TABLE G: Improvement Activities with Changes for the Quality Payment Program Year 2 and Future Years

Current Improvement Activity	
Current Activity ID:	**IA_AHE_1**
Current Subcategory:	Achieving Health Equity
Current Activity Title:	Engagement of New Medicaid Patients and Follow-up
Current Activity Description:	Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare.
Current Weighting:	High
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Change Activity Description to**: Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. A timely manner is defined as within 10 business days for this activity.
Comments:	We received a few comments of support for this activity description modification. One commenter asked for additional clarification on the application of the activity.
Response:	We appreciate the comments of support for this improvement activity. We purposefully proposed this improvement activity in a generalized manner such that many activities may fit under this improvement activity. We are updating this improvement activity to define timely manner as 10 business days. After consideration of the public comments, we are finalizing this improvement activity as proposed.
Rationale:	We updated this improvement activity to clarify the meaning of "a timely manner."
Finalized Change:	**Change Activity Description to**: Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. A timely manner is defined as within 10 business days for this activity.
Finalized Improvement Activity	
Activity ID:	**IA_AHE_1**
Subcategory:	Achieving Health Equity
Activity Title:	Engagement of New Medicaid Patients and Follow-up
Activity Description:	Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. A timely manner is defined as within 10 business days for this activity.
Weighting:	High
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_AHE_3**
Current Subcategory:	Achieving Health Equity
Current Activity Title:	Leveraging a QCDR to Promote Use of PRO Tools
Current Activity Description:	Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision making capabilities.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information	No

Bonus:	
Proposed Change:	**Change Activity Title to**: Promote Use of Patient-Reported Outcome Tools **Change Activity Description to**: 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, PRO MIS instruments, patient reported Wound-Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening. **Change Weight to**: High **Proposed change to eligibility for advancing care information bonus**: Change to "yes" for eligible for advancing care information bonus. We believe MIPS eligible clinicians may utilize EHR to capture this information to include standardized data capture and incorporating patient generated health data.
Comments:	We received several comments of support for this activity description modification related to the increase in weighting and the addition of eligibility for the advancing care information bonus. One commenter urged us to specify that registries which qualify for improvement activities be limited to those developed by medical specialty societies with goals of quality improvement and advancing public health. One commenter stated that this activity should be a "high" weighting.
Response:	We appreciate the comments of support for this improvement activity. We purposefully proposed the improvement activity in a generalized manner such that many activities may fit under this improvement activity. We are implementing this improvement activity with updates to the activity description to include possible PRO tools and data collection activities, to an increased weight of this activity given the importance of this activity and a change in eligibility for the advancing care information bonus (for clinicians who collect PRO data via their electronic health record), because MIPS eligible clinicians may utilize an EHR to capture this information, including standardized data capture and incorporating patient generated health data. We disagree with the commenter; registries cannot be limited to those developed by medical specialty societies alone as other clinicians may qualify for MIPS participation as well. Furthermore, while the focus is on quality improvement, advancing public health may encompass other areas such as patient engagement and patient safety. After consideration of public comments, we are finalizing this improvement activity as proposed.
Rationale:	We revised this improvement activity to expand its application to include employing the PRO tools and corresponding collection of PRO data. In addition, we provided additional examples of activities that may be appropriate for this improvement activity.
Finalized Change:	**Change Activity Title to**: Promote Use of Patient-Reported Outcome Tools **Change Activity Description to**: 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. **Change Weight to**: High **Change to eligibility for advancing care information bonus**: Change to "yes" for eligible for advancing care information bonus.
Finalized Improvement Activity	
Activity ID:	**IA_AHE_3**

Subcategory:	Achieving Health Equity
Activity Title:	Promote Use of Patient-Reported Outcome Tools
Activity Description:	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.
Weighting:	High
Eligible for Advancing Care Information Bonus:	Yes
Current Improvement Activity	
Current Activity ID:	**IA_BE_14**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Engage Patients and Families to Guide Improvement in the System of Care
Current Activity Description:	Engage patients and families to guide improvement in the system of care.
Current Weighting:	High
Currently Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	**Changed activity description to**: 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, including 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 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. **Change Weight to**: High **Change to eligibility for advancing care information bonus:** Change to "yes" for eligible for advancing care information bonus.
Comments:	We received several comments of support for this activity. One commenter requested that regional health improvement collaboratives - RHICs be added to this improvement activity.
Response:	We appreciate the comments of support for this improvement activity. Regional health improvement collaboratives - RHICs would not automatically qualify

	unless they meet the specific criteria of the improvement activity described above. After consideration of public comments, we are finalizing this improvement activity as proposed.
Rationale:	We believe that the use of digital technologies that provide either one-way or two-way data between MIPS eligible clinicians and patients is valuable, including for the purposes of promoting patient self-management, enabling remote monitoring, and detecting early indicators of treatment failure. We changed the weighting to "high" because of increased cost and time considerations for digital tools for ongoing guidance and assessment outside of encounter. We changed the advancing care information bonus to "yes." We believe MIPS eligible clinicians will use health IT including providing patients access to health information and educational resources as well as incorporating PGHD for this activity to include standardized data capture and incorporating patient generated health data.
Finalized Change:	**Changed activity description to**: 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, including 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 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. **Change Weight to**: High **Change to eligibility for advancing care information bonus:** Change to "yes" for eligible for advancing care information bonus.
Finalized Improvement Activity	
Activity ID:	**IA_BE_14**
Subcategory:	Beneficiary Engagement
Activity Title:	Engage Patients and Families to Guide Improvement in the System of Care
Activity Description:	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, including 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 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.
Weighting:	High
Eligible for Advancing Care Information Bonus:	Yes
Current Improvement Activity	
Current Activity ID:	**IA_BE_15**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Engagement of Patients, Family, and Caregivers in Developing a Plan of Care
Current Activity Description:	Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified electronic health record (EHR) technology.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	**Change Activity Description to**: Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the electronic health record (EHR) technology.
Comments:	We received several comments of support for this activity description modification. One commenter requested that regional health improvement collaboratives - RHICs be added to this improvement activity.
Response:	We appreciate the comments of support for this improvement activity. Regional health improvement collaboratives - RHICs would not automatically qualify unless they meet the specific criteria of the improvement activity of engaging patients, families, and caregivers in developing a plan of care. After consideration of public comments, we are finalizing this improvement activity as proposed.
Rationale:	We removed the requirement that EHR technology be certified. We do not believe this improvement activity should be limited to certified EHR technology and can be accomplished without it; however, when certified technology is used, eligible clinicians may qualify for the advancing care information bonus.
Finalized Change:	**Change Activity Description to**: Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the electronic health record (EHR) technology.
Finalized Improvement Activity	
Activity ID:	**IA_BE_15**
Subcategory:	Beneficiary Engagement
Activity Title:	Engagement of Patients, Family, and Caregivers in Developing a Plan of Care
Activity Description:	Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the electronic health record

