<table>
<thead>
<tr>
<th>Activity ID</th>
<th>Category Name</th>
<th>Activity Name</th>
<th>Activity Description</th>
<th>Activity Target</th>
<th>Validation</th>
<th>Suggested Documentation/Evidence of Achievements: Select all that apply 90-day or prior reporting period</th>
</tr>
</thead>
<tbody>
<tr>
<td>E208A.1</td>
<td>Improved Practice Access</td>
<td>Provide 24/7 access to eligible clinicians or groups who have expanded access to care for patients’ medical record</td>
<td>Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for eligible clinicians or groups, who have expanded access to care for patients’ medical record, including access to medical record, cross coverage with access to medical record, or protocols where there is access to medical record. This could include access to more of the medical record than in prior years.</td>
<td>High</td>
<td>Documented participation of patients who are diabetic and prescribed antidiabetic agents; and documented glycemic treatment goals; and the goals take into account patient-specific factors.</td>
<td>MIPS Data Validation Criteria</td>
</tr>
<tr>
<td>E208A.2</td>
<td>Improved Practice Access</td>
<td>Involvement of a QCDR to generate local practice improvement plans based on quality measures</td>
<td>Involvement of a QCDR to generate local practice improvement plans based on quality measures. (Could be obtained from claims.)</td>
<td>High</td>
<td>Activity to improve specific chronic conditions within the community by improving health outcomes.</td>
<td>MIPS Data Validation Criteria</td>
</tr>
<tr>
<td>E208A.3</td>
<td>Improved Practice Access</td>
<td>Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consultations or telemedicine sites that assess ability to deliver quality care to patients.</td>
<td>Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consultations or telemedicine sites that assess ability to deliver quality care to patients.</td>
<td>High</td>
<td>Activity to improve specific chronic conditions within the community by improving health outcomes.</td>
<td>MIPS Data Validation Criteria</td>
</tr>
<tr>
<td>E208A.4</td>
<td>Improved Practice Access</td>
<td>Use of electronic health record and telephone calls</td>
<td>Use of electronic health record and telephone calls as a mechanism of data collection.</td>
<td>Medium</td>
<td>Activity to improve specific chronic conditions within the community by improving health outcomes.</td>
<td>MIPS Data Validation Criteria</td>
</tr>
<tr>
<td>E208A.5</td>
<td>Improved Practice Access</td>
<td>Use of Medicare services and participation in data analysis assessing provision of quality care with face-to-face visits.</td>
<td>Use of Medicare services and participation in data analysis assessing provision of quality care with face-to-face visits.</td>
<td>High</td>
<td>Activity to improve specific chronic conditions within the community by improving health outcomes.</td>
<td>MIPS Data Validation Criteria</td>
</tr>
<tr>
<td>E208A.6</td>
<td>Improved Practice Access</td>
<td>Collection and use of patient experience and satisfaction data</td>
<td>Collection and use of patient experience and satisfaction data</td>
<td>Medium</td>
<td>Activity to improve specific chronic conditions within the community by improving health outcomes.</td>
<td>MIPS Data Validation Criteria</td>
</tr>
<tr>
<td>E208B.1</td>
<td>Improved Practice Access</td>
<td>Enrollment of Indian Health Service Medium</td>
<td>Participation in RHC, HIS, or FQHC occurs and clinical management tools that involve systematic and coordinated care, including clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic MMH testing, follow-up, and patient communication of results and dosing decisions; and/or</td>
<td>High</td>
<td>Activity to improve specific chronic conditions within the community by improving health outcomes.</td>
<td>MIPS Data Validation Criteria</td>
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<tr>
<td>E208B.2</td>
<td>Improved Practice Access</td>
<td>Use of Medicare services and participation in data analysis assessing provision of quality care with face-to-face visits.</td>
<td>Use of Medicare services and participation in data analysis assessing provision of quality care with face-to-face visits.</td>
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<td>E208B.3</td>
<td>Improved Practice Access</td>
<td>Collection and use of patient experience and satisfaction data</td>
<td>Collection and use of patient experience and satisfaction data</td>
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<td>Activity to improve specific chronic conditions within the community by improving health outcomes.</td>
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<tr>
<td>E208B.4</td>
<td>Improved Practice Access</td>
<td>Expanded</td>
<td>Enrollment of Indian Health Service Medium</td>
<td>Participation in RHC, HIS, or FQHC occurs and clinical management tools that involve systematic and coordinated care, including clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic MMH testing, follow-up, and patient communication of results and dosing decisions; and/or</td>
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<td>Activity to improve specific chronic conditions within the community by improving health outcomes.</td>
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<td>E208B.5</td>
<td>Improved Practice Access</td>
<td>Use of Medicare services and participation in data analysis assessing provision of quality care with face-to-face visits.</td>
<td>Use of Medicare services and participation in data analysis assessing provision of quality care with face-to-face visits.</td>
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**Notes:**
- **High** indicates a high level of evidence demonstrated, such as from claim data or other authoritative sources.
- **Medium** indicates a medium level of evidence demonstrated, such as from claims data, quality improvement reports, or other relevant data sources.
- **Low** indicates a low level of evidence demonstrated, such as anecdotal evidence or other less authoritative sources.
- MIPS Data Validation Criteria refers to the specific criteria and documentation requirements outlined in the MIPS manual for validating and reporting quality improvement activities.
- **Activity** refers to a specific chronic condition within the community for which health outcomes are being improved, such as diabetes, hypertension, or dyslipidemia.
- **Local QIO** refers to the local Quality Improvement Organization responsible for overseeing and coordinating MIPS activities in the local area.

**Documentation Evidence:**
- **MIPS Data Validation Criteria**
- **Report detailing activity as outlined by the local QIO**
Population

Implementation of at least one recommended QIN-
Functionality of reporting abnormal test results in a
Management of empaneled patients’ chronic and
Care
Functionality of providing information by specialist to
Care
Participation in the CMS Transforming Clinical Practice Initiative.

IA_CC_2
IA_PM_15
IA_PM_13
IA_PM_10
IA_PM_9

Coordination
Regular training in care

Use of QCDR to promote use of standard practices, tools, and processes for quality improvement (e.g., documentation of medical care visits and outcomes for patients with high risk factors for adverse outcomes).

IA_PM_8
IA_PM_7
IA_PM_6
IA_PM_5
IA_PM_4
IA_PM_3
IA_PM_2
IA_PM_1
IA_PM_1

Implementation of additional improvements that contribute to ongoing monitoring/review for a targeted patient population; and
Implementation of regular reviews of targeted patient population needs which include access to reports that show unique characteristics of eligible clinicians or groups, identification of vulnerable patients, and how treatment needs are being met, if necessary, by address unique needs and what resources in the community are available to meet those needs.

IA_PM_12
IA_PM_11
IA_PM_10
IA_PM_9
IA_PM_8
IA_PM_7
IA_PM_6
IA_PM_5
IA_PM_4
IA_PM_3
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Care

Care

Care

Care

Care

Care

Care

Beneficiary Functionality of patient portal that includes patient self-management tools.

Use of QIN-QIO to implement self-management tools.

Patient experience and satisfaction data on beneficiary engagement.

Availability of formal links to community-based health services.

Participation in a QCDR to promote use of processes that provide patient experience information.

Participation in Community-Wide Health Information Exchange.

Achievement of improvements for adherence to treatment plans.

Participation in QCDR promoting engagement of patients for adherence to treatment plans.

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Beneficiary

Patient Safety & 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). Performance of monthly activities to assess performance in practice or national outcomes registry or quality assessment program; and regular assessments of the patient care experience to improve the experience where patients families have been engaged, survey results from patients and/or families; and documentation (e.g. survey results, advisory council notes and/or other methods) showing improvements made in the system of care.

Beneficiary

Use of tools that assist specialty practices in tracking specific patient safety measures meaningful to their practice, for eligible clinicians or groups not participating in MIPS.

Medium

Provision of training and obtaining an approved waiver for provision of medications-assisted treatment of opioid use disorders using buprenorphine.

Certificate of completion from AMA's STEPS Forward program

MIPS Data Validation Criteria

Certificate of completion of training to prescribe and dispense buprenorphine.

Participation in PDMP and activation of PDMP account

Use group visits for common chronic conditions (e.g., diabetes).

Use of tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or My Healhty).

Use of evidence-based decision aids to support shared decision-making with beneficiary.

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Participation in Joint Commission Ongoing Professional Practice Improvement activities, including, training, integration into staff duties, identifying and testing practice changes, regular team meetings to review data and plan improvement cycles, team practice and patient level quality of care, patient experience and utilization data with staff, and foster transparency and engage patients and families by sharing practice level data with patients and families.

