CROSSWALK: STAGE 2 ELIGIBLE PROFESSIONAL MU AND NCQA PCMH 2014 STANDARDS

Stage 2 EP MU Core Measures			NCQA PCMH 2014 Standards		
Objective		**Measure(s)**	**Standard**	**Element**	**Factor(s)**
CPOE for Medication, Laboratory and Radiology Orders	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.	**4: Care Management and Support**	4D: Use Electronic Prescribing The practice uses an electronic prescription system with the following capabilities.	4D-2: Enters electronic medication orders in the medical record for more than 60 percent of medications.
			5: Care Coordination and Care Transitions	5A: Test Tracking and Follow-Up The practice has a documented process for and demonstrates that it:	5A-7: More than 30 percent of laboratory orders are electronically recorded in the patient record.
					5A-8: More than 30 percent of radiology orders are electronically recorded in the patient record.
e-Prescribing (eRx)	Generate and transmit permissible prescriptions electronically (eRx).	More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using certified electronic health record technology (CEHRT).	**4: Care Management and Support**	4D: Use Electronic Prescribing The practice uses an electronic prescription system with the following capabilities.	4D-1: More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies.

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Record Demographics	Record the following demographics: preferred language, sex, race, ethnicity, date of birth.	More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.	**3: Population Health Management**	3A: Patient Information The practice uses an electronic system to record patient information, including capturing information for factors 1-13 as structured (searchable) data for more than 80 percent of its patients	3A-1: Date of birth
					3A-2: Sex
					3A-3: Race
					3A-4: Ethnicity
					3A-5: Preferred language
Record Vital Signs	Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0–20 years, including BMI.	More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.	**3: Population Health Management**	3B: Clinical Data The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1–5 and 8–11 as structured (searchable) data	3B-3: Blood pressure, with the date of update for more than 80 percent of patients 3 years and older.
					3B-4: Height/length for more than 80 percent of patients.
					3B-5: Weight for more than 80 percent of patients.
					3B-6: System calculates and displays BMI.
					3B-7: System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices).
Record Smoking Status	Record smoking status for patients 13 years old or older.	More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	**3: Population Health Management**	3B: Clinical Data The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1–5 and 8–11 as structured (searchable) data	3B-8: Status of tobacco use for patients 13 years and older for more than 80 percent of patients.

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Clinical Decision Support Rule	Use clinical decision support to improve performance on high-priority health conditions.	Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.	**3: Population Health Management**	3E: Implement Evidence-Based Decision Support The practice implements clinical decision support (e.g. point-of-care reminders) following evidence-based guidelines for:	3E-1: A mental health or substance use disorder.
					3E-2: A chronic medical condition.
					3E-3: An acute condition.
					3E-4: A condition related to unhealthy behaviors.
					3E-5: Well child or adult care.
					3E-6: Overuse/ appropriateness issues.
		Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	**4: Care Management and Support**	4D: Use Electronic Prescribing The practice uses an electronic prescription system with the following capabilities.	4D-3: Performs patient-specific checks for drug-drug and drug-allergy interactions.
Patient Electronic Access	Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.	Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information, with the ability to view, download, and transmit to a third party.	**1: Patient-Centered Access**	1C: Electronic Access The following information and services are provided to patients/ families/caregivers, as specified, through a secure electronic system	1C-1: More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice
		Measure 2: More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.			1C-2: More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party.

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Clinical Summaries	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.	**1: Patient-Centered Access**	1C: Electronic Access The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system.	1C-3: Clinical summaries are provided within 1 business day(s) for more than 50 percent of office visits.
Protect Electronic Health Information	Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis, including addressing the encryption/security of data stored in CEHRT, and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.	**6: Performance Measurement and Quality Improvement**	6G: Use Certified EHR Technology The practice uses a certified EHR system.	6G-2: The practice conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies.
Clinical Lab-Test Results	Incorporate clinical lab-test results into CEHRT as structured data	More than 55 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in CEHRT as structured data	**5: Care Coordination and Care Transitions**	5A: Test Tracking and Follow-Up The practice has a documented process for and demonstrates that it:	5A-9: Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record.
Patient Lists	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP with a specific condition.	**3: Population Health Management**	3D: Use Data for Population Management At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:	3D-1: At least two different preventive care services. 3D-2: At least two different immunizations. 3D-3: At least three different chronic or acute care services.

