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

IA_AHE_1: Engagement of New Medicaid Patients and Follow-Up
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.

IA_AHE_3: Promote Use of Patient-Reported Outcome Tools
Finalized Changes:
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: Chang to "yes" for eligible for advancing care information bonus.

IA_BE_14: Engage Patients and Families to Guide Improvement in the System of Care
Finalized Changes:
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 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.

IA_BE_15: Engagement of Patients, Family, and Caregivers in Developing a Plan of Care
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.

IA_BE_21: Improved Practices that Disseminate Appropriate Self-Management Materials
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".

IA_BE_22: Improved Practices that Engage Patients Pre-Visit
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.

IA_BMH_7: Implementation of Integrated Patient Centered Behavioral Health Model
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 MIIPS 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.

IA_CC_1: Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop
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 HER technology.

IA_CC_4: TCPI Participation
Finalized Change: Change Weight to: Medium

IA_CC_9: Implementation of practices/processes for developing regular individual care plans

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 ta patient's goals and priorities, as well as desired outcomes of care.

IA_CC_13: Practice Improvements for Bilateral Exchange of Patient Information
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

IA_CC_14: Practice Improvements that Engage Community Resources to Support Patient Health Goals
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 to available community resources.

IA_EPA_1: Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
Finalized Change: 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-riven 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.

PM_1: Participation in Systematic Anticoagulation Program IA_
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).

IA_PM_2: Anticoagulant Management Improvements
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 educations, 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.

IA_PM_8: Participation in CMMI models such as the Million Hearts Campaign
Finalized Change: We are finalizing removal of this activity from the Inventory as proposed

IA_PM_11: Regular Review Practices in Place on Targeted Patient Population Needs
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.

IA_PM_13: Chronic Care and Preventative Care Management for Empaneled Patients
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.

IA_PSPA_2: Participation in MOC Part IV
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.

IA_PSPA_3: Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS or Other Similar 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.

IA_PSPA_4: Administration of the AHRQ Survey of Patient Safety Culture
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 AHRRQ 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.

IA_PSPA_6: Consultation of the Prescription Drug Monitoring Program
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 75 percent review of applicable patient's history performance.

IA_PSPA_8: Use of Patient Safety Tools
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.

IA_PSPA_14: Participation in Quality Improvement Initiatives
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.

IA_PSPA_15: Implementation of an ASP

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 caer 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 inquires 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

IA_PSPA_18: Measurement and Improvement at the Practice and Panel Level

Finalized Change: Change Activity Description to: Measure and improve quality at the practice and panel level, such as the American Board of Orthopedic 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.

IA_PSPA_19: Implementation of formal quality improvement methods, practice changes, or other practice improvement processes

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.