GUARDIAN CMS APPROVED QUALIFIED MIPS REGISTRY RESOURCE MATERIAL

MIPS IMPROVEMENT ACTIVITIES (IA) PERFORMANCE CATEGORY DESCRIPTIONS, VALIDATION EXPECTATIONS, AND DOCUMENTATION RECOMMENDATIONS

The table below provides a breakdown of the 92 Improvement Activities that qualify for high or medium point values distributed across the following **eight sub-categories** of the MIPS Improvement Activities Performance Category:

1. Expanded Practice Access (EPA) Improvement Activities
2. Care Coordination (CC) Improvement Activities
3. Beneficiary Engagement (BE) Improvement Activities
4. Population Management (PM) Improvement Activities
5. Patient Safety and Practice Assessment (PSPA) Improvement Activities
6. Behavioral and Mental Health (BMH) Improvement Activities
7. Achieving Health Equity (AHE) Improvement Activities
8. Emergency Preparedness and Response (EPR) Improvement Activities

Within the table, specific reference is made for a) each activity within the eight subcategories, b) the required information to validate an attestation of performance of a given activity, and 3) the suggested documentation that should be available to support attestations.

MIPS eligible providers are granted an opportunity to select and attest to performance of improvement activities that fit their practice. During the transition performance year (2017), eligible providers or groups can elect to either earn **minimal credit** (and corresponding minimal payment in 2019) through **test participation** in the MIPS IA Performance Category, or they can choose to satisfy **partial (90-day) or full year participation** requirements (and correspondingly increase their potential payment for this performance category). The expectations associated with these MIP Improvement Activity Performance Category participation options are:

- **Test Participation**. To earn Test Participation credit for the MIS IA Performance Category, MIPS eligible providers or groups must submit data to CMS for at least one improvement activity, which can be high weight or medium weight.

- **Partial Participation and Full Year Participation.** To meet partial (90-day) participation or Full Year participation requirements for the transition performance year 2017 for the 2019 payment year, MIPS eligible providers or groups must submit data to CMS attesting that they have completed improvement activities that meet one of the following combinations:

- ✓ 2 high-weighted activities
- ✓ 1 high-weighted activity and 2 medium-weighted activities, or
- ✓ At least 4 medium-weighted activities.

In light of the fact the this performance category is NEW, CMS reduced the number of activities required to achieve full credit from six medium-weighted or three high-weighted activities to four medium-weighted or two high-weighted activities in this performance category for the 2017 Transition Year. Further, for small practices, rural practices, or practices located in geographic health professional shortage areas (HPSAs), and non-patient facing MIPS eligible providers, CMS reduced the requirement to only one high-weighted or two medium-weighted activities. For performance years 2018 and beyond, the expectations (mix and number of IA activities) of CMS for this performance category will increase.

For the 2017 Transition Year, the final Improvement Activities (IA) Performance Category score will be determined by taking the number of points earned based on activity data reported to CMS and dividing that number by the maximum number of points that can be earned (40) and multiplying the total by 100. The Improvement Activities Performance Category will be weighted at 15% of an eligible providers MIPS Final Composite Score.

IMPORTANT NOTE: Handout Number Two provides **several examples** of the activities that qualify for high or medium point values for each of the eight sub-categories of the MIPS Improvement Activities (IA) Performance Category that can be documented and reported through the use of the Guardian HIE architecture, the Guardian CMS Approved Qualified Registry, and/or the Guardian Care Management (GCM) Programs. This Handout serves to clearly demonstrate the interrelationship between this MIPS Performance Category and the clinical integration capability of the Guardian HIE architecture, and the range of unique Programs and Platforms operated by Guardian Care Management and driven by the Guardian architecture.

EXPANDED PRACTICE ACCESS (EPA) IMPROVEMENT ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
IA_EPA_1 High	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.	Functionality of 24/7 or expanded practice hours with access to medical records or ability to increase access methods or same day or next day visits.	Patient Record from a Certified Electronic Health Record (CEHR) with date and timestamp indicating service provided outside normal business hours for the MIPS eligible provider; **OR** Patient encounter medical record claim indicating patient was seen or services provided outside normal business hours for the MIPS eligible provider; **OR** patient encounter/medical record claim indicating that patient was seen the same-day or next-day to a consistent MIPS eligible provider for urgent or transitional care.
IA_EPA_2 Medium	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or tele-audiology pilots that	Documentation of telehealth services and analysis of data for quality improvement.	Documentation of telehealth services through 1) claims adjudication (e.g., identification of G Code), 2) a Certified Electronic Health Record (CEHR), or 3) other medical record document

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	assess ability to still deliver quality care to patients.		identifying telehealth services, consults or referrals for a patient; **AND** Participation in or performance of quality improvement analysis showing delivery of quality care to patients through a telehealth medium (e.g., excel spreadsheet; word document).
IA_EPA_3 Medium	Collection of patient experience and satisfaction data on access to care and development of an improvement plan (e.g., outlining steps to improving communication with patients to help understand their urgent access needs.	Development and use of a access to care improvement plan based on collected patient experience and satisfaction data.	Documented patient experience and satisfaction data on access to care; **AND** access to a corresponding improvement plan.
IA_EPA_4 Medium	As a result of Quality Improvement Organization (QIO) technical assistance, perform additional activities that improve access to services (e.g., investment in an on-site diabetes educator) (Medium).	Implementation of additional processes, practices, or technology to improve access to services resulting from QIO technical assistance.	Confirmation of technical assistance from a QIO; **AND** Documentation of improvement activities that improve access including support for any additional services offered.

CARE COORDINATION IMPROVEMENT ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
IA_CC_1 Medium	Performance of regular practices that include providing specialist reports back to the referring MIPS eligible provider or group to close the referral loop or where the referring MIPS eligible provider or group initiates regular inquires to specialists for specialist reports which could be documented or noted in Certified Electronic Health Record (CEHR).	Functionality of providing information by specialist to referring provider or inquiring provider receives and documents specialist report.	Sample of specialist reports reported to referring provider or group; **OR** Specialist reports documented in inquiring providers CEHR.
IA_CC_2 Medium	Timely communication of test results with patients defined as timely identification of abnormal test results with timely follow-up.	Functionality of reporting abnormal test results to patients in a timely manner with follow-up.	Reports from a Certified Electronic Health Record (CEHR), **OR** medical records demonstrating timely communication of abnormal test results to patient.
IA_CC_3 Medium	Implementation of at least one additional recommended activity from the Quality Innovation Network-Quality Improvement Organization QIN-QIO) after technical assistance has been provided related to improving care coordination.	Implementation of at least one QIN-QIO activity related to care coordination.	Documentation of QIN-QIO technical assistance; **AND** documentation that at least one recommended care coordination activity has been implemented.
IA_CC_4 Medium	Participation in the CMS Transforming Clinical Practice (TCP) Initiative.	Active participation in TCP Initiative.	Confirmation of participation in the TCP Initiative for the target performance year (e.g., CMS confirmation e-mail).
IA_CC_5 Medium	Membership and participation in a CMS Partnership for Patients Hospital Engagement Network.	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 the target performance year (e.g., CMS confirmation e-mail).

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IA_CC_6 Medium	Participation in a Qualified Clinical Data Registry (QCDR), 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 provider or groups).	Active participation in a QCDR to promote standard practices, tools and processes for quality improvement.	Participation in a QCDR demonstrating promotion of standard practices, tools and processes for quality improvement (e.g., regular feedback reports from the QCDR that demonstrate use of QCDR data to promote use of standard practices, tools and processes for quality improvement, including preventative screenings.
IA_CC_7 Medium	Implementation of regular care coordination training.	Inclusion of regular care coordination training in practice.	Documentation of implementation of regular care coordination training within practice (e.g., training curriculum, training materials, attendance roster or training certification register/documents).
IA_CC_8 Medium	Implementation of practices/processes that document care coordination activities.	Processes and practices are implemented to improve care coordination.	Documentation that supports implementation of care coordination activities (e.g., documented care coordination encounter that tracks clinical staff involved in communications from date patient is scheduled through the day of procedure or office visit).
IA_CC_9 Medium	Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s).	Individual care coordination plans are regularly developed and up-dated for high-risk patients and shared with patient or caregiver.	Documented practices/processes for developing regularly individual care plans for high-risk patients (e.g., care plan template); **AND** patient medical records documenting care plan being shared with patient or caregiver.

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IA_CC_10 Medium	Implementation of practices/processes for care transition that include documentation of how a MIPS eligible provider or group carried out a patient-centered action plan for first 30 days following a discharge.	Patient centered care transition action plan is carried out for 30 days post discharge.	Documentation of care transition practices/processes including patient centered action plan for first 30 days following discharge (e.g., staff involved, phone calls conducted in support of transition, accompaniments, navigation actions, home visits, patient information access, etc.).
IA_CC_11 Medium	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.	Functionality of information flow during transition of care to ensure seamless transitions.	Documentation of formal lines of communication to manage transitions of care with local settings (e.g., hospital care transitions of care services) in which empaneled patients receive care to ensure documented flow of information and seamless care; **OR** Documentation showing partnership with hospital transitions of care services.
IA_CC_12 Medium	Establish effective care coordination and active referral management that could include one or more of the following: • Establish a care coordination agreements with frequently used consultants that detail 1) expectations regarding the flow of information, 2) the role and expectations of MIPS eligible providers or groups, and 3) provides	Functionality of effective care coordination and care management.	Sample of care coordination agreement(s) that establish documented flow of information and provides patients with information to set consistent expectations; **OR** medical record or Certified Electronic Health Record (CEHR) documentation demonstrating complete tracking of patients referred to specialists; **OR** sample of specialists referral information systematically into the plan of care.

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	patients with information that sets their expectations consistently with the care coordination agreements. • **AND/OR** Track patients through the entire care coordination referral process to specialists. • **AND/OR** Systematically integrate information from referrals into the plan of care.		
IA_CC_13 Medium	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 (HIE) if available; and/or Use structured referral notes.	Functionality of bilateral exchange of patient information to guide patient care.	Conformation of participation in a HIE (e.g., e-mail confirmation, screen shots demonstrating active engagement with the HIE); **OR** samples of specialist referral information systematically integrated into the plan of care.
IA_CC_14 Medium	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	Availability of formal links to community-based health and wellness programs.	Documentation of community-based chronic disease self-care management support programs, exercise programs, and other wellness resources (including specific name) with which practices have formal referral links and have potential bidirectional flow of information; OR medical record demonstrating provision of a guide to community resources.

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	with the potential for bidirectional flow of information. • **AND/OR** provide a guide to available community resources.		

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IA_BE_1 Medium	In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (e.g.,	Functionality of patient reported outcomes in CEHR.	Report from the CEHR, showing the capture of PROs or the patient activation measures performed; **OR**

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	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 a Certified Electronic Health Record (CEHR), containing this data in a separate queue for provider recognition and review**.**		Documentation showing the call out of this data for provider recognition and review (e.g. within a report or a screen-shot).
IA_BE_2 Medium	Participation in a Qualified Clinical Data Registry (QCDR), demonstrating performance of activities that promote implementation of shared clinical decision making capabilities.	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	Engagement with a Quality Innovation Network-Quality Improvement Organization (QIN-QIO), which may include participation in self-management training programs such as diabetes, CHF, or COPD.	Use of QIN-QIO to implement self-management training programs.	Documentation from QIN-QIO of MIPS eligible provider or group's engagement and use of services to assist with self-care management (e.g., self-care management training program(s) such as diabetes, CHF, or COPD).
IA_BE_4 Medium	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.	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).

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IA_BE_5 Medium	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. This includes designing a patient portal or website that is compliant with section 508 of the Rehabilitation Act of 1973.	Section 508 compliant practice website/tools are regularly updated and enhanced.	Documentation of regular updates and Section 508 compliance process for the clinician's patient portal or website; **AND** 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 High	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.	Patient experience and satisfaction data on beneficiary engagement is collected and follow up occurs through an improvement plan.	Documentation of collection and follow-up on patient experience and satisfaction (e.g. survey results); **AND** Documented patient experience and satisfaction improvement plan.

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IA_BE_7 Medium	Participation in a Qualified Clinical Data Registry (QCDR), that promotes use of patient engagement tools.	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 Medium	Participation in a Qualified Clinical Data Registry (QCDR), that promotes collaborative learning network opportunities that are interactive.	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 Medium	Use of Qualified Clinical Data Registry (QCDR) patient experience data to inform and advance improvements in beneficiary engagement.	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 Medium	Participation in a Qualified Clinical Data Registry (QCDR) that promotes implementation of patient self-action plans.	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 Medium	Participation in a Qualified Clinical Data Registry (QCDR) that promotes use of	Participation in a QCDR to promote use of processes and	Participation in QCDR promoting engagement of patients for adherence to treatment plans (e.g., regular feedback

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	processes and tools that engage patients for adherence to treatment plan.	tools to engage patients to adhere to treatment plans.	reports provided by the QCDR showing the promotion of processes and tools that engage patients for adherence to treatment plans).
IA_BE_12 Medium	Use evidence-based decision aids to support shared decision-making.	Use of evidence based decision aids to support shared decision-making with patient.	Documentation (e.g. checklist, algorithms, tools, screen shots) demonstrating the use of evidence-based decision aids to support shared decision-making with patients.
IA_BE_13 Medium	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.	Conduct of regular assessments of patient care experience.	Documentation (e.g. survey results, advisory council notes and/or other methods) demonstrating regular assessments of the patient care experience to improve overall patient experiences.
IA_BE_14 Medium	Engage patients and families to guide improvement in the system of care.	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).
IA_BE_15 Medium	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the Certified Electronic Health Record (CEHR).	Inclusion of patients, family and caregivers in plan of care and prioritizing goals for action, as documented in the CEHR.	Report from the CEHR showing the plan of care and prioritized goals for action with engagement of the patient, family and caregivers, if applicable
IA_BE_16 Medium	Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with	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

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	structured follow-up, Teach Back, action planning or motivational interviewing.		(e.g., eligible providers' completed office visit checklist, Electronic Health Record (EHR) report of completed checklist).
IA_BE_17 Medium	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).	Use of tools to assist patient self-management.	Documentation in patient record or Electronic Health Record (EHR) demonstrating use of Patient Activation Measure, How's My Health, or similar tools to assess patients need for support for self-management.
IA_BE_18 Medium	Provide peer-led support for self-care management.	Provision of self-management materials appropriate for literacy level and language.	Documented provision in Electronic Health Record (HER) 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_19 Medium	Use group visits for common chronic conditions (e.g., diabetes, CHF, COPD).	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 Medium	Provide condition-specific chronic disease self-care management support programs or coaching or link patients to those programs in the community.	Use of condition-specific chronic disease self-management programs or coaching or link to community programs.	Documentation from medical record or Electronic Health Record (HER) showing condition specific chronic disease self-management support program or coaching; **OR** Documentation of referral/link of patients to condition specific chronic disease self-

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			management support programs in the community.
IA_BE_21 Medium	Provide self-management materials at an appropriate literacy level and in an appropriate language.	Provision of self-management materials appropriate for literacy level and language.	Documented provision in Electronic Health Record (HER) 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 Medium	Provide a pre-visit development of a shared visit agenda with the patient.	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 Medium	Provide coaching between visits with follow-up on care plan and goals.	Use of coaching between visits with follow-up on care plan and goals. Could be supported by claims.	Documentation of Medical claims with codes for coaching provided between visits; **OR** Copy of documentation provided to patients (e.g. letter, email, portal screenshot) that includes coaching on care plan and goals.

POPULATION MANAGEMENT ACTIVITIES			
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IA_PM_1 High	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).	Documented participation of patients in a systematic anticoagulation program. Could be supported by claims.	Total number of patients receiving anti-coagulation medications; **AND** Documented number of referrals to a coagulation/anti-coagulation clinic; number of patients performing patient self-reporting; or number of patients participating in self-care management.
IA_PM_2 High	MIPS eligible providers 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: **1.** 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; **AND/OR** **2.** Patients are being managed according to validated electronic decision support	Documented participation of patients being managed by one or more clinical practice improvement activities. Could be supported by claims.	Document total number of outpatients prescribed oral Vitamin K antagonist therapy; **AND** Number of outpatients prescribed oral Vitamin K antagonist therapy and who are being managed by one or more of the four activities identified.

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	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; **AND/OR** 3. 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** 4. For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient self-care management program. **NOTE**: The performance threshold for this MIPS IA Performance Category activity will increase to 75 percent for the second performance year and onward. Eligible providers would attest that, 60 percent for the transition year, or 75 percent for the second year, of their ambulatory care		

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	patients receiving warfarin participated in an anticoagulation management program for at least 90 days during the performance period.		
IA_PM_3 High	Participating in a Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center (FQHC) 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 providers 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.	Participation in RHC, HIS, or FQHC occurs and clinical quality improvement occurs.	Identified name of RHC, IHS, or FQHC in which the practice participates in ongoing engagement activities; **AND** 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 High	For outpatient Medicare patients with diabetes and who are prescribed antidiabetic agents (e.g., insulin,	Report listing patients who are diabetic and prescribed antidiabetic agents and have documented	Total number of outpatients who are diabetic and prescribed antidiabetic agents; **AND**

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	sulfonylureas), MIPS eligible providers 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. **NOTE:** The performance threshold for this MIPS IA Performance Category activity will increase to 75 percent for the second performance year and onward. Providers 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.	glycemic treatment goals based on patient-specific factors.	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 Medium	Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to	Activity to improve specific chronic condition within the community is being undertaken.	Screenshot of website or other correspondence identifying key partners and stakeholders and relevant initiative including specific chronic condition; **AND**

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	implement evidenced-based practices to improve a specific chronic condition. **NOTE:** 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.		Report detailing steps being taken to satisfy the activity (e.g., timeline, purpose, and outcome that is in compliance with the local QIO).
IA_PM_6 Medium	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. **NOTE:** 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.	Activity to improve health disparities.	Documentation of resources used (e.g., Population Health Toolkit; **AND** Report detailing the steps in implementing the inactivity as outlined by the local QIO.
IA_PM_7 High	Use of a Qualified Clinical Data Registry (QCDR) to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.	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).

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IA_PM_8 Medium	Participation in Center for Medicare and Medicaid Innovation (CMMI) models such as the Million Hearts Cardiovascular Risk Reduction Model.	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 Medium	Participation in research that identifies interventions, tools or processes that can improve a targeted patient population.	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 Medium	Participation in a Qualified Clinical Data Registry (QCDR), or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. **NOTE:** 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).	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 Medium	Implementation of regular reviews of targeted patient population needs which includes access to reports that show unique characteristics of eligible	Participation in reviews of targeted patient population needs including access to reports and community resources.	Documentation of method for identification and ongoing monitoring/review for a targeted patient population; **AND**

POPULATION MANAGEMENT ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
	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.		Reports that show unique characteristics of patient population and identification of vulnerable patients; **AND** Medical records demonstrating ways clinical treatment needs are being tailored to meet unique needs including additional community resources, if necessary.
IA_PM_12 Medium	Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible provider or group or care team. **NOTE:** Empanelment identifies the patients and population for whom the MIPS eligible provider or group and/or care team is responsible and is the foundation for the relationship continuity between patient and MIPS eligible provider or group /care team that is at the heart of comprehensive primary care.	Functionality of patient population empanelment including use of panels for health management	Identification of "active population" of the practice with empanelment and assignment confirmation linking patients to MIPS eligible provider or care team; **AND** Documentation of process for review and update of panel assignments.
IA_PM_13 Medium	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	Management of empaneled patients' chronic and preventive care needs (could use EHR or medical records).	Annual opportunity for development and/or adjustment of an individualized plan of care appropriate to age and health status; **OR** Use of condition-specific pathways for chronic conditions with evidence-based protocols, **OR** Use of pre-visit planning to optimize preventive care and team

POPULATION MANAGEMENT ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
	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.		management; **OR** Use of panel support tools to identify services that are due; **OR** Use of reminders and outreach to alert and educate patients about services due; **OR** Use of routine medication reconciliation.
IA_PM_14 **Medium**	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	Longitudinal care management to patients at high risk for adverse health outcome or harm.	Identification of patients at high risk for adverse health outcome or harm; **AND** Documented use of longitudinal care management methods including at least one

POPULATION MANAGEMENT ACTIVITIES			
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	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.		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 Medium	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.	Provision of episodic care management practice improvements (could use medical records or claims).	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** Care management through new diagnoses, injuries and exacerbations of illness (medical record).

POPULATION MANAGEMENT ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
IA_PM_16	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.	Inclusion of medication management practice improvements.	Patient medical records demonstrating periodic structured medication reviews or reconciliation; **OR** Evidence of pharmacist integrated into care team; **OR** Reconciliation and coordination of mediations across transitions of care; **OR** Report detailing medication management practice improvement plan and outcomes, if available.

PATIENT SAFETY AND PRACTICE ASSESSMENT ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
IA_PSPA_1 Medium	Participation in an Agency for Health Research and Quality (AHRQ)-listed patient safety organization.	Participation in an AHRQ-listed patient safety organization.	Documentation from an AHRQ-listed patient safety organization (PSO) confirming the eligible providers or group's participation with the PSO. PSOs listed by AHRQ are here: http://www.pso.ahrq.gov/listed.
IA_PSPA_2 Medium	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.	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.	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** 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 Medium	New engagement for MOC Part IV, such as IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS®.	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 Medium	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-	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.

PATIENT SAFETY AND PRACTICE ASSESSMENT ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
	patient-safety/patientsafetyculture/index.html).		
IA_PSPA_5 Medium	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 providers and groups must participate for a minimum of 6 months.	Annual registration in the prescription drug monitoring program of the state and participation for a minimum of 6 months.	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 High	Providers attest (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.	Provision of consulting with PDMP before issuance of a controlled substance schedule II opioid prescription that lasts longer than 3 days.	Total number of issuances of a CSII prescription that lasts longer than 3 days over the same time period as those consulted; **AND** 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 Medium	Use of Qualified Clinical Data Registry (QCDR) data, for ongoing practice assessment and improvements in patient safety.	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 Medium	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.	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.

PATIENT SAFETY AND PRACTICE ASSESSMENT ACTIVITIES			
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IA_PSPA_9	Completion of the American Medical Association's STEPS Forward program.	Completion of AMA STEPS Forward program.	Certificate of completion from AMA's STEPS Forward program.
IA_PSPA_10 Medium	Completion of training and obtaining an approved waiver for provision of medication -assisted treatment of opioid use disorders using buprenorphine.	Completion of training and obtaining approved waiver for provision of medication assisted treatment of opioid use disorders using buprenorphine.	SAMHSA letter confirming waiver and physician prescribing ID number; **AND** Certificate of completion of training to prescribe and dispense buprenorphine dated during the selected reporting period.
IA_PSPA_11 High	Participation in the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) or other supplemental questionnaire items (e.g., Cultural Competence or Health Information Technology supplemental item sets).	Participation in CAHPS or other supplemental questionnaire.	CAHPS participation report; **OR** Other supplemental patient safety questionnaire items, e.g., cultural competence or health information technology item sets.
IA_PSPA_12 Medium	Participation in designated private payer clinical practice improvement activities.	Participation in private payer clinical practice improvement activities.	Documents showing participation in private payer clinical practice improvement activities.
IA_PSPA_13 Medium	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative.	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 Medium	Participation in other quality improvement programs such as Bridges to Excellence.	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 Medium	Implementation of an antibiotic stewardship program that measures the	Functionality of an antibiotic stewardship program.	Documentation of implementation of an antibiotic stewardship program that

PATIENT SAFETY AND PRACTICE ASSESSMENT ACTIVITIES			
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	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.		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 Medium	Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	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 Medium	Build the analytic capability required to manage total cost of care for the practice population that could include one or more of the following: • Training appropriate staff on interpretation of cost and utilization information; and/or • Regular use of available data to analyze opportunities to reduce cost through improved care.	Use of analytic capabilities to manage total cost of care for practice population.	Documentation of staff training on interpretation of cost and utilization information (e.g., training certificate); **OR** Documentation of availability of cost/resource use data for the practice population that is used regularly to analyze opportunities to reduce cost.
IA_PSPA_18 Medium	Measure and improve quality at the practice and panel level that could include one or more of the following:	Measure and improve quality at the practice and panel level.	Copy of a quality improvement program/plan or review of quality, utilization, patient

PATIENT SAFETY AND PRACTICE ASSESSMENT ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
	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 provider or group(panel); **AND/OR** Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.		satisfaction and other measures to improve one or more elements of this activity; **OR** 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 Medium	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: • Training all staff in quality improvement methods; • Integrating practice change/quality improvement into staff duties; • Engaging all staff in identifying and testing practices changes; • Designating regular team meetings to review data and plan improvement cycles; • Promoting transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; **AND/OR**	Implementation of a formal model for quality improvement and creation of a culture in which staff actively participates in one or more improvement activities.	Documentation of adoption of a formal model for quality improvement and creation of a culture in which staff actively participate in improvement activities; **AND** Documentation of staff participation in one or more of the six identified improvement activities.

PATIENT SAFETY AND PRACTICE ASSESSMENT ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
IA_PSPA_20 Medium	• Promoting transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families. 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.	Functionality of leadership engagement in regular guidance and demonstrated commitment for implementing improvements	Documentation of clinical and administrative leadership role descriptions include responsibility for practice improvement change (e.g. position description); **OR** Documentation of allocated time for clinical and administrative leadership participating in improvement efforts, e.g. regular team meeting agendas and post meeting summary; **OR** 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 Medium	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	Functionality of fall screening and assessment programs.	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**

PATIENT SAFETY AND PRACTICE ASSESSMENT ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
	medications, such as benzodiazepines, that increase fall risk).		Documentation of progress made on falls screening and assessment after implementation of tool.

BEHAVIORAL AND MENTAL HEALTH ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
IA_BMH_1 Medium	Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.	Performance of diabetes screening for patients with schizophrenia or bipolar disease who are using antipsychotic medication.	Report from Certified Electronic Health Record (CEHR), 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 Medium	Tobacco use: Regular engagement of MIPS eligible providers or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.	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 Electronic Health Record (CEHR), Qualified Clinical Data Registry (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 Medium	Unhealthy alcohol use: Regular engagement of MIPS eligible provider or groups in integrated prevention and treatment interventions, including screening and brief counseling for patients with co-occurring conditions of behavioral or mental health conditions.	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 Electronic Health Record (CEHR), Qualified Clinical Data Registry (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 Medium	Regular engagement of MIPS eligible providers or groups in integrated prevention and treatment interventions, including depression screening and follow-up plan for patients with co-occurring	Performance of regular engagement in integrated prevention and treatment interventions including depression screening and follow-up	Report from Certified Electronic Health Record (CEHR), Qualified Clinical Data Registry (QCDR), Clinical Registry or documentation from medical charts showing regular practice for depression screening and

BEHAVIORAL AND MENTAL HEALTH ACTIVITIES			
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	conditions of behavioral or mental health conditions.	plan for patients with co-conditions of behavioral or mental health.	follow-up plan for these patients with co-conditions of behavioral or mental health.
IA_BMH_5 Medium	Regular engagement of MIPS eligible providers or groups in integrated prevention and treatment interventions, including suicide risk assessment for mental health patients with co-occurring conditions of behavioral or mental health conditions.	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 Electronic Health Record (CEHR), Qualified Clinical Data Registry (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 High	Integration facilitation, and promotion of the colocation of mental health and substance use disorder services in primary and/or non-primary clinical care settings.	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 High	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:	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.

BEHAVIORAL AND MENTAL HEALTH ACTIVITIES			
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	• 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_8 Medium	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	Use of Electronic Health Record (HER) to capture additional data on behavioral health populations and use data for additional decision-making.	Screen shots from Certified Electronic Health Record (CEHR) or from other software/tools integrated with the CEHIR and reports showing how additional behavioral health data is captured and used for additional decision-making.

BEHAVIORAL AND MENTAL HEALTH ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
	depression screening for at-risk patient not previously identified).		

ACHIEVING HEALTH EQUITY ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
IA_AHE_1 High	Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare.	Functionality of practice in seeing new and follow-up Medicaid patients in a timely manner including patients dually eligible.	Statistics from Certified Electronic Health Record (CEHR) 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** Assessment of new and follow-up visit appointment statistics to identify and implement improvement activities.
IA_AHE_2 Medium	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.	Participation in a Qualified Clinical Data Registry (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 Electronic Health Record Technology (CEHRT).	Participation in QCDR for standardizing screening processes for social determinants (e.g., regular feedback reports from QCDR showing screening practices for social determinants); **AND** 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 Medium	Participation in a Qualified Clinical Data Registry (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).	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.

ACHIEVING HEALTH EQUITY ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
IA_AHE_4 Medium	Participation in a Qualified Clinical Data Registry (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).	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.

EMERGENCY PREPAREDNESS AND RESPONSE ACTIVITIES			
ACTIVITY ID AND WEIGHT	**ACTIVITY DESCRIPTION AND WEIGHT IN PARENTHESES**	**VALIDATION**	**DOCUMENTATION**
IA_ERP_1	Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. Activities that simply involve registration are not sufficient. MIPS eligible providers and MIPS eligible provider groups must be registered for a minimum of 6 months as a volunteer for disaster or emergency response.	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	Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible providers and groups attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater.	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.