Exhibit of practice change/quality improvement into staff duties; training all staff in quality improvement methods; engaging all staff in identifying and testing practice changes; integrating practice change/quality improvement into staff duties; implementing improvements and documenting performance of activities for use of patient-reported outcome (PRO) tools and corresponding collection of PRO data, e.g., use of PHQ-2 or PHQ-9 and PROMIS instruments.

Participation in Bridges to Excellence or other similar quality improvement programs such as Quality Improvement Organizations.

Impact of antibiotic stewardship program on the appropriate use of antibiotics for certain indications (e.g., in treatment of pharyngitis, Bronchitis Rx in adults) according to clinical guidelines for diagnostics and therapeutics.

Implementation of an antipsychotic stewardship program that promotes the appropriate use of antipsychotics for certain indications (e.g., in treatment of patients with schizophrenia or bipolar disease who are using antipsychotic medication).

Patient Safety

Participation in designated patient safety clinical practice improvement activities. Document participation in Joint Commission Ongoing Professional Practice Improvement activities.

Participation in domestic or international humanitarian volunteer work. Activities in support of patients may include, training, integration into staff duties, identifying and testing practice changes, regular team meetings to review data and plan improvement cycles, team practice and patient level quality of care, patient experience and utilization data with staff, and foster transparency and engage patients and families by sharing practice level data with patients and families.

Participation in other quality improvement programs such as Bridges to Excellence or other similar programs.

Achieving Health Functionality of practice in seeing new and follow-up patients.

Use of decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.

Use of analytic capabilities to manage total cost of care for practice population.

Use of relevant data sources to create benchmarks and goals for performance at the practice level and panel level.

Exhibit of quality improvement program/plan or review of quality, utilization, patient satisfaction and other data sources to create benchmarks and goals for performance at the practice level.

Participation in a QCDR and demonstrated performance of activities for use of patient-reported outcome (PRO) tools and corresponding collection of PRO data, e.g., use of PHQ-2 or PHQ-9 and PROMIS instruments.

Use of standardized treatment protocols to manage workflow in the team to meet patient needs.

Participation in Joint Commission Ongoing Professional Practice Improvement activities, including, training, integration into staff duties, identifying and testing practice changes, regular team meetings to review data and plan improvement cycles, team practice and patient level quality of care, patient experience and utilization data with staff, and foster transparency and engage patients and families by sharing practice level data with patients and families.

Ensure full engagement of clinical and administrative leadership in practice improvement efforts, e.g., regular team meetings involving implementation guidance and demonstrated commitment for improvement activities;

Ensure all staff in identifying and testing practice changes, integration of practice change/quality improvement into staff duties; training all staff in quality improvement methods; implementing improvements and documenting performance of activities for use of patient-reported outcome (PRO) tools and corresponding collection of PRO data, e.g., use of PHQ-2 or PHQ-9 and PROMIS instruments.

Ensure full engagement of clinical and administrative leadership in practice improvement efforts, e.g., regular team meetings involving implementation guidance and demonstrated commitment for improvement activities; or measure, 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 review of practice performance.

Use of relevant data sources to create benchmarks and goals for performance at the practice level and panel level.

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Use of EHR to capture additional data on behavioral or mental health is required. MIPS eligible clinicians or groups must document regular engagement of MIPS eligible clinicians 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 for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.

Report from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice of tobacco screening for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.

Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and follow-up plan for these patients with co-conditions of behavioral or mental health.

Performance of regular engagement in integrated prevention and treatment interventions for patients with co-occurring conditions of behavioral or mental health and at risk factors for unhealthy alcohol use.

Report from certified EHR, QCDR, clinical registry or documentation from medical charts showing regular practice for unhealthy alcohol use screening for patients with co-occurring conditions of behavioral or mental health.

Provision of integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions program and services that pertain to the patient-centered medical home model.

Implementing or documenting EHR to capture additional data on behavioral or mental health populations and use that data for additional decision-making purposes (e.g., capture of additional data for high depression screening for at-risk patient not previously identified).

Performance of standards and expectations that pertain to the patient-centered medical home model.

Experiential implementation of patient-centered medical home activities and improvements that pertain to care coordination, patient outcomes, or comprehensiveness of care, among others.