Choosing Improvement Activities

If you answer "Yes" to any of the questions, you may be eligible for the Improvement Activity listed.

Do you remind pts of missed or overdue services?

IA_PM_13

Do you have a process to identify and care for pts post hospitalization or ED visit?

IA_PM_15
IA_CC_10

Are you involved in any community or international volunteer efforts (e.g. disaster planning, national relief)?

IA_ERP_1
IA_ERP_2

Do you have an established process to prepare for the next day's visits?

IA_PM_13
IA_BE_22

Do you have an established rooming work flow to optimize provider time, having all staff work to their highest license (e.g. medication reconciliation, review of overdue services)?

IA_PM_13
IA_PM_16
IA_BE_22

Do you utilize the Prescription Monitoring Program prior to dispensing opioids or applied for waiver to treat patients with buprenorphine?

IA_PSPA_6
IA_PSPA_5
IA_PSPA_10

If your patients are assigned a primary provider, do you understand your panel profile and routinely assess (e.g. chronic conditions, payer mix, 3rd next available, etc.)

IA_PM_9
IA_PM_11
IA_PSPA_17
IA_AHE_1

Do you have a standard process for placing and tracking orders (referrals, diagnostics) or notifying patients of results?

IA_CC_1
IA_CC_2
IA_CC_12
IA_CC_13

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Choosing Improvement Activities

Do you offer services such as telehealth, chronic disease group visits, peer support groups?

IA_EPA_2
IA_BE_18
IA_BE_19
IA_BE_20
IA_EPA_4

Do you have a process for staff education and assessment?

IA_CC_7
IA_PSPA_4
IA_PSPA_11
IA_PSPA_19
IA_PSPA_20

Do you distribute patient-satisfaction surveys, safety surveys or have a patient Advisory Council?

IA_EPA_3
IA_BE_6
IA_BE_13
IA_BE_14
IA_PSPA_4
IA_PSPA_11

Do you have any ancillary staff embedded in your practice (Care Manager, Social Worker, PharmD, Certified Diabetes Educator, Nutritionist, peer counselor)?

IA_PM_14
IA_PM_15
IA_PM_16
IA_BE_17
IA_BE_23
IA_BMH_6
IA_BMH_7

Have you incorporated behavioral health services and screenings into your practice (e.g. colocation of services, screening efforts for tobacco, diabetes, alcohol, depression)?

IA_BMH_6
IA_BMH_7
IA_BMH_1
IA_BMH_2
IA_BMH_3
IA_BMH_4
IA_BMH_5
IA_BMH_8

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Choosing Improvement Activities

Have you incorporated efforts to enhance patient education, self-management and care- planning efforts into your workflow or your EMR?

IA_PM_14	IA_BE_16
IA_CC_9	IA_BE_17
IA_CC_14	IA_BE_20
IA_BE_12	IA_BE_21
IA_BE_14	IA_BE_23
IA_BE_15	

Do you provide longitudinal Case Management for patients?

IA_PM_14	IA_CC_14
IA_PM_15	IA_BE_15
IA_CC_8	IA_BE_16
IA_CC_9	IA_BE_22
IA_CC_10	IA_BE_23
IA_CC_11	IA_PM_13

Does your EMR offer advanced functionality (i.e. interface with HIE, patient education, decision support, DME interfaces, patient portal, risk tools, order completion, referral loop, registry)?

IA_CC_1	IA_PSPA_8
IA_CC_13	IA_PSPA_15
IA_BE_1	IA_PSPA_16
IA_BE_4	IA_BMH_7
IA_BE_5	IA_PM_4
IA_BE_12	IA_PSPA_21

Have you integrated evidence based performance improvement processes within your office (e.g. identifying high risk patients, Chronic Disease, Diabetes Mellitus, improving patient satisfaction, reducing cost, falls screen, optimizing antibiotic use, anticoagulation, managing medication effectively, shared decision making, risk reduction)?

IA_PM_2	
IA_PM_4	IA_PSPA_17
IA_PM_11	IA_PSPA_18
IA_PM_13	IA_PSPA_19
IA_PSPA_8	IA_PSPA_20
IA_PSPA_15	IA_PSPA_21
IA_PSPA_16	IA_PM_1

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Choosing Improvement Activities

Do you participate in a Qualified Clinical Data Registry (QCDR)?

IA_PM_4	IA_BE_9
IA_PM_7	IA_BE_10
IA_PM_10	IA_BE_11
IA_CC_6	IA_PSPA_7
IA_BE_2	IA_AHE_3
IA_BE_7	IA_AHE_4
IA_BE_8	IA_AHE_2

Are you currently involved in any national or payer quality improvement efforts (e.g. State Innovations, Million Hearts, Transforming Clinical Practice Initiative (TCPI), Practice Transformation Network (PTN), working with your local Quality Improvement Network, Quality Improvement Organization (QIN/ QIO), Maintenance of Certification (MOC) Part IV, AQHR participation, etc.)?

IA_EPA_4	IA_PSPA_1
IA_PM_5	IA_PSPA_3
IA_PM_6	IA_PSPA_2
IA_PM_8	IA_PSPA_9
IA_PM_9	IA_PSPA_12
IA_CC_4	IA_PSPA_13
IA_EPA_4	IA_PSPA_14
IA_CC_5	IA_AHE_5
IA_BE_3	IA_CC_3

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Activity ID	Activity Name	Activity Description	Activity Weighting	Subcategory Name
IA_EPA_4	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	Expanded Practice Access
IA_PSPA_4	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	Patient Safety & Practice Assessment
IA_PSPA_5	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	Patient Safety & Practice Assessment
IA_PM_2 *	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.	High	Population Management
IA_CC_12	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	Care Coordination
IA_CC_10	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	Care Coordination
IA_CC_11	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	Care Coordination

* Measure is eligible for ACI extra credit
Updated: 7/31/2017

Activity ID	Activity Name	Activity Description	Activity Weighting	Subcategory Name
IA_PM_13 *	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.	Medium	Population Management
IA_CC_5	CMS partner in Patients Hospital Engagement Network	Membership and participation in a CMS Partnership for Patients Hospital Engagement Network.	Medium	Care Coordination
IA_BE_6	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	Beneficiary Engagement
IA_EPA_3	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	Expanded Practice Access
IA_PSPA_9	Completion of the AMA STEPS Forward program	Completion of the American Medical Association's STEPS Forward program.	Medium	Patient Safety & Practice Assessment
IA_PSPA_10	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.	Medium	Patient Safety & Practice Assessment
IA_PSPA_6	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.	High	Patient Safety & Practice Assessment
IA_BMH_4	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	Behavioral and Mental Health
IA_BMH_1	Diabetes screening	Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.	Medium	Behavioral and Mental Health
IA_BMH_8 *	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	Behavioral and Mental Health

Activity ID	Activity Name	Activity Description	Activity Weighting	Subcategory Name
IA_PM_5	**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	Population Management
IA_AHE_1	**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	Achieving Health Equity
IA_BE_15 *	**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	Beneficiary Engagement
IA_BE_4 *	**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	Beneficiary Engagement
IA_BE_3	**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	Beneficiary Engagement
IA_BE_14	**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	Beneficiary Engagement
IA_BE_5	**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	Beneficiary Engagement
IA_BE_16	**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	Beneficiary Engagement

Activity ID	Activity Name	Activity Description	Activity Weighting	Subcategory Name
IA_PM_4 *	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	Population Management
IA_CC_3	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	Care Coordination
IA_PSPA_17	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	Patient Safety & Practice Assessment
IA_PSPA_15	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	Patient Safety & Practice Assessment
IA_BMH_6	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.	High	Behavioral and Mental Health
IA_BE_20	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	Beneficiary Engagement
IA_CC_8 *	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	Care Coordination
IA_PM_15 *	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	Population Management
IA_PSPA_21	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	Patient Safety & Practice Assessment

Activity ID	Activity Name	Activity Description	Activity Weighting	Subcategory Name
IA_PSPA_19	**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	Patient Safety & Practice Assessment
IA_CC_2	**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	Care Coordination
IA_BMH_7 *	**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	Behavioral and Mental Health
IA_PM_16 *	**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	Population Management
IA_PM_14 *	**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	Population Management
IA_CC_9 *	**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	Care Coordination
IA_CC_1 *	**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	Care Coordination

Activity ID	Activity Name	Activity Description	Activity Weighting	Subcategory Name
IA_BE_21 *	Improved practices that disseminate appropriate self-management materials	Provide self-management materials at an appropriate literacy level and in an appropriate language.	Medium	Beneficiary Engagement
IA_BE_22	Improved practices that engage patients pre-visit	Provide a pre-visit development of a shared visit agenda with the patient.	Medium	Beneficiary Engagement
IA_BE_23	Integration of patient coaching practices between visits	Provide coaching between visits with follow-up on care plan and goals.	Medium	Beneficiary Engagement
IA_PSPA_20	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	Patient Safety & Practice Assessment
IA_AHE_4	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	Achieving Health Equity
IA_AHE_3	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	Achieving Health Equity
IA_AHE_2	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	Achieving Health Equity
IA_BMH_5	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	Behavioral and Mental Health
IA_PSPA_18	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	Patient Safety & Practice Assessment
IA_PSPA_3	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)	Medium	Patient Safety & Practice Assessment
IA_ERP_2	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.	High	Emergency Response & Preparedness

* Measure is eligible for ACI extra credit

Activity ID	Activity Name	Activity Description	Activity Weighting	Subcategory Name
IA_PSPA_1	**Participation in an AHRQ-listed patient safety organization.**	Participation in an AHRQ-listed patient safety organization.	Medium	Patient Safety & Practice Assessment
IA_BE_8	**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	Beneficiary Engagement
IA_BE_10	**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	Beneficiary Engagement
IA_BE_7	**Participation in a QCDR, that promotes use of patient engagement tools.**	Participation in a QCDR, that promotes use of patient engagement tools.	Medium	Beneficiary Engagement
IA_BE_11	**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	Beneficiary Engagement
IA_PSPA_14	**Participation in Bridges to Excellence or other similar program**	Participation in other quality improvement programs such as Bridges to Excellence	Medium	Patient Safety & Practice Assessment
IA_PSPA_11	**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	Patient Safety & Practice Assessment
IA_PM_8	**Participation in CMMI models such as Million Hearts Campaign**	Participation in CMMI models such as the Million Hearts Cardiovascular Risk Reduction Model	Medium	Population Management
IA_PSPA_13	**Participation in Joint Commission Evaluation Initiative**	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative	Medium	Patient Safety & Practice Assessment
IA_PSPA_2	**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	Patient Safety & Practice Assessment
IA_PM_9	**Participation in population health research**	Participation in research that identifies interventions, tools or processes that can improve a targeted patient population.	Medium	Population Management

Activity ID	Activity Name	Activity Description	Activity Weighting	Subcategory Name
IA_PSPA_12	**Participation in private payer CPIA**	Participation in designated private payer clinical practice improvement activities.	Medium	Patient Safety & Practice Assessment
IA_AHE_5	**Participation in State Innovation Model funded activities**	Participation in State Innovation Model funded activities.	Medium	Achieving Health Equity
IA_PM_1	**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).	High	Population Management
IA_ERP_1	**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	Emergency Response & Preparedness
IA_PM_12	**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	Population Management
IA_CC_13 *	**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	Care Coordination
IA_CC_14	**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	Care Coordination
IA_EPA_1 *	**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	Expanded Practice Access

Activity ID	Activity Name	Activity Description	Activity Weighting	Subcategory Name
IA_BE_18	**Provide peer-led support for self-management.**	Provide peer-led support for self-management.	Medium	Beneficiary Engagement
IA_BE_13	**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	Beneficiary Engagement
IA_PM_11	**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	Population Management
IA_CC_7	**Regular training in care coordination**	Implementation of regular care coordination training.	Medium	Care Coordination
IA_PM_3	**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.	High	Population Management
IA_CC_4	**TCPI participation**	Participation in the CMS Transforming Clinical Practice Initiative.	High	Care Coordination
IA_BMH_2	**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	Behavioral and Mental Health
IA_BMH_3	**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	Behavioral and Mental Health
IA_BE_12	**Use evidence-based decision aids to support shared decision-making**	Use evidence-based decision aids to support shared decision-making.	Medium	Beneficiary Engagement
IA_BE_19	**Use group visits for common chronic conditions (e.g., diabetes)**	Use group visits for common chronic conditions (e.g., diabetes).	Medium	Beneficiary Engagement
IA_BE_1 *	**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	Beneficiary Engagement

* Measure is eligible for ACI extra credit

Activity ID	Activity Name	Activity Description	Activity Weighting	Subcategory Name
IA_PSPA_16 *	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	Patient Safety & Practice Assessment
IA_PSPA_8	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	Patient Safety & Practice Assessment
IA_PSPA_7	Use of QCDR data for ongoing practice assessment and improvements	Use of QCDR data, for ongoing practice assessment and improvements in patient safety.	Medium	Patient Safety & Practice Assessment
IA_PM_10 *	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	Population Management
IA_PM_7	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	Population Management
IA_BE_9	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	Beneficiary Engagement
IA_CC_6	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	Care Coordination
IA_BE_2	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	Beneficiary Engagement
IA_EPA_2	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	Expanded Practice Access
IA_PM_6	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	Population Management
IA_BE_17	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	Beneficiary Engagement

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Updated: 7/31/2017