	(EHR) technology.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Current Improvement Activity	
Current Activity ID:	**IA_BE_21**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Improved Practices that Disseminate Appropriate Self-Management Materials
Current Activity Description:	Provide self-management materials at an appropriate literacy level and in an appropriate language.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	**Change to eligibility for advancing care information bonus**: We proposed to correct the "eligible for advancing care information bonus" for this improvement activity to "No."
Comments:	We received several comments of support for this activity description modification, as well as several comments opposing the change in eligibility for the advancing care information bonus to "No".
Response	We appreciate the comments of support for this improvement activity. We believe the advancing care information bonus must be changed from "Yes" to "No", because this activity does not involve meaningful use of CEHRT and the prior "yes" designation was an error. After consideration of public comments, we are finalizing this update as proposed.
Rationale:	For the transition year of MIPS, we will award bonus points for improvement activities that utilize CEHRT and for reporting to a public health or clinical data registry, reflecting the belief that the advancing care information performance category should align with the other performance categories to achieve the unified goal of quality improvement which can be found at the following link; https://qpp.cms.gov/docs/QPP_ACI_Fact_Sheet.pdf. However, this improvement activity does not involve the meaningful use of CEHRT and was erroneously designated as eligible for the bonus.
Finalized Change:	**Change to eligibility for advancing care information bonus**: We are correcting the "eligible for advancing care information bonus" for this improvement activity to "No."
Finalized Improvement Activity	
Activity ID:	**IA_BE_21**
Subcategory:	Beneficiary Engagement
Activity Title:	Improved Practices that Disseminate Appropriate Self-Management Materials
Activity Description:	Provide self-management materials at an appropriate literacy level and in an appropriate language.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_BE_22**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Improved Practices that Engage Patients Pre-Visit
Current Activity Description:	Provide a pre-visit development of a shared visit agenda with the patient.

Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Change Activity Description to:** Implementation of workflow changes that engage patients prior to the visit, such as a pre-visit development of a shared visit agenda with the patient, or targeted pre-visit laboratory testing that will be resulted and available to the MIPS eligible clinician to review and discuss during the patient's appointment.
Comments:	We received a few comments of support for this improvement activity description modification. One commenter requested that regional health improvement collaboratives - RHICs be added to this improvement activity.
Response:	We appreciate the comments of support for this improvement activity. We disagree that Regional health improvement collaboratives (RHICs) should automatically be added to this improvement activity. – RHICs, however, could qualify if they meet the specific criteria of the improvement activity. After consideration of public comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We revised the type of actions that qualify for this improvement activity.
Finalized Change:	**Change Activity Description to**: Implementation of workflow changes that engage patients prior to the visit, such as a pre-visit development of a shared visit agenda with the patient, or targeted pre-visit laboratory testing that will be resulted and available to the MIPS eligible clinician to review and discuss during the patient's appointment.
Finalized Improvement Activity	
Activity ID:	**IA_BE_22**
Subcategory:	Beneficiary Engagement
Activity Title:	Improved Practices that Engage Patients Pre-Visit
Activity Description:	Implementation of workflow changes that engage patients prior to the visit, such as a pre-visit development of a shared visit agenda with the patient, or targeted pre-visit laboratory testing that will be resulted and available to the MIPS eligible clinician to review and discuss during the patient's appointment.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_BMH_7**
Current Subcategory:	Behavioral and Mental Health
Current Activity Title:	Implementation of Integrated Patient Centered Behavioral Health Model
Current Activity Description:	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 a registry or 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.
Current Weighting:	High
Currently Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	**Change Activity Description to**: Offer integrated behavioral health services to support patients with behavioral health needs who also have conditions such as dementia or other poorly controlled chronic illnesses. 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 MIPS 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 health information technology functionality to support active care management and outreach to patients in treatment; • 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 surveyor guidance.
Comments:	We did not receive any comments on this improvement activity.
Response:	We are finalizing this improvement activity with updates to revise the wording of this improvement activity to clarify that the list of chronic illnesses is not limited to these examples and to include an additional example related to the dementia care aspect of this activity. There were no public comments received; therefore, we are finalizing updates to this improvement activity as proposed.
Rationale:	We revised the wording of this improvement activity to clarify that the list of chronic illnesses is not limited to these examples.
Finalized Change:	**Change Activity Description to**: Offer integrated behavioral health services to support patients with behavioral health needs who also have conditions such as dementia or other poorly controlled chronic illnesses. 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 MIPS 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 health information technology functionality to support active care management and outreach to patients in treatment; • 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 surveyor guidance.
Finalized Improvement Activity	

