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TABLE 8: Improvement Activities Eligible for the Advancing Care Information Performance Category Bonus

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Expanded Practice Access	Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (for example, 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 (for example, 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 (for example, senior centers and assisted living centers); and/or Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.	High	Provide Patient Access Secure Messaging Send A Summary of Care Request/Accept Summary of Care

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Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Population Management	Anticoagulant management improvements	MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, in the first performance period, 60 percent or more of their ambulatory care patients receiving warfarin are being managed by one or more of these improvement activities: Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care*, incorporating comprehensive patient education, systematic INR testing, tracking, follow-up, and patient communication of results and dosing decisions; Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic INR testing, tracking, follow-up, and patient communication of results and dosing decisions; For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic INR testing, tracking, follow-up, and patient communication of results and dosing decisions; and/or For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program. The performance threshold will increase to 75 percent for the second performance period and onward. Clinicians would attest that, 60 percent for first year, or 75 percent for the second year, of their ambulatory care patients receiving warfarin participated in an anticoagulation management program for at least 90 days during the performance period.	High	Provide Patient Access Patient-Specific Education View, Download, Transmit Secure Messaging Patient Generated Health Data or Data from Non-Clinical Setting Send a Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation Exchange Clinical Decision Support (CEHRT Function Only)

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Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Population Management	Glycemic management services	For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (for example, insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance period, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Is reassessed at least annually. The performance threshold will increase to 75 percent for the second performance period and onward. Clinicians would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.	High	Patient Generated Health Data Clinical Information Reconciliation Clinical Decision Support, CCDS, Family Health History (CEHRT functions only)

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Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Population Management	Chronic care and preventative care management for empanelled patients	Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning; Use condition-specific pathways for care of chronic conditions (for example, 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 (for example, phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or Routine medication reconciliation.	Medium	Provide Patient Access Patient-Specific Education View, Download, Transmit Secure Messaging Patient Generated Health Data or Data from Non-Clinical Setting Send A Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation Clinical Decision Support, Family Health History (CEHRT functions only)

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Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Population Management	Implementation of methodologies for improvements in longitudinal care management for high risk patients	Provide longitudinal care management to patients at high risk for adverse health outcome or harm that could include one or more of the following: Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.	Medium	Provide Patient Access Patient-Specific Education Patient Generated Health Data or Data from Non-clinical Settings Send A Summary of Care Request/Accept Summary of Care Clinical information reconciliation Clinical Decision Support, CCDS, Family Health History, Patient List (CEHRT functions only)
Population Management	Implementation of episodic care management practice	Provide episodic care management, including management across transitions and referrals that could include one or more of the following: Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management; and/or Managing care intensively through new diagnoses, injuries and exacerbations of illness.	Medium	Send A Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation

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Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Population Management	Implementation of medication management practice improvements	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; Integrate a pharmacist into the care team; and/or Conduct periodic, structured medication reviews.	Medium	Clinical Information Reconciliation Clinical Decision Support, Computerized Physician Order Entry Electronic Prescribing (CEHRT functions only)
Care Coordination	Implementation of use of specialist reports back to referring	Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the CEHRT.	Medium	Send A Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation
Care Coordination	Implementation of documentation improvements for	Implementation of practices/processes that document care coordination activities (for example, a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure).	Medium	Secure Messaging Send A Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation

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Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Care Coordination	Implementation of practices/processes for developing regular individual care plans	Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s).	Medium	Provide Patient Access (formerly Patient Access) View, Download, Transmit Secure Messaging Patient Generated Health Data or Data from Non-Clinical Setting
Care Coordination	Practice improvements for bilateral exchange of patient information	Ensure that there is bilateral exchange of necessary patient information to guide patient care that could include one or more of the following: Participate in a Health Information Exchange if available; and/or Use structured referral notes.	Medium	Send A Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation
Beneficiary Engagement	Use of certified EHR to capture patient reported outcomes	In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (for example, 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 CEHRT, containing this data in a separate queue for clinician recognition and review.	Medium	Provide Patient Access Patient-Specific Education Care Coordination through Patient Engagement
Beneficiary Engagement	Engagement of patients through implementation	Access to an enhanced patient portal that provides up to date information related to relevant chronic disease health or blood pressure control, and includes interactive features allowing patients to enter health information and/or enables bidirectional communication about medication changes and adherence.	Medium	Provide Patient Access Patient-Specific Education

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Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Beneficiary Engagement	Engagement of patients, family and caregivers in developing a plan of care	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the CEHRT.	Medium	Provide Patient Access Patient-specific Education View, Download, Transmit (Patient Action) Secure Messaging
Patient Safety and Practice	Use of decision support	Use decision support and protocols to manage workflow in the team to meet patient needs.	Medium	Clinical Decision Support (CEHRT function only)
Achieving Health Equity	Leveraging a QCDR to standardize processes for	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 CEHRT is also suggested.	Medium	Patient Generated Health Data or Data from a Non-Clinical Setting Public Health and Clinical Data Registry Reporting

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Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Integrated Behavioral and Mental Health	Implementation of integrated PCBH model	Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions that could include one or more of the following: Use evidence-based treatment protocols and treatment to goal where appropriate; Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services; Ensure regular communication and coordinated workflows between eligible clinicians in primary care and behavioral health; Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment; Use of a registry or certified health information technology functionality to support active care management and outreach to patients in treatment; and/or Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.	High	Provide Patient Access Patient-Specific Education View, Download, Transmit Secure Messaging Patient Generated Health Data or Data from Non-Clinical Setting Care coordination through Patient Engagement Send A Summary of Care Request/Accept Summary of Care
Integrated Behavioral and Mental Health	Electronic Health Record Enhancements for BH data capture	Enhancements to an electronic health record to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (for example, capture of additional BH data results in additional depression screening for at-risk patient not previously identified).	Medium	Patient Generated Health Data or Data from Non-Clinical Setting Send A Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation

* Several measure names have changed since the proposed rule. This table reflects those changes. We refer readers to section II.E.5.g.(7) of this final rule with comment period for further discussion of measure name changes.

After consideration of the comments, we will award a 10 percent bonus in the advancing