HIGH = 20 PTS | MEDIUM = 10 PTS

EXPANDED PRACTICE ACCESS	
Activities	Score
Provide 24/7 access to advice about urgent & emergent care	**HIGH**
Use telehealth services & analysis of data for quality improvement	**MEDIUM**
Collect patient experience & satisfaction data on access to care & develop an improvement plan	**MEDIUM**
Perform additional activities that improve access to services as a result of QIN-QIO technical assistance	**MEDIUM**

CARE COORDINATION	
Activities	Score
Performance of regular practices that provide specialist reports back to the referring MIPS EC or group to close the referral loop or where the referring MIPS EC or group initiates regular inquiries to specialist for specialist reports	**MEDIUM**
Timely communication of test results defined as timely identification of abnormal test results with timely follow-up	**MEDIUM**
Implement 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**
Participate in the CMS Transforming Clinical Practice Initiative	**HIGH**
Membership & participation in a CMS Partnership for Patients Hospital Engagement Network	**MEDIUM**

Participate in a QCDR, demonstrating performance of activities that promote use of standard practices, tools & processes for quality improvement	**MEDIUM**
Implement regular care coordination training	**MEDIUM**
Implement practices/processes that document care coordination activities	**MEDIUM**
Implement practices/processes to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s)	**MEDIUM**
Implement practices/processes for care transition that include documentation of how a MIPS EC or group carried out a patient-centered action plan for first 30 day following a discharge	**MEDIUM**
Establish standard operations to manage transitions of care that could include one of the following: - establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information & seamless transitions in care - partner with community or hospital-based transitional care services	**MEDIUM**
Establish effective care coordination & 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 & MIPS EC or group expectations between settings - track patients referred to specialist through the entire process - systematically integrate information from referrals into the plan of care	**MEDIUM**
Ensure there is bilateral exchange of necessary patient information to guide care that could include one or more of the following: - participate in Health Information Exchange - use structured referral notes	**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 & other wellness resources with the potential for bidirectional flow of information - provide a guide to available community resources	**MEDIUM**

EMERGENCY RESPONSE & PREPAREDNESS

Activities	Score
Participate in Disaster Medical Assistance Teams or Community Emergency Responder Teams for a minimum of 6 months	**MEDIUM**
Participate in domestic or international humanitarian volunteer work for a minimum of 6 months	**MEDIUM**

ACHIEVING HEALTH EQUITY

Activities	Score
Seeing new & follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid & Medicare	**HIGH**
Participate in a QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health	**MEDIUM**
Participate in a QCDR, demonstrating performance of activities for promoting use of patient-reported outcome (PRO) tools & corresponding collection of PRO data	**MEDIUM**
Participate in a QCDR, demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status	**MEDIUM**
Participate in State Innovation Model funded activities	**MEDIUM**

POPULATION MANAGEMENT

Activities	Score
Participate in a systematic anticoagulation program for 60% of patients who receive anti-coagulation medications in year 1 & 75% in year 2.	**HIGH**
Manage 60%+ of patients (in year 1) receiving warfarin by one or more of the following CPIA for 90+ days during the performance period: - **an anticoagulant management service** - **according to validated electronic decision support & clinical management tools** - **remote monitoring or telehealth options for rural or remote patients** - **patient self-testing (PST) or patient-self-management (PSM) program**	**HIGH**
Participate in a Rural Health Clinic (RHC), Indian Health Service (IHS) or Federally Qualified Health Center in ongoing engagement activities that contribute to more formal quality reporting & receive quality data back for quality improvement	**MEDIUM**
Document an individualized glycemic treatment goal (that takes patient-specific factors into account & is reassessed annually) in 60% of medical records (year 1) for outpatient Medicare beneficiaries with diabetes who are prescribed antidiabetic agents	**HIGH**
Take steps to improve health status of communities (e.g., collaborate to implement evidence-based practices to improve a specific chronic condition)	**MEDIUM**
Take steps to improve healthcare disparities (e.g., Population Health Toolkit)	**MEDIUM**
Use QCDR to generate regular feedback reports that summarize local practice patterns & treatment outcomes (including for vulnerable populations)	**HIGH**
Participate in CMMI models (e.g., Million Hearts Campaign)	**MEDIUM**
Participate in research that identifies interventions, tools or processes that can improve a targeted patient population	**MEDIUM**

Participate in QCDR (for quality improvement), clinical data registries or other registries run by other government agencies (e.g., FDA), or private entities (e.g., surgical society)	**MEDIUM**
Implement regular reviews of targeted patient population needs, which includes access to reports that shows EC's patient population, identification of vulnerable patients, & how clinical treatment needs are being tailored to the needs of the community	**MEDIUM**
Empanel the total population, linking each patient to a MIPS EC or group or care team	**MEDIUM**
Proactively manage chronic & preventive care for empaneled patients, that could include one or more of the following: - **provide an annual opportunity for development and/or adjustment of an individualized plan of care** - **use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes)** - **use pre-visit planning to optimize preventive care & team management of patients with chronic conditions** - **use panel support tools to identify services due** - **use reminders & outreach to educate patients about services due** - **routine medication reconciliation**	**MEDIUM**
Provide longitudinal care management to at-risk patients, that could include one or more of the following: - **use a consistent method to assign & adjust global risk status** - **use a personalized plan of care for at-risk patients** - **use on-site practice-based or shared managers to proactively monitor & coordinate care for high-risk patients**	**MEDIUM**
Provide episodic care management (including management across transitions & referrals), that could include one or more of the following: - **routine & timely follow-up to hospitalizations, ED visits & other stays in other institutional settings** - **manage care intensively through new diagnoses, injuries & exacerbations of illnesses**	**MEDIUM**
Manage medications to maximize efficiency, effectiveness & safety, that could include one or more of the following: - reconcile & coordinate medications & provide medication management - integrate a pharmacist into the care team - conduct periodic, structured medication reviews	**MEDIUM**

BENEFICIARY ENGAGEMENT

Activities	Score
Perform additional activities that enable capture of patient reported outcomes or patient activation measure through the use of certified EHR technology	**MEDIUM**
Participate in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision making capabilities	**MEDIUM**
Engage with a QIN-QIO, possibly including participation in self-management training programs	**MEDIUM**
Access to an enhanced patient portal that provides up-to-date information related to relevant chronic disease health or blood pressure control & includes interactive features, allowing patients to enter health information and/or enables bidirectional communication about medication changes & adherence	**MEDIUM**
Enhancements & ongoing regular updates & use of websites/tools that include consideration for compliance with section 508 of the Rehabilitation Act of 1973 for improved design for patients with cognitive disabilities	**MEDIUM**
Collection & follow-up on patient experience & satisfaction data on beneficiary engagement, including development of improvement plan	**HIGH**
Participate in a QCDR that promotes use of patient engagement tools	**MEDIUM**
Participate in a QCDR that promotes interactive collaborative learning network opportunities	**MEDIUM**
Use QCDR patient experience data to inform & advance improvements in beneficiary engagement	**MEDIUM**
Participate in a QCDR that promotes implementation of patient self-action plans	**MEDIUM**

Participate in a QCDR that promotes use of processes & tools that engage patients for adherence to treatment plan	**MEDIUM**
Use evidence-based decision aids to support shared decision-making	**MEDIUM**
Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms	**MEDIUM**
Engage patients & families to guide improvement in the system of care	**MEDIUM**
Engage patients, family & caregivers in developing a plan of care & prioritizing their goals for action, documented in the certified EHR technology	**MEDIUM**
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**
Use tools to assist patients in assessing their need for support for self-management	**MEDIUM**
Provide peer-led support for self-management	**MEDIUM**
Use group visits for common chronic conditions	**MEDIUM**
Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community	**MEDIUM**
Provide self-management materials at an appropriate literacy level & in an appropriate language	**MEDIUM**
Provide a pre-visit development of a shared visit agenda with the patient	**MEDIUM**
Provide coaching between visits with follow-up on care plan & goals	**MEDIUM**

PATIENT SAFETY & PRACTICE ASSESSMENT

Activities	Score
Participate in an AHRQ-listed patient safety organization	**MEDIUM**
Participate in Maintenance of Certification Part IV for improving professional practice, including participation in a local, regional or national outcomes registry, or quality assessment program.	**MEDIUM**
For EC's not participating in MOC Part IV, new engagement for MOC Part IV (e.g., AHRQ Team STEPPS)	**MEDIUM**
Administer the AHRQ Survey of Patient Safety Culture & submit the data to the comparative database	**MEDIUM**
Annually register in the prescription drug monitoring program of the state where they practice & participate for a minimum of 6 months	**MEDIUM**
Consult the Prescription Drug Monitoring Program prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription that lasts for more than 3 days	**HIGH**
Use QCDR data for ongoing practice assessment & improvements in patient safety	**MEDIUM**
Use tools that assist specialty practices in tracking specific measures that are meaningful to their practice	**MEDIUM**
Complete the American Medical Associations STEPS Forward program	**MEDIUM**
Complete the training & obtain an approved waiver for provision of medication-assisted treatment of opioid use disorders using buprenorphine	**MEDIUM**
Participate in the Consumer Assessment of Healthcare Providers & Systems Survey or other supplemental questionnaire items	**MEDIUM**

Participate in designated private payer CPIAs	**MEDIUM**
Participate in Joint Commission Ongoing Professional Practice Evaluation initiative	**MEDIUM**
Participate in other quality improvement programs (e.g., Bridges to Excellence)	**MEDIUM**
Implement an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions according to clinical guidelines for diagnostics & therapeutics	**MEDIUM**
Use decision support & protocols to manage workflow in the team to meet patient needs	**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: - train appropriate staff on interpretation of cost & utilization - use available data regularly to analyze opportunities to reduce cost through improved care	**MEDIUM**
Measure & improve quality at the practice & panel level, that could include one or more of the following: - regularly review measures of quality, utilization, patient satisfaction & other measures - use relevant data sources to create benchmarks & goals for performance	**MEDIUM**
Adopt a formal model for quality improvement & 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 & testing practices changes - designate regular team meetings to review data & plan improvement cycles - promote transparency & accelerate improvement by sharing practice level & panel level quality of care, patient experience & utilization data with staff - promote transparency & engage patients by sharing practice level quality of care, patient experience & utilization data with patients and families.	**MEDIUM**

Ensure full engagement of clinical & administrative leaders in practice improvement that could include one or more of the following: - make responsibility for guidance of practice change a component of clinical & administrative leadership roles - allocate time for clinical & administrative leadership for practice improvement efforts, including participation in regular team meetings - incorporate population health, quality & patient experience metrics in regular reviews of practice performance	**MEDIUM**
Implement fall screening & assessment programs to identify patients at risk for falls & address modifiable risk factors	**MEDIUM**

INTEGRATED BEHAVIORAL & MENTAL HEALTH

Activities	Score
Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication	**MEDIUM**
Tobacco use: Regularly engage in integrated prevention & treatment interventions (including screening & cessation interventions) for patients with co-occurring conditions of behavioral or mental health & at risk factors for tobaccos dependence	**MEDIUM**
Unhealthy alcohol use: Regularly engage in integrated prevention & treatment interventions (including screening & brief counseling) for patients with co-occurring conditions of behavioral or mental health conditions	**MEDIUM**
Depression screening & follow-up plan: Regularly engage in integrated prevention & treatment for patients with co-occurring conditions of behavioral or mental health conditions	**MEDIUM**
Major depressive disorder: Regularly engage in integrated prevention & treatment interventions (including suicide risk assessment) for mental health patients with co-occurring conditions of behavioral or mental health conditions	**MEDIUM**
Integrate facilitation & promotion of the colocation of mental health services in primary and/or non-primary clinical care settings	**HIGH**

Offer integrated behavioral health services to support patients with behavioral health needs, dementia & poorly controlled chronic conditions, that could include one or more of the following: - use evidence-based treatment protocols & treatment to goal where appropriate - use evidence-based screening & case finding strategies to identify individuals at risk & in need of services - ensure regular communication & coordinated workflows between ECs in primary care & behavioral health - conduct regular case reviews for at-risk or unstable patients & those who are not responding to treatment - use a registry or certified health information technology functionality to support active care management & outreach to patients in treatment - integrate behavioral health & medical care plans & facilitate integration through co-location of services when feasible	**HIGH**
Enhancements to an EHR to capture additional data on behavioral health populations & use the data for additional decision-making purposes	**MEDIUM**