Activity ID:	**IA_BMH_7**
Subcategory:	Behavioral and Mental Health
Activity Title:	Implementation of Integrated Patient Centered Behavioral Health Model
Activity Description:	Offer integrated behavioral health services to support patients with behavioral health needs who also have conditions such as dementia or other poorly controlled chronic illnesses. 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 MIPS 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 health information technology functionality to support active care management and outreach to patients in treatment; • 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 surveyor guidance.
Weighting:	High
Eligible for Advancing Care Information Bonus:	Yes
Current Improvement Activity	
Current Activity ID:	**IA_CC_1**
Current Subcategory:	Care Coordination
Current Activity Title:	Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop
Current Activity Description:	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 certified EHR technology.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	**Change Activity Description to**: Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.
Comments:	We received a few comments of support for this activity description modification.
Response:	We appreciate the commenters' support. After consideration of comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We removed the requirement that the EHR technology be certified. We do not believe this improvement activity should be limited to certified EHR technology, however, when certified technology is used, eligible clinicians may qualify for the advancing care information bonus.

Finalized Change:	**Change Activity Description to**: Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.
Finalized Improvement Activity	
Activity ID:	**IA_CC_1**
Subcategory:	Care Coordination
Activity Title:	Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop
Activity Description:	Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Current Improvement Activity	
Current Activity ID:	**IA_CC_4**
Current Subcategory:	Care Coordination
Current Activity Title:	TCPI Participation
Current Activity Description:	Participation in the CMS Transforming Clinical Practice Initiative
Current Weighting:	High
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Change Weight to**: We proposed to change the weight of this improvement activity from high to medium for MIPS Year 2 and future years.
Comments:	We received a few comments of support for this activity. We received several comments urging that this improvement activity remain as high weighted, and asked for clarification of the impact of TCPI participation on improvement activity performance category scoring.
Response:	We appreciate the comments of support for this improvement activity. We intended that this activity be high-weighted for the transition year of MIPS only (81 FR 77008), and proposed to change the weight of this improvement activity from high to medium for MIPS Year 2 and future years due to the Transforming Clinical Practice Initiative (TCPI) having a designation as a MIPS APM. As a MIPS APM, TCPI participants will be assigned an improvement activity score, which may be higher than one half of the highest potential score (82 FR 30010). After consideration of public comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	In accordance with section 1848(q)(5)(C)(ii) of the Act, MIPS eligible clinicians that are participating in MIPS APMs will be assigned an improvement activity score, which may be higher than one half of the highest potential score. This assignment is based on the extent to which the requirements of the specific model meet the list of activities in the Inventory. In addition, we anticipate that most MIPS eligible clinicians that are fully active TCPI participants will participate in additional practice improvement activities and will be able to select additional improvement activities to achieve the improvement activities highest score.
Finalized Change:	**Change Weight to**: Medium

Finalized Improvement Activity	
Activity ID:	**IA_CC_4**
Subcategory:	Care Coordination
Activity Title:	TCPI Participation
Activity Description:	Participation in the CMS Transforming Clinical Practice Initiative
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_CC_9**
Current Subcategory:	Care Coordination
Current Activity Title:	Implementation of practices/processes for developing regular individual care plans
Current Activity Description:	Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s).
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	**Change Activity Description to:** 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.
Comments:	We received several comments of support for this activity description modification.
Response:	We appreciate the comments of support for this improvement activity. After consideration of public comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	The activity description was revised, because by having an open conversation on care, we believe patients and MIPS eligible clinicians can work together to evaluate care options and opportunities that are based on an individual patient's values and priorities.
Finalized Change:	**Change Activity Description to:** 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.
Finalized Improvement Activity	
Activity ID:	**IA_CC_9**
Subcategory:	Care Coordination
Activity Title:	Implementation of practices/processes for developing regular individual care plans
Activity Description:	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.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes

Current Improvement Activity	
Current Activity ID:	**IA_CC_13**
Current Subcategory:	Care Coordination
Current Activity Title:	Practice Improvements for Bilateral Exchange of Patient Information
Current Activity Description:	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.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	**Change Activity Description to**: 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.
Comments:	We received several comments including: one comment stating support, one comment requesting a "high" weighting, and one comment requesting that regional health improvement collaboratives - RHICs be added to this improvement activity.
Response:	We appreciate the comment of support for this improvement activity. We believe that high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and do not believe this improvement activity satisfies this. Furthermore, we disagree that RHICs should automatically be added to this improvement activity. RHICs, however, could qualify if they meet the specific criteria of the improvement activity. After consideration of public comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We provided additional examples of activities that would qualify for this improvement activity.
Finalized Change:	**Change Activity Description to**: 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.
Finalized Improvement Activity	
Activity ID:	**IA_CC_13**
Subcategory:	Care Coordination
Activity Title:	Practice Improvements for Bilateral Exchange of Patient Information
Activity Description:	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.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Current Improvement Activity	
Current Activity ID:	**IA_CC_14**
Current Subcategory:	Care Coordination

Current Activity Title:	Practice Improvements that Engage Community Resources to Support Patient Health Goals
Current Activity Description:	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/or provide a guide to available community resources.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	**Change Activity Description to:** 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; • 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 needs using tools that are preferably health IT 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.
Comments:	We received many comments of support for this activity description update, notably regarding the addition of screening patients for health-harming legal needs as a pathway to neighborhood/community-based resources to support patient health goals.
Response:	We appreciate the comments of support for this improvement activity. After consideration of public comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We added screening patients for health harming legal needs to this activity; as such screening can help MIPS eligible clinicians address the social determinants that contribute to the most challenging problems related to coordinating care.
Finalized Change:	**Change Activity Description to:** 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 needs using tools that are preferably health IT 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.
Finalized Improvement Activity	
Activity ID:	**IA_CC_14**
Subcategory:	Care Coordination

Activity Title:	Practice Improvements that Engage Community Resources to Support Patient Health Goals
Activity Description:	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 needs using tools that are preferably health IT 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.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Current Improvement Activity	
Current Activity ID:	**IA_EPA_1**
Current Subcategory:	Expanded Practice Access
Current Activity Title:	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
Current Activity Description:	• Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., MIPS 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.
Current Weighting:	High
Currently Eligible for Advancing Care Information Bonus:	Yes
Comments:	We received several comments of support for this activity description update, as well as several comments opposing the change in weighting from high to medium.
Response:	We intended to designate this activity as high-weighted for the transition year of MIPS only. After consideration of public comments, we are finalizing updates to this improvement activity with modification. We are finalizing updates to the activity description as proposed. However, we are not finalizing our proposal to change the weight of this improvement activity from high to medium for MIPS Year 2 and future years; instead, we are leaving it as high weighted.
Rationale:	We believe that high weighting should be used for activities that directly

	address areas with the greatest impact on beneficiary care, safety, health, and well-being. We believe this improvement activity meets this standard, because it has the ability to improve beneficiaries' quality of and access to care in a timely manner and thus qualifies as a high-weighted activity.
Finalized Change:	**Weight**: We are not finalizing our proposal to change the weight of this improvement activity from high to medium for MIPS Year 2 and future years and leaving the weighting as high. **Change Activity Description to**: • 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 individual MIPS eligible clinicians and groups, such as telehealth, 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.
Finalized Improvement Activity	
Activity ID:	**IA_EPA_1**
Subcategory:	Expanded Practice Access
Activity Title:	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
Activity Description:	• Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., MIPS 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.
Weighting:	High
Eligible for Advancing Care Information Bonus:	Yes
Current Improvement Activity	
Current Activity ID:	**IA_PM_1**
Current Subcategory:	Population Management
Current Activity Title:	Participation in Systematic Anticoagulation Program
Current Activity Description:	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).
Current Weighting:	High
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Change Activity Description to:** Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program) 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, who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors).
Comments:	We did not receive any comments for this improvement activity.
Response:	We did not receive any public comments on this activity; therefore, we are finalizing updates to this improvement activity as proposed.
Rationale:	We updated the activity description such that the 75 percent performance target extends into future years.
Finalized Change:	**Change Activity Description to:** Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program) 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, who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors).
Finalized Improvement Activity	
Activity ID:	**IA_PM_1**
Subcategory:	Population Management
Activity Title:	Participation in Systematic Anticoagulation Program
Activity Description:	Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program) 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, who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors).
Weighting:	High
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Activity ID:	**IA_PM_2**
Current Subcategory:	Population Management
Current Activity Title:	Anticoagulant Management Improvements
Current Activity Description:	MIPS eligible clinicians 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: • 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. MIPS eligible clinicians would attest that, 60 percent for the transition 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.
Current Weighting:	High
Currently Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	**Change:** Currently, MIPS eligible groups and clinicians must attest that, in the transition performance year, CY 2017, 60 percent or more of their ambulatory care patients receiving warfarin are being managed by one or more of these clinical practice improvement activities. We are clarifying here that the proposed update in percentage to a 75 percent threshold applies to Quality Payment Program Year 2 and future years to be consistent with thresholds in other improvement activities. **Change Activity Description to**: Individual MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, 75 percent or more of 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.
Comments:	We received several comments of support for updates to this improvement activity.
Response:	We appreciate the comments of support for our updates to this improvement activity. It has come to our attention that the way the proposed updated activity description was worded could leave some confusion. We are clarifying here that the proposed update in percentage to a 75% percent threshold applies to Quality Payment Program Year 2 and future years. Therefore, after consideration of comments, we are finalizing this update to our improvement activity with clarification that 75 percent of practice patients applies for the Quality Payment Program Year 2 and future years.

Rationale:	We are clarifying which actions qualify for this improvement activity for the Quality Payment Program Year 2 and future years.
Finalized Change:	**Change Activity Description to**: 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.
Finalized Improvement Activity	
Activity ID:	**IA_PM_2**
Subcategory:	Population Management
Activity Title:	Anticoagulant Management Improvements
Activity Description:	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.
Weighting:	High

Eligible for Advancing Care Information Bonus:	Yes
Current Improvement Activity	
Activity ID:	**IA_PM_8**
Current Subcategory:	Population Management
Current Activity Title:	Participation in CMMI models such as the Million Hearts Campaign
Current Activity Description:	Participation in CMMI models such as the Million Hearts Cardiovascular Risk Reduction Model
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	We proposed to delete this activity from the Inventory.
Comments:	We received one comment opposing the removal of this improvement activity from the Inventory as the commenter believed that we should consider implementing a consistent, multi-year process for phasing out improvement activities.
Response:	We believe it is appropriate to remove this activity, because participants in an APM already receive 50 percent credit in the improvement activity performance category, and we believe they should not be provided additional credit for this improvement activity. We will consider the suggestion of a consistent, multi-year process for phasing out of improvement activities, however, as we develop policy for future years. After consideration of comments, we are finalizing the removal of this improvement activity as proposed.
Rationale:	We do not believe participants in an APM, who have already received 50 percent credit in the improvement activity performance category, should not be provided additional credit for this improvement activity based solely on their participation in this specific APM.
Finalized Change:	We are finalizing removal of this activity from the Inventory as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_PM_8 (This activity is being removed from the Inventory)**
Subcategory:	None
Activity Title:	None
Activity Description:	None
Weighting:	None
Eligible for Advancing Care Information Bonus:	None
Current Improvement Activity	
Activity ID:	**IA_PM_11**
Current Subcategory:	Population Management
Current Activity Title:	Regular Review Practices in Place on Targeted Patient Population Needs
Current Activity Description:	Implementation of regular reviews of targeted patient population needs which includes access to reports that show unique characteristics of eligible 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.
Current Weighting:	Medium
Currently Eligible for	No

Advancing Care Information Bonus:	
Proposed Change:	**Change Activity Description to**: Implementation of regular reviews of targeted patient population needs, such as structured clinical case reviews, which includes access to reports that show unique characteristics of eligible clinician'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.
Comments:	One commenter suggested alignment of medication management with this improvement activity.
Response:	We will consider the suggestion of alignment of medication management with this improvement activity as we develop policy for future years. After consideration of comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We have updated the improvement activity with additional examples of types of patient interventions (to include reviews such as structured clinical case reviews) that would qualify for this improvement activity.
Finalized Change:	**Change Activity Description to**: Implementation of regular reviews of targeted patient population needs, such as structured clinical case reviews, which includes access to reports that show unique characteristics of eligible clinician'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.
Finalized Improvement Activity	
Activity ID:	**IA_PM_11**
Subcategory:	Population Management
Activity Title:	Regular Review Practices in Place on Targeted Patient Population Needs
Activity Description:	Implementation of regular reviews of targeted patient population needs, such as structured clinical case reviews, which includes access to reports that show unique characteristics of eligible clinician'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.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_PM_13**
Current Subcategory:	Population Management
Current Activity Title:	Chronic Care and Preventative Care Management for Empaneled Patients
Current Activity Description:	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 (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment • 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 predictive analytical models to predict risk, onset and progression of chronic diseases; or • 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.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Changes:** We proposed to delete the language "advance care planning" from this improvement activity, because we are creating a new improvement activity focused specifically on advance care planning. **Change Activity Description to**: 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; and plan of care for chronic conditions; • 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; • 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 predictive analytical models to predict risk, onset and progression of chronic diseases; or • 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.
Comments:	We received several comments of support for this improvement activity description update. One commenter suggested that we remove the term "empaneled" from this improvement activity to allow specialists to participate in this improvement activity and to incentivize the use of CEHRT. Another commenter stated that RHICs be added to this improvement activity.
Response:	We appreciate the comments of support for this improvement activity. We do not believe the word "empaneled" prevents clinicians or specialists from participating in this improvement activity. We will consider the addition of RHICs and the applicability of CEHRT to this improvement activity as we develop policy for future years. After consideration of comments, we are finalizing updates to this improvement activity with clarification.
Rationale:	We proposed to delete the language "and advance care planning" from this improvement activity, because we are creating a new improvement activity focused specifically on advance care planning.
Finalized Change:	**Change Activity Description to**: 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; and plan of care for chronic conditions;

	• 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; such as a CDC-recognized diabetes prevention program ; • 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 predictive analytical models to predict risk, onset and progression of chronic diseases; or • 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.
Finalized Improvement Activity	
Activity ID:	**IA_PM_13**
Subcategory:	Population Management
Activity Title:	Chronic Care and Preventative Care Management for Empaneled Patients
Activity Description:	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; and plan of care for chronic conditions; • 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; such as a CDC-recognized diabetes prevention program; • 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 predictive analytical models to predict risk, onset and progression of chronic diseases; or • 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.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_2**
Current Subcategory:	Patient Safety & Practice Assessment
Current Activity Title:	Participation in MOC Part IV
Current Activity Description:	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.
Current Weighting:	Medium
Currently Eligible for	No

Advancing Care Information Bonus:	
Proposed Change:	**Changes:** We are updating the activity with additional examples of programs through which clinicians can receive (MOC) Part IV credit that would qualify for this improvement activity. **Change Activity Description to**: Participation in Maintenance of Certification (MOC) Part IV, such as the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or ASA Simulation Education Network, 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.
Comments:	We received many comments of support for our updates to this improvement activity. One commenter stated that this improvement activity should be weighted as "high."
Response:	We appreciate the comments of support for this improvement activity. We believe that high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being. We do not believe this activity should be weighted as high, because it does not directly impact beneficiary quality of or access to care. . After consideration of comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We have updated the improvement activity with additional examples of programs through which clinicians can receive (MOC) Part IV credit that would qualify for this improvement activity.
Finalized Change:	**Change Activity Description to**: Participation in Maintenance of Certification (MOC) Part IV, such as the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or ASA Simulation Education Network, 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.
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_2**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Participation in MOC Part IV
Activity Description:	Participation in Maintenance of Certification (MOC) Part IV, such as the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or ASA Simulation Education Network, 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.

Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_3**
Current Subcategory:	Patient Safety & Practice Assessment
Current Activity Title:	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or Other Similar Activity
Current Activity Description:	For eligible professionals not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS®.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Changes:** We are updating the activity to clarify that other MOC programs are eligible for this improvement activity. **Change Activity Description to**: For MIPS eligible clinicians not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as the Institute for Healthcare Improvement (IHI) Training/Forum Event; National Academy of Medicine, Agency for Healthcare Research and Quality (AHRQ) Team STEPPS®, or the American Board of Family Medicine (ABFM) Performance in Practice Modules.
Comments:	We received a few comments of support for this improvement activity.
Response:	We appreciate the comments of support for this improvement activity. After consideration of comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We are finalizing to update the activity to add other MOC programs (listed above) are eligible for this improvement activity.
Finalized Change:	**Change Activity Description to**: For MIPS eligible clinicians not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as the Institute for Healthcare Improvement (IHI) Training/Forum Event; National Academy of Medicine, Agency for Healthcare Research and Quality (AHRQ) Team STEPPS®, or the American Board of Family Medicine (ABFM) Performance in Practice Modules.
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_3**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or Other Similar Activity
Activity Description:	For MIPS eligible clinicians not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as the Institute for Healthcare Improvement (IHI) Training/Forum Event; National Academy of Medicine, Agency for Healthcare Research and Quality (AHRQ) Team STEPPS®, or the American Board of Family Medicine (ABFM) Performance in Practice Modules.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	

Current Activity ID:	**IA_PSPA_4**
Current Subcategory:	Patient Safety & Practice Assessment
Current Activity Title:	Administration of the AHRQ Survey of Patient Safety Culture
Current Activity Description:	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-patient-safety/patientsafetyculture/index.html).
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Changes:** We are revising the wording of this improvement activity to specify that it may be selected once every 4 years to achieve the improvement activities performance category score. **Change Activity Description to:** 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.alrrq.gov/professionals/quality-patientsafety /patientsafetyculture/index.html). **Note**: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.
Comments:	We received one comment of support and another commenter requested that RHICs be added to this improvement activity.
Response:	We appreciate the comments of support for this improvement activity. We will consider the addition of RHICs to this improvement activity as we develop policy for future years. After consideration of comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We revised the wording of this improvement activity to specify that it may be selected once every 4 years to achieve the performance category score.
Finalized Change:	**Change Activity Description to:** 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-patient-safety/patientsafetyculture/index.html). **Note**: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_4**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Administration of the AHRQ Survey of Patient Safety Culture
Activity Description:	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-patient-safety/patientsafetyculture/index.html).

	Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_6**
Current Subcategory:	Patient Safety & Practice Assessment
Current Activity Title:	Consultation of the Prescription Drug Monitoring Program
Current Activity Description:	Clinicians would attest that 60 percent for the first 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.
Current Weighting:	High
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Changes:** We are updating this improvement activity such that 75% also applies to future years. In other words, for the Quality Payment Program Year 2 and future years, clinicians attest to 75 percent review of applicable patient's history performance. **Change Activity Description to**: Clinicians would attest to reviewing the patients' history of controlled substance prescription using state prescription drug monitoring program (PDMP) data prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription lasting longer than 3 days. For the transition year, clinicians would attest to 60 percent review of applicable patient's history. For the Quality Payment Program Year 2 and future years, clinicians would attest to 75 percent review of applicable patient's history performance.
Comments:	We received one comment of support for this improvement activity description change.
Response:	We appreciate the comment of support for updates to this improvement activity. After consideration of comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We are finalizing to update that clinicians would attest to 60 percent review of applicable patient's history for the transition year. In the Quality Payment Program Year 2 and future years, clinicians would attest to 75 percent review of applicable patient's history performance.
Finalized Change:	**Change Activity Description to**: Clinicians would attest to reviewing the patients' history of controlled substance prescription using state prescription drug monitoring program (PDMP) data prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription lasting longer than 3 days. For the transition year, clinicians would attest to 60 percent review of applicable patient's history. For the Quality Payment Program Year 2 and future years, clinicians would attest to 75 percent review of applicable patient's history performance.
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_6**
Subcategory:	Patient Safety & Practice Assessment

Activity Title:	Consultation of the Prescription Drug Monitoring Program
Activity Description:	Clinicians would attest to reviewing the patients' history of controlled substance prescription using state prescription drug monitoring program (PDMP) data prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription lasting longer than 3 days. For the transition year, clinicians would attest to 60 percent review of applicable patient's history. For the Quality Payment Program Year 2 and future years, clinicians would attest to 75 percent review of applicable patient's history performance.
Weighting:	High
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_8**
Current Subcategory:	Patient Safety & Practice Assessment
Current Activity Title:	Use of Patient Safety Tools
Current Activity Description:	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.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Changes:** We proposed to include additional examples of tools that may be utilized to assist specialty practices in tracking specific measures that are meaningful to their practice, including evidence based protocols such as Enhanced Recovery After Surgery (ERAS) protocols, the CDC Guide for Infection Prevention for Outpatient Settings and the use of tools and protocols that promote appropriate use criteria. **Change Activity Description to**: Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of a surgical risk calculator, evidence based protocols such as Enhanced Recovery After Surgery (ERAS) protocols, the CDC Guide for Infection Prevention for Outpatient Settings, (https://www.cdc.gov/hai/settings/outpatient/outpatient-care-guidelines.html), predictive algorithms, or other such tools.
Comments:	We received a few comments of support for our proposed updates to this improvement activity description. One commenter stated that that use of the Surgical Risk Calculator would be better classified on its own as a separate activity in the Beneficiary Engagement subcategory rather than being assigned to the Patient Safety and Practice Assessment subcategory.
Response:	We appreciate the comments of support for this improvement activity. To be clear, we did not propose to change our example of a surgical risk calculator as a tool that assists specialty practices in tracking specific measures that are meaningful to their practice the current subcategory (Patient Safety & Practice Assessment) for this activity. However, to be responsive to commenters, we believe the Surgical Risk Calculator continues to fit appropriately under the Patient Safety and Practice Assessment subcategory due to its function as a tool to assist tracking risk used to provide accurate risk assessment to patients to make safety and practice assessments. After consideration of comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We included additional examples of tools that may be utilized to assist specialty practices in tracking specific measures that are meaningful to their practice, including evidence based protocols such as Enhanced Recovery After Surgery (ERAS) protocols, the CDC Guide for Infection Prevention for Outpatient Settings and the use of tools and protocols that promote appropriate use criteria.

Finalized Change:	**Change Activity Description to**: Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of a surgical risk calculator, evidence based protocols such as Enhanced Recovery After Surgery (ERAS) protocols, the CDC Guide for Infection Prevention for Outpatient Settings, (https://www.cdc.gov/hai/settings/outpatient/outpatient-care-guidelines.html), predictive algorithms, or other such tools.
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_8**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Use of Patient Safety Tools
Activity Description:	Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of a surgical risk calculator, evidence based protocols such as Enhanced Recovery After Surgery (ERAS) protocols, the CDC Guide for Infection Prevention for Outpatient Settings, (https://www.cdc.gov/hai/settings/outpatient/outpatient-care-guidelines.html), predictive algorithms, or other such tools.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_14**
Current Subcategory:	Patient Safety & Practice Assessment
Current Activity Title:	Participation in Bridges to Excellence or Other Similar Programs
Current Activity Description:	Participation in other quality improvement programs such as Bridges to Excellence.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Changes:** We are revising the wording of this improvement activity to update that other programs are eligible for this improvement activity. **Proposed Activity Title**: Participation in Quality Improvement Initiatives **Proposed Activity Description**: Participation in other quality improvement programs, such as Bridges to Excellence or American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.
Comments:	We received one comment of support for this updated improvement activity description that also stated that that RHICs should be added to this improvement activity.
Response:	We appreciate the comment of support for this improvement activity. We will consider the addition of RHICs to this improvement activity as we develop policy for future years. After consideration of comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We revised the wording of this improvement activity to update that other programs are eligible for this improvement activity.
Finalized Change:	**Change Activity Title to**: Participation in Quality Improvement Initiatives **Change Activity Description to:** Participation in other quality improvement programs such as Bridges to Excellence or American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.

Finalized Improvement Activity	
Activity ID:	**IA_PSPA_14**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Participation in Quality Improvement Initiatives
Activity Description:	Participation in other quality improvement programs such as Bridges to Excellence or American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_15**
Current Subcategory:	Patient Safety & Practice Assessment
Current Activity Title:	Implementation of an ASP
Current Activity Description:	Implementation of an antibiotic stewardship program that measures the 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.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Changes:** We are updating the description to provide additional examples of actions that may be appropriate for this improvement activity and specified the locations of these activities as facilities or practices. **Change Activity Description to:** Leadership of an Antimicrobial Stewardship Program (ASP) that includes implementation of an ASP that measures the appropriate use of antibiotics for several different conditions (such as upper respiratory infection treatment in children, diagnosis of pharyngitis, and bronchitis treatment in adults) according to clinical guidelines for diagnostics and therapeutics. Specific activities may include: • Develop facility-specific antibiogram and prepare report of findings with specific action plan that aligns with overall hospital strategic plan. • Lead the development, implementation, and monitoring of patient care and patient safety protocols for the delivery of ASP including protocols pertaining to the most appropriate setting for such services (i.e., outpatient or inpatient). • Assist in improving ASP service line efficiency and effectiveness by evaluating and recommending improvements in the management structure and workflow of ASP processes. • Manage compliance of the ASP policies and assist with implementation of corrective actions in accordance with hospital compliance policies and hospital medical staff by-laws. • Lead the education and training of professional support staff for the purpose of maintaining an efficient and effective ASP. • Coordinate communications between ASP management and hospital personnel regarding activities, services, and operational/clinical protocols to achieve overall compliance and understanding of the ASP. • Assist, at the request of the hospital, in preparing for and responding to third-party requests, including but not limited to payer audits, govenm1ental inquiries, and professional inquiries that pertain to the

	ASP service line.
Comments:	We received several comments of support for this updated improvement activity description, suggestions for changing the setting in which these activities apply and enhancing the examples of actions that may be appropriate for this improvement activity. One commenter urged that we change the language to indicate that this activity could occur in outpatient settings and suggested additional examples of appropriate actions under this activity, such as implementing evidence-based policies to improve antibiotic prescribing and decision support for common infections. Another commenter recommended the proposed activity align with the recommendations in the Centers for Disease Control and Prevention's Core Elements of Outpatient Antibiotic Stewardship guidance (https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6506.pdf).
Response:	We appreciate the comments of support for this improvement activity. We have purposefully proposed updates to this improvement activity in a generalized manner such that many activities may be applicable to this improvement activity. We believe that expanding the applicable setting is appropriate, because these activities could take place in either a facility or hospital. In line with our intentions and in response to the commenter who suggested we change the language to indicate that this activity could occur in outpatient settings, we are modifying our proposal to expand the settings in which these activities may apply. Specifically, we are modifying the proposal by changing the term "hospital" throughout the specific activity examples to refer to "facility or practice" where appropriate. We also incorporated the suggestions of commenters to add activity references to implementing evidence-based protocols and decision-support and tracking an evidence-based policy or practice for common or high priority infections as we agreed that these are common applications of an Antimicrobial Stewardship Program. We also referenced the Centers for Disease Control and Prevention's Core Elements of Outpatient Antibiotic Stewardship guidance, per a commenter's suggestion, as we want to explicitly align with CDC's guidance on this matter. After consideration of public comments, we are finalizing our proposed updates to this improvement activity with modifications as described above.
Rationale:	We are finalizing, with modification, the proposed updates to the activity description to provide additional examples of actions that may be appropriate for this improvement activity and specified the locations of these activities as facilities or practices. We are modifying our proposed updates by changing the term "hospital" to "facility or practice."

Finalized Change:	**Change Activity Description to:** Leadership of an Antimicrobial Stewardship Program (ASP) that includes implementation of an ASP that measures the appropriate use of antibiotics for several different conditions (such as but not limited to upper respiratory infection treatment in children, diagnosis of pharyngitis, bronchitis treatment in adults) according to clinical guidelines for diagnostics and therapeutics. Specific activities may include: • Develop facility-specific antibiogram and prepare report of findings with specific action plan that aligns with overall facility or practice strategic plan. • Lead the development, implementation, and monitoring of patient care and patient safety protocols for the delivery of ASP including protocols pertaining to the most appropriate setting for such services (i.e., outpatient or inpatient). • Assist in improving ASP service line efficiency and effectiveness by evaluating and recommending improvements in the management structure and workflow of ASP processes. • Manage compliance of the ASP policies and assist with implementation of corrective actions in accordance with facility or practice compliance policies and facility or practice medical staff by-laws. • Lead the education and training of professional support staff for the purpose of maintaining an efficient and effective ASP. • Coordinate communications between ASP management and facility or practice personnel regarding activities, services, and operational/clinical protocols to achieve overall compliance and understanding of the ASP. • Assist, at the request of the facility or practice, in preparing for and responding to third-party requests, including but not limited to payer audits, governmental inquiries, and professional inquiries that pertain to the ASP service line. • Implementing and tracking an evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions. • Developing and implementing evidence-based protocols and decision-support for diagnosis and treatment of common infections. • Implementing evidence-based protocols that align with recommendations in the Centers for Disease Control and Prevention's Core Elements of Outpatient Antibiotic Stewardship guidance
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_15**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Implementation of an ASP
Activity Description:	**Change Activity Description to:** Leadership of an Antimicrobial Stewardship Program (ASP) that includes implementation of an ASP that measures the appropriate use of antibiotics for several different conditions (such as but not limited to upper respiratory infection treatment in children, diagnosis of pharyngitis, bronchitis treatment in adults) according to clinical guidelines for diagnostics and therapeutics. Specific activities may include: • Develop facility-specific antibiogram and prepare report of findings with specific action plan that aligns with overall facility or practice strategic plan. • Lead the development, implementation, and monitoring of patient care and patient safety protocols for the delivery of ASP including protocols pertaining to the most appropriate setting for such services (i.e.,

	outpatient or inpatient). • Assist in improving ASP service line efficiency and effectiveness by evaluating and recommending improvements in the management structure and workflow of ASP processes. • Manage compliance of the ASP policies and assist with implementation of corrective actions in accordance with facility or clinic compliance policies and hospital medical staff by-laws. • Lead the education and training of professional support staff for the purpose of maintaining an efficient and effective ASP. • Coordinate communications between ASP management and facility or practice personnel regarding activities, services, and operational/clinical protocols to achieve overall compliance and understanding of the ASP. • Assist, at the request of the facility or practice, in preparing for and responding to third-party requests, including but not limited to payer audits, governmental inquiries, and professional inquiries that pertain to the ASP service line. • Implementing and tracking an evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions. • Developing and implementing evidence-based protocols and decision-support for diagnosis and treatment of common infections. • Implementing evidence-based protocols that align with recommendations in the Centers for Disease Control and Prevention's Core Elements of Outpatient Antibiotic Stewardship guidance
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_18**
Current Subcategory:	Patient Safety & Practice Assessment
Current Activity Title:	Measurement and Improvement at the Practice and Panel Level
Current Activity Description:	Measure and improve quality at the practice and panel level that could include one or more of the following: • 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 clinician or group (panel); and/or • Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.
Current Weighting:	Medium
Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Changes**: We are providing additional examples of actions that may be appropriate for this improvement activity. **Change Activity Description to**: Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic Surgery (ABOS) Physician Scorecards, that could include one or more of the following: 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 clinician or group (panel); and/or Use relevant data

	sources to create benchmarks and goals for performance at the practice level and panel level.
Comments:	One commenter requested that RHICs be added to this improvement activity.
Response:	We will consider the addition of RHICs to this improvement activity as we develop policy for future years. After consideration of public comments, we are finalizing updates to this improvement activity as proposed.
Rationale:	We provided additional examples of activities that may be appropriate for this improvement activity.
Finalized Change:	**Change Activity Description to**: Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic Surgery (ABOS) Physician Scorecards, that could include one or more of the following: • 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 clinician or group (panel); and/or • Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_18**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Measurement and Improvement at the Practice and Panel Level
Activity Description:	Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic Surgery (ABOS) Physician Scorecards, that could include one or more of the following: • 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 clinician or group (panel); and/or • Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_19**
Current Subcategory:	Patient Safety & Practice Assessment
Current Activity Title:	Implementation of formal quality improvement methods, practice changes, or other practice improvement processes
Current Activity Description:	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: • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.
Current Weighting:	Medium

Currently Eligible for Advancing Care Information Bonus:	No
Proposed Change:	**Changes:** We are adding another bullet with additional examples of actions that may be appropriate for this improvement activity. **Change Activity Description to:** 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 such as: • Multi-Source Feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data.
Comments:	We received several comments of support for the proposed changes to this activity description and suggestions for enhancing the examples of actions that may be appropriate for this improvement activity, such as activities in which clinicians act upon patient experience data, patient safety, and quality improvement activities that reflect the role of patients and families in driving safer, high-quality care.
Response:	We appreciate the comments of support for this improvement activity. Based on these comments, we are modifying this improvement activity to include additional examples of actions that reflect the role of patients and families in driving safer, high-quality care and in which clinicians act upon patient experience data, patient safety that may be appropriate for this improvement activity in the last bullet. After consideration of public comments, we are finalizing updates to this improvement activity with modifications.
Rationale:	We are including additional examples of actions that may be appropriate for this improvement activity in the last bullet.
Finalized Change:	**Change Activity Description to:** 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 such as: • Multi-Source Feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data.
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_19**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Implementation of formal quality improvement methods, practice changes, or

	other practice improvement processes
Activity Description:	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 such as: • Multi-Source Feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No

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