TABLE 6: Improvement Activities Eligible for the Advancing Care Information Performance Category Bonus Beginning with the 2018 Performance Period

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, MIPS eligible clinician and care team access to CEHRT, cross-coverage with access to CEHRT, or protocol-driven nurse line with access to CEHRT) 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.	Medium	Provide Patient Access Secure Messaging Send A Summary of Care Request/Accept Summary of Care
Patient Safety and Practice Assessment	Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event	A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75 percent of case visits that result from a clinically significant adverse drug event, the MIPS eligible clinician transmits information, including through the use of CEHRT to the patient's primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, supratherapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization.	Medium	Secure Messaging Send A Summary of Care Request/Accept Summary of Care
Patient Safety and Practice Assessment	Consulting AUC using clinical decision support when ordering advanced diagnostic imaging	Clinicians attest that they are consulting specified applicable AUC through a qualified clinical decision support mechanism for all applicable imaging services furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2018. This activity is for clinicians that are early adopters of the Medicare AUC program (2018 performance year) and for clinicians that begin the Medicare AUC program in future years as	High	Clinical Decision Support (CEHRT function only)

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		specified in our regulation at §414.94. The AUC program is required under section 218 of the Protecting Access to Medicare Act of 2014. Qualified mechanisms will be able to provide a report to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.		
Patient Safety and Practice Assessment	Cost Display for Laboratory and Radiographic Orders	Implementation of a cost display for laboratory and radiographic orders, such as costs that can be obtained through the Medicare clinical laboratory fee schedule.	Medium	Clinical Decision Support (CEHRT function only)
Population Management	Glycemic Screening Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the 2018 performance period and 75 percent in future years, of CEHRT with documentation of screening patients for abnormal blood glucose according to current US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines.	Medium	Patient-Specific Education Patient Generated Health Data or Data from Non-clinical Settings
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: o Takes into account patient-specific factors, including, at least (1) age, (2) comorbidities, and (3) risk for hypoglycemia, and o 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)
Population Management	Glycemic Referring Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the CY 2018 performance period and 75 percent in future years, of CEHRT with documentation	Medium	Patient-Specific Education Patient Generated Health Data or Data from Non-clinical Settings

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		of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.		
Population Management	Anticoagulant management improvements	Individual MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, for 60 percent of practice patients in the transition year and 75 percent of practice patients in Quality Payment Program Year 2 and future years, their ambulatory care patients receiving warfarin are being managed by one or more of the following improvement activities: • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-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 PT-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 PT-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.	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)
Population Management	Provide Clinical-Community Linkages	Engaging community health workers to provide a comprehensive link to community resources through family-based services focusing on success in health, education, and self-sufficiency. This activity supports individual MIPS eligible clinicians or groups that coordinate with primary care and other clinicians, engage and support patients, use of CEHRT, and employ quality measurement and improvement processes. An example of this community based program is the NCQA Patient-Centered Connected Care (PCCC) Recognition Program or other such programs	Medium	Provide Patient Access Patient-Specific Education Patient-Generated Health Data

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		that meet these criteria.		
Population Management	Advance Care Planning	Implementation of practices/processes to develop advance care planning that includes: documenting the advance care plan or living will within CEHRT, educating clinicians about advance care planning motivating them to address advance care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare policy side of advance care planning.	Medium	Patient-Specific Education Patient-Generated Health Data
Population Management	Chronic care and preventative care management for empanelled patients	Proactively manage chronic and preventive care for empanelled 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)
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	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

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		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.		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
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)
Achieving Health Equity	Promote use of patient-reported outcome tools	Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data (e.g., use of PQH-2 or PHQ-9 and PROMIS instruments) such as patient reported Wound Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening.	High	Public Health Registry Reporting Clinical Data Registry Reporting Patient-Generated Health Data
Care Coordination	Practice Improvements that Engage Community Resources to Support Patient Health Goals	Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following: • Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information and provide a guide to available community resources. • Including through the use of tools that facilitate electronic communication between settings; • Screen patients for health-harming legal needs; • Screen and assess patients for social	Medium	Send a Summary of Care Request/Accept Summary of Care Patient-Generated Health Data

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		needs using tools that are CEHRT enabled and that include to any extent standards-based, coded question/field for the capture of data as is feasible and available as part of such tool; and/or • Provide a guide to available community resources.		
Care Coordination	Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients	The primary care and behavioral health practices use the same CEHRT system for shared patients or have an established bidirectional flow of primary care and behavioral health records.	Medium	Send a Summary of Care Request/ Accept Summary of Care
Care Coordination	PSH Care Coordination	Participation in a Perioperative Surgical Home (PSH) that provides a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated patient care, which coordinates care from pre-procedure assessment through the acute care episode, recovery, and post-acute care. This activity allows for reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a PSH. The clinician must perform one or more of the following care coordination activities: • Coordinate with care managers/navigators in preoperative clinic to plan and implementation comprehensive post discharge plan of care; • Deploy perioperative clinic and care processes to reduce post-operative visits to emergency rooms; • Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients; or • Implement processes to ensure effective communications and education of patients' post-discharge instructions.	Medium	Send a Summary of Care Request/ Accept Summary of Care Clinical Information Reconciliation Health Information Exchange
Care Coordination	Implementation of use of specialist reports back to referring clinician or group to close referral loop	Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the CEHRT.	Medium	Send A Summary of Care Request/ Accept Summary of Care Clinical Information Reconciliation
Care Coordination	Implementation of documentation improvements for developing regular individual care plans	Implementation of practices/processes, including a discussion on care, to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s). Individual care plans should include consideration of a patient's goals and priorities, as well as desired outcomes of care.	Medium	Secure Messaging Send A Summary of Care Request/ Accept Summary of Care

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				Clinical Information Reconciliation
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,such as Open Notes, 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	Engage Patients and Families to Guide Improvement in the System of Care	Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-to-work and patient quality of life improvement. Platforms and devices that collect patient-generated health data (PGHD) must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient. Includes patient reported outcomes (PROs). Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bi-directional systems, and other devices that transmit clinically valid objective and subjective data back to care teams. Because many consumer-grade devices capture PGHD (for example, wellness devices), platforms or devices eligible for this improvement activity must be, at a minimum, endorsed and offered clinically by care teams to patients to automatically send ongoing guidance (one way). Platforms and devices that additionally collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient (e.g. automated patient-facing instructions based on glucometer readings). Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and	High	Patient-Generated Health Data Provide Patient Access View, Download, or Transmit

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		platforms can inform the patient or the clinical care team in a timely manner of important parameters regarding a patient's status, adherence, comprehension, and indicators of clinical concern.		
Beneficiary Engagement	Use of CEHRT 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
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 and standardized treatment protocols	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	Promote Use of Patient-Reported Outcome Tools	Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data such as the use of PQH-2 or PHQ-9, PROMIS instruments, patient reported Wound Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening.	Medium	Patient Generated Health Data or Data from a Non-Clinical Setting Public Health and Clinical Data Registry Reporting
Behavioral and Mental Health	Implementation of integrated Patient Centered Behavioral Health (PCBH) model	Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions. The services 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	High	Provide Patient Access Patient-Specific Education View, Download, Transmit Secure Messaging Patient Generated Health Data or Data from Non-Clinical Setting

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		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; and/or • Participate in the National Partnership to Improve Dementia Care Initiative, which promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training, and revised survey or guidance.		Care coordination through Patient Engagement Send A Summary of Care Request/Accept Summary of Care
Behavioral and Mental Health	Electronic Health Record Enhancements for BH data capture	Enhancements to CEHRT 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