Appendix 2

PCMH 2014 and CMS Modified Stage 2 Meaningful Use Requirements

APPENDIX 2
PCMH 2014 AND CMS MODIFIED STAGE 2 MEANINGFUL USE REQUIREMENTS

Medicare and Medicaid Electronic Health Record Incentive Program Meaningful Use Requirements

The NCQA PCMH Recognition program was developed to align with Meaningful Use Stage 2 criteria. Alignment has been updated to reflect the Meaningful Use Modified Stage 2 Final Rule released in October 2015.

The Modified Stage 2 rule includes:

- A single set of 10 objectives is now required.
- No changes to Clinical Quality Measures or reporting.

For more information about CMS Modified Stage 2, go to: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

For specific information about Objectives and Measures required in the Modified Stage 2 Final Rule, go to: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage3Overview2015_2017.pdf

Notes

- *Alignment with the Modified Stage 2 rule has been indicated next to applicable factors in the PCMH 2014 Standards & Guidelines.*
- *For requirements previously aligned with the Stage 2 rule that have changed in the Modified Stage 2 rule, please consult the Standards and Guidelines for notes or updates about the required documentation for PCMH 2014. Unless otherwise noted in the explanation or documentation sections, documentation must demonstrate the factors as written.*
- *For aligned factors, NCQA accepts published final CMS exclusions applying to the current Meaningful Use stage. If a practice responds NA, a written explanation is required.*

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements[1]
PCMH 1: Patient-Centered Access		
Element A: Patient-Centered Appointment Access	The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on: 1. Providing same-day appointments for routine and urgent care. 2. Providing routine and urgent-care appointments outside regular business hours. 3. Providing alternative types of clinical encounters. 4. Availability of appointments. 5. Monitoring no show rates. 6. Acting on identified opportunities to improve access.	NA
Element B: 24/7 Access to Clinical Advice	The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on: 1. Providing continuity of medical record information for care and advice when the office is closed. 2. Providing timely clinical advice by telephone. 3. Providing timely clinical advice using a secure, interactive electronic system. 4. Documenting clinical advice in patient records.	NA
Element C: Electronic Access	The following information and services are provided to patients/ families/caregivers, as specified, through a secure electronic system. **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+.** **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+.** 3. Clinical summaries are provided within 1 business day(s) for more than 50 percent of office visits. **4. A secure message was sent by more than 5 percent of patients+.** 5. Patients have two-way communication with the practice. 6. Patients can request appointments, prescription refills, referrals and test results.	**Objective 8: Patient Electronic Access (VDT)** **EP Measure 1:** More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information. **EP Measure 2:** For an EHR reporting period in 2015, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.

[1]Modified Stage 2 Reference Grid: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage3_EP.pdf

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 1: Patient-Centered Access		
		Exclusions: Any EP who: a. Neither orders nor creates any of the information listed for inclusion as part of the measures; or b. Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period. **Objective 9: Secure Messaging** **Measure:** For an EHR reporting period in 2015, the capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period. **Exclusion:** Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.
PCMH 2: Team-Based Care		
Element A: Continuity	The practice provides continuity of care for patients/families by: 1. Assisting patients/families to select a personal clinician and documenting the selection in practice records. 2. Monitoring the percentage of patient visits with selected clinician or team. 3. Having a process to orient new patients to the practice. 4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care.	NA

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 2: Team-Based Care		
Element B: Medical Home Responsibilities	The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information: 1. The practice is responsible for coordinating patient care across multiple settings. 2. Instructions for obtaining care and clinical advice during office hours and when the office is closed. 3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice. 4. The care team provides access to evidence-based care, patient/family education and self-management support. 5. The scope of services available within the practice including how behavioral health needs are addressed. 6. The practice provides equal access to all of their patients regardless of source of payment. 7. The practice gives uninsured patients information about obtaining coverage. 8. Instructions on transferring records to the practice, including a point of contact at the practice.	NA
Element C: Culturally and Linguistically Appropriate Services	The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by: 1. Assessing the diversity of its population. 2. Assessing the language needs of its population. 3. Providing interpretation or bilingual services to meet the language needs of its population. 4. Providing printed materials in the languages of its population.	NA
Element D: The Practice Team	The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members. 2. Identifying practice organizational structure and staff leading and sustaining team based care. 3. Having regular patient care team meetings or a structured communication process focused on individual patient care. 4. Using standing orders for services. 5. Training and assigning members of the care team to coordinate care for individual patients. 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change. 7. Training and assigning members of the care team to manage the patient population. 8. Holding regular team meetings addressing practice functioning. 9. Involving care team staff in the practice's performance evaluation and quality improvement activities. 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council.	NA

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 3: Population Health Management		
Element A: Patient Information	The practice uses an electronic system to records patient information, including capturing information for factors 1–13 as structured (searchable) data for more than 80 percent of its patients: 1. Date of birth. 2. Sex. 3. Race. 4. Ethnicity. 5. Preferred language. 6. Telephone numbers. 7. E-mail address. 8. Occupation (NA for pediatric practices). 9. Dates of previous clinical visits. 10. Legal guardian/health care proxy. 11. Primary caregiver. 12. Presence of advance directives (NA for pediatric practices). 13. Health insurance information. 14. Name and contact information of other health care professionals involved in patient's care.	NA
Element B: 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. 1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients. 2. Allergies, including medication allergies and adverse reactions for more than 80 percent of patients. 3. Blood pressure, with the date of update for more than 80 percent of patients 3 years and older. 4. Height/length for more than 80 percent of patients.+ 5. Weight for more than 80 percent of patients. 6. System calculates and displays BMI. 7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices). 8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients. 9. List of prescription medications with date of updates for more than 80 percent of patients. 10. More than 20 percent of patients have family history recorded as structured data.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.	NA

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 3: Population Health Management		
Element C: Comprehensive Health Assessment	To understand the health risks and information needs of patients/ families, the practice collects and regularly updates a comprehensive health assessment that includes: 1. Age- and gender appropriate immunizations and screenings. 2. Family/social/cultural characteristics. 3. Communication needs. 4. Medical history of patient and family. 5. Advance care planning (NA for pediatric practices). 6. Behaviors affecting health. 7. Mental health/substance use history of patient and family. 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients). 9. Depression screening for adults and adolescents using a standardized tool. 10. Assessment of health literacy.	NA
Element D: 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: 1. At least two different preventive care services. 2. At least two different immunizations. 3. At least three different chronic or acute care services. 4. Patients not recently seen by the practice 5. Medication monitