Clinical Practice Improvement Activities

	A	B	C	D	E
1	**ACTIVITY NAME**	**ACTIVITY DESCRIPTION**	**ACTIVITY ID**	**SUBCATEGORY NAME**	**ACTIVITY WEIGHTING**
2	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).	IA_EPA_4	Expanded Practice Access	Medium
3	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)	IA_PSPA_4	Patient Safety & Practice Assessment	Medium
4	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.	IA_PSPA_5	Patient Safety & Practice Assessment	Medium
5	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 first 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.	IA_PM_2	Population Management	High
6	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.	IA_CC_12	Care Coordination	Medium
7	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.).	IA_CC_10	Care Coordination	Medium
8	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.	IA_CC_11	Care Coordination	Medium
9	Chronic care and preventative care management for empanelled 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.	IA_PM_13	Population Management	Medium
10	CMS partner in Patients Hospital Engagement Network	Membership and participation in a CMS Partnership for Patients Hospital Engagement Network.	IA_CC_5	Care Coordination	Medium
11	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.	IA_BE_6	Beneficiary Engagement	High
12	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	Medium
13	Completion of the AMA STEPS Forward program	Completion of the American Medical Association's STEPS Forward program.	IA_PSPA_9	Patient Safety & Practice Assessment	Medium

Clinical Practice Improvement Activities

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1	**ACTIVITY NAME**	**ACTIVITY DESCRIPTION**	**ACTIVITY ID**	**SUBCATEGORY NAME**	**ACTIVITY WEIGHTING**
14	Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments	Completion of training and obtaining an approved waiver for provision of medication-assisted treatment of opioid use disorders using buprenorphine.	IA_PSPA_10	Patient Safety & Practice Assessment	Medium
15	Consultation of the Prescription Drug Monitoring program	Clinicians would attest that, 60 percent for first 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.	IA_PSPA_6	Patient Safety & Practice Assessment	High
16	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.	IA_BMH_4	Behavioral and Mental Health	Medium
17	Diabetes screening	Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.	IA_BMH_1	Behavioral and Mental Health	Medium
18	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).	IA_BMH_8	Behavioral and Mental Health	Medium
19	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.	IA_PM_5	Population Management	Medium
20	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.	IA_AHE_1	Achieving Health Equity	High
21	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.	IA_BE_15	Beneficiary Engagement	Medium
22	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.	IA_BE_4	Beneficiary Engagement	Medium
23	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.	IA_BE_3	Beneficiary Engagement	Medium
24	Engage patients and families to guide improvement in the system of care.	Engage patients and families to guide improvement in the system of care.	IA_BE_14	Beneficiary Engagement	Medium
25	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	Medium
26	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.	IA_BE_16	Beneficiary Engagement	Medium
27	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.	IA_PM_4	Population Management	High
28	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.	IA_CC_3	Care Coordination	Medium
29	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.	IA_PSPA_17	Patient Safety & Practice Assessment	Medium

Clinical Practice Improvement Activities

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1	**ACTIVITY NAME**	**ACTIVITY DESCRIPTION**	**ACTIVITY ID**	**SUBCATEGORY NAME**	**ACTIVITY WEIGHTING**
30	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	IA_PSPA_15	Patient Safety & Practice Assessment	Medium
31	Implementation of co-location PCP and MH services	Integration facilitation, and promotion of the colocation of mental health services in primary and/or non-primary clinical care settings.	IA_BMH_6	Behavioral and Mental Health	High
32	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.	IA_BE_20	Beneficiary Engagement	Medium
33	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	Medium
34	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.	IA_PM_15	Population Management	Medium
35	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 & Practice Assessment	Medium
36	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.	IA_PSPA_19	Patient Safety & Practice Assessment	Medium
37	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	Medium
38	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.	IA_BMH_7	Behavioral and Mental Health	High
39	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.	IA_PM_16	Population Management	Medium
40	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.	IA_PM_14	Population Management	Medium
41	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).	IA_CC_9	Care Coordination	Medium
42	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.	IA_CC_1	Care Coordination	Medium
43	Improved practices that disseminate appropriate self-management materials	Provide self-management materials at an appropriate literacy level and in an appropriate language.	IA_BE_21	Beneficiary Engagement	Medium
44	Improved practices that engage patients pre-visit	Provide a pre-visit development of a shared visit agenda with the patient.	IA_BE_22	Beneficiary Engagement	Medium

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1	**ACTIVITY NAME**	**ACTIVITY DESCRIPTION**	**ACTIVITY ID**	**SUBCATEGORY NAME**	**ACTIVITY WEIGHTING**
45	Integration of patient coaching practices between visits	Provide coaching between visits with follow-up on care plan and goals.	IA_BE_23	Beneficiary Engagement	Medium
46	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.	IA_PSPA_20	Patient Safety & Practice Assessment	Medium
47	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).	IA_AHE_4	Achieving Health Equity	Medium
48	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).	IA_AHE_3	Achieving Health Equity	Medium
49	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.	IA_AHE_2	Achieving Health Equity	Medium
50	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.	IA_BMH_5	Behavioral and Mental Health	Medium
51	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.	IA_PSPA_18	Patient Safety & Practice Assessment	Medium
52	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS(R) 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(R)	IA_PSPA_3	Patient Safety & Practice Assessment	Medium
53	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 attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater.	IA_ERP_2	Emergency Response & Preparedness	High
54	Participation in an AHRQ-listed patient safety organization.	Participation in an AHRQ-listed patient safety organization.	IA_PSPA_1	Patient Safety & Practice Assessment	Medium
55	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.	IA_BE_8	Beneficiary Engagement	Medium
56	Participation in a QCDR, that promotes implementation of patient self-action plans.	Participation in a QCDR, that promotes implementation of patient self-action plans.	IA_BE_10	Beneficiary Engagement	Medium
57	Participation in a QCDR, that promotes use of patient engagement tools.	Participation in a QCDR, that promotes use of patient engagement tools.	IA_BE_7	Beneficiary Engagement	Medium
58	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.	IA_BE_11	Beneficiary Engagement	Medium
59	Participation in Bridges to Excellence or other similar program	Participation in other quality improvement programs such as Bridges to Excellence	IA_PSPA_14	Patient Safety & Practice Assessment	Medium
60	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).	IA_PSPA_11	Patient Safety & Practice Assessment	High
61	Participation in CMMI models such as Million Hearts Campaign	Participation in CMMI models such as the Million Hearts Cardiovascular Risk Reduction Model	IA_PM_8	Population Management	Medium
62	Participation in Joint Commission Evaluation Initiative	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative	IA_PSPA_13	Patient Safety & Practice Assessment	Medium

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1	**ACTIVITY NAME**	**ACTIVITY DESCRIPTION**	**ACTIVITY ID**	**SUBCATEGORY NAME**	**ACTIVITY WEIGHTING**
63	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.	IA_PSPA_2	Patient Safety & Practice Assessment	Medium
64	Participation in population health research	Participation in research that identifies interventions, tools or processes that can improve a targeted patient population.	IA_PM_9	Population Management	Medium
65	Participation in private payer CPIA	Participation in designated private payer clinical practice improvement activities.	IA_PSPA_12	Patient Safety & Practice Assessment	Medium
66	Participation in State Innovation Model funded activities	Participation in State Innovation Model funded activities.	IA_AHE_5	Achieving Health Equity	Medium
67	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 year 1 and 75 percent of practice patients in year 2 who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors).	IA_PM_1	Population Management	High
68	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 & Preparedness	Medium
69	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."
70	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.	IA_CC_13	Care Coordination	Medium
71	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.	IA_CC_14	Care Coordination	Medium
72	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	IA_EPA_1	Expanded Practice Access	High
73	Provide peer-led support for self-management.	Provide peer-led support for self-management.	IA_BE_18	Beneficiary Engagement	Medium
74	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.	IA_BE_13	Beneficiary Engagement	Medium
75	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.	IA_PM_11	Population Management	Medium
76	Regular training in care coordination	Implementation of regular care coordination training.	IA_CC_7	Care Coordination	Medium

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1	**ACTIVITY NAME**	**ACTIVITY DESCRIPTION**	**ACTIVITY ID**	**SUBCATEGORY NAME**	**ACTIVITY WEIGHTING**
77	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 in line with Section 1848(q)(2)(B)(iii) of the Act that requires the Secretary to give consideration to the circumstances of practices located in rural areas and geographic HPSAs. Rural Health Clinics would be included in that definition for consideration of practices in rural areas.	IA_PM_3	Population Management	High
78	TCPI participation	Participation in the CMS Transforming Clinical Practice Initiative.	IA_CC_4	Care Coordination	High
79	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	Medium
80	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.	IA_BMH_3	Behavioral and Mental Health	Medium
81	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	Medium
82	Use group visits for common chronic conditions (e.g., diabetes).	Use group visits for common chronic conditions (e.g., diabetes).	IA_BE_19	Beneficiary Engagement	Medium
83	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.	IA_BE_1	Beneficiary Engagement	Medium
84	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.	IA_PSPA_16	Patient Safety & Practice Assessment	Medium
85	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.	IA_PSPA_8	Patient Safety & Practice Assessment	Medium
86	Use of QCDR data for ongoing practice assessment and improvements	Use of QCDR data, for ongoing practice assessment and improvements in patient safety.	IA_PSPA_7	Patient Safety & Practice Assessment	Medium
87	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).	IA_PM_10	Population Management	Medium
88	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.	IA_PM_7	Population Management	High
89	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.	IA_BE_9	Beneficiary Engagement	Medium
90	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).	IA_CC_6	Care Coordination	Medium
91	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.	IA_BE_2	Beneficiary Engagement	Medium
92	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.	IA_EPA_2	Expanded Practice Access	Medium
93	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.	IA_PM_6	Population Management	Medium
94	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).	IA_BE_17	Beneficiary Engagement	Medium