identified; including, training, integration into staff duties, identifying and testing practice changes, regular team meetings to review data and plan improvement cycles, share practice and panel level quality of care, patient experience and utilization data with staff, or share practice level quality of care, patient experience and utilization data with patients and families
IA_PSPA_20	Patient Safety and Practice Assessment	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.	Medium	Functionality of leadership engagement in regular guidance and demonstrated commitment for implementing improvements	1) Clinical and Administrative Leadership Role Descriptions - Documentation of clinical and administrative leadership role descriptions include responsibility for practice improvement change (e.g. position description); or; 2) Time for Leadership in Improvement Activities - Documentation of allocated time for clinical and administrative leadership participating in improvement efforts, e.g. regular team meeting agendas and post meeting summary; or; 3) Population Health, Quality, and Health Experience Incorporated into Performance Reviews - Documentation of population health, quality and health experience metrics incorporated into regular practice performance reviews, e.g., reports, agendas, analytics, meeting notes
IA_PSPA_21	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).	Medium	Functionality of fall screening and assessment programs	1) Implementation of a Falls Screening and Assessment Program - Implementation of a falls screening and assessment program that uses valid and reliable tools to identify patients at risk for falls and address modifiable risk factors, for example, the STEADI program for identification of falls risk; and 2) Implementation Progress- Documentation of progress made on falls screening and assessment after implementation of tool
IA_AHE_1	Achieving Health Equity	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.	High	Functionality of practice in seeing new and follow-up Medicaid patients in a timely manner including patients dually eligible	1) Timely Appointments for Medicaid and Dually Eligible Medicaid/Medicare Patients - Statistics from certified EHR or scheduling system (may be manual) on time from request for appointment to first appointment offered or appointment made by type of visit for Medicaid and dual eligible patients; and 2) Appointment Improvement Activities - Assessment of new and follow-up visit appointment statistics to identify and implement improvement activities
IA_AHE_2	Achieving Health Equity	Leveraging a QCDR to standardize processes for screening	Participation in a QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health such as food security, employment and housing. Use of supporting tools that can be incorporated into the certified EHR technology is also suggested.	Medium	Participation in a QCDR and demonstrated performance of activities for use of standardized processes for screening for social determinants of health including use of supporting tools into certified EHR technology	1) QCDR for Standardizing Screening Processes - Participation in QCDR for standardizing screening processes for social determinants, e.g., regular feedback reports from QCDR showing screening practices for social determinants; and 2) Integration of Tools into Certified EHR (suggested) - Integration of one or more of the following tools into practice as part of the EHR, e.g., http://www.cdc.gov/socialdeterminants /tools/index.htm showing regular referral to one or more of these tools
IA_AHE_3	Achieving Health Equity	Leveraging a QCDR to promote use of patient-reported outcome tools	Participation in a QCDR, demonstrating performance of activities for promoting use of patient-reported outcome (PRO) tools and corresponding collection of PRO data (e.g., use of PQH-2 or PHQ-9 and PROMIS instruments).	Medium	Participation in a QCDR and demonstrated performance of activities to promote use of patient-report outcome tools and corresponding collection of PRO data	Participation in QCDR, for use of patient-reported outcome tools, e.g., regular QCDR feedback reports demonstrating use of patient-reported outcome tools and corresponding collection of PRO data, e.g., use of PHQ-2 or PHQ-9 and PROMIS instruments
IA_AHE_4	Achieving Health Equity	Leveraging a QCDR for use of standard questionnaires	Participation in a QCDR, demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status (e.g., use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment).	Medium	Participation in a QCDR and demonstrated performance of activities for use of standard questionnaires for assessing improvement in health disparities related to functional health status	Participation in QCDR, to use of standard questionnaires for assessing improvements in health disparities, e.g., regular feedback reports from QCDR, demonstrating performance of activities for using standard questionnaires for assessing improvements in health disparities related to functional health status
IA_ERP_1	Emergency Response & Preparedness	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.	Medium	Participation in Disaster Medical Assistance Team or Community Emergency Responder Team for at least 6 months as a volunteer	Documentation of participation in Disaster Medical Assistance or Community Emergency Responder Teams for at least 6 months including registration and active participation, e.g., attendance at training, on-site participation, etc.

IA_ERP_2	Emergency Response & 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.	High	Participation in domestic or international humanitarian volunteer work of at least a continuous 60 days duration	Documentation of participation in domestic or international humanitarian volunteer work of at least a continuous 60 days duration including registration and active participation, e.g., identification of location of volunteer work, timeframe, and confirmation from humanitarian organization
IA_BMH_1	Behavioral and Mental Health	Diabetes screening	Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.	Medium	Performance of diabetes screening for patients with schizophrenia or bipolar disease who are using antipsychotic medication	Report from certified EHR, documentation from medical charts, or claims showing regular practice for diabetes screening of patients with schizophrenia or bipolar disease who are using antipsychotic medications
IA_BMH_2	Behavioral and Mental Health	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.	Medium	Performance of regular engagement in integrated prevention and treatment interventions including tobacco use screening and cessation interventions for patients with co-conditions of behavioral or mental health and at risk factors for tobacco dependence	Report 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
IA_BMH_3	Behavioral and Mental Health	Unhealthy alcohol use	Unhealthy alcohol use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including screening and brief counseling (refer to NQF #2152) for patients with co-occurring conditions of behavioral or mental health conditions.	Medium	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	Report 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 conditions.
IA_BMH_4	Behavioral and Mental Health	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.	Medium	Performance of regular engagement in integrated prevention and treatment interventions including depression screening and follow-up plan for patients with co-conditions of behavioral or mental health	Report 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-conditions of behavioral or mental health
IA_BMH_5	Behavioral and Mental Health	MDD prevention and treatment interventions	Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment (refer to NQF #0104) for mental health patients with co-occurring conditions of behavioral or mental health conditions.	Medium	Performance of regular engagement in integrated prevention and treatment interventions including suicide risk assessment for mental health patients with co-conditions of behavioral or mental health	Report from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice for screening including suicide risk assessment for mental health patients with co-occurring conditions of behavioral or mental health conditions
IA_BMH_6	Behavioral and Mental Health	Implementation of co-location PCP and MH services	Integration facilitation, and promotion of the colocation of mental health and substance use disorder services in primary and/or non-primary clinical care settings.	High	Integration of facilitation and promotion of mental health and substance use disorder services in primary and/or non-primary clinical care settings	Documentation of integration and promotion of the colocation of mental health and substance use disorder services in primary and/or non-primary clinical care settings, e.g., list of NPIs that participate as behavioral health specialists, mental health clinicians or primary care clinicians in co-located setting or patient claims showing mental health and substance use disorder services collocated in primary and/or non-primary clinical care settings
IA_BMH_7	Behavioral and Mental Health	Implementation of integrated PCBH model	Offer 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 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 certified health information technology functionality to support active care management and outreach to patients in treatment; and/or Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.	High	Provision of integrated behavioral health services to support patients with behavioral health needs and poorly controlled chronic conditions (May use certified EHR, QCDR, clinical registry or medical records)	Documented integration of behavioral health services with primary care to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions program and services including one or more of the six activities described in the activity description
IA_BMH_8	Behavioral and Mental Health	Electronic Health Record Enhancements for BH data capture	Enhancements to an electronic health record to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (e.g., capture of additional BH data results in additional depression screening for at-risk patient not previously identified).	Medium	Use of EHR to capture additional data on behavioral health populations and use data for additional decision-making	Screen shots from certified EHR or from other software/tools integrated with the certified EHR and reports showing how additional behavioral health data is captured and used for additional decision-making
NA	NA	Implementation of Patient-Centered Medical Home model	Implementation of the patient-centered medical home model to continually improve comprehensive care coordination and accessibility within the primary care setting. This may include implementing a wide range of practice and patient focused standards that pertain to the care coordination, patient-centeredness, comprehensiveness of care, systems based on safety and quality, among others.		Performance of standards and expectation that pertain to the patient-centered medical home model.	1) Documented implementation of patient-centered medical home activities and improvements that pertain to care coordination, patient-centeredness, or comprehensiveness of care, among others; or 2) Documented recognition as a patient-centered medical home from accredited body, combined with continual improvements