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Reminders	Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.	More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.	**6: Performance Measurement and Quality Improvement**	6G: Use Certified EHR Technology The practice uses a certified EHR system.	6G-10: The practice generates lists of patients and, based on their preferred method of communication, proactively reminds more than 10 percent of patients/families/ caregivers about needed preventive/follow-up care.
Patient-Specific Education Resources	Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.	Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.	**4: Care Management and Support**	4E: Support Self-Care and Shared Decision Making The practice has, and demonstrates use of, materials to support patients and families/ caregivers in self-management and shared decision making. The practice:	4E-1: Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients.
Medication Reconciliation	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.	**4: Care Management and Support**	4C: Medication Management The practice has a process for managing medications, and systematically implements the process in the following ways:	4C-1: Reviews and reconciles medications for more than 50 percent of patients received from care transitions.

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Summary of Care	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	Measure 1: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.	**5: Care Coordination and Care Transitions**	Element B: Referral Tracking and Follow-Up The practice:	5B-7: Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50 percent of referrals.
				Element C: Coordinate Care Transitions The practice:	5C-7: Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care.
		Measure 2: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is an eHealth Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the eHealth Exchange.		Element B: Referral Tracking and Follow-Up The practice:	5B-7: Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50 percent of referrals.
				Element C: Coordinate Care Transitions The practice:	5C-7: Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care.
		Measure 3: An EP must satisfy one of the following criteria: • Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (with a recipient who has EHR technology that was developed by a different EHR technology developer than the sender's EHR technology certified to 2014 Edition CEHRT). • Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.		Element B: Referral Tracking and Follow-Up The practice:	5B-7: Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50 percent of referrals.
				Element C: Coordinate Care Transitions The practice:	5C-7: Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care.

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Immunization Registries Data Submission	Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.	**6: Performance Measurement and Quality Improvement**	6G: Use Certified EHR Technology The practice uses a certified EHR system.	6G-7: The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically.
Use Secure Electronic Messaging	Use secure electronic messaging to communicate with patients on relevant health information.	A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.	**1: Patient-Centered Access**	1C: Electronic Access The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system.	1C-4: A secure message was sent by more than 5 percent of patients.

Stage 2 EP MU Menu Measures			NCQA PCMH 2014 Standards		
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Syndromic Surveillance Data Submission	Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.	**6: Performance Measurement and Quality Improvement**	6G: Use Certified EHR Technology The practice uses a certified EHR system.	6G-3: The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically.
Electronic Notes	Record electronic notes in patient records.	Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.	**3: Population Health Management**	3B: Clinical Data The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1-5 and 8-11 as structured (searchable) data	3B-11: At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of patients with at least one office visit.
Imaging Results	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.	More than 10 percent of all tests whose result is one or more image.	**5: Care Coordination and Care Transitions**	5A: Test Tracking and Follow-Up The practice has a documented process for and demonstrates that it:	5A-10: More than 10 percent of scans and tests that result in an image are accessible electronically.

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Family Health History	Record patient family health history as structured data.	More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.	**3: Population Health Management**	3B: Clinical Data The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1-5 and 8-11 as structured (searchable) data	3B-10: More than 20 percent of patients have family history recorded as structured data.
Report Cancer Cases	Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.	**6: Performance Measurement and Quality Improvement**	6G: Use Certified EHR Technology The practice uses a certified EHR system.	6G-4: The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically.
Report Specific Cases	Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.	**6: Performance Measurement and Quality Improvement**	6G: Use Certified EHR Technology The practice uses a certified EHR system.	6G-5: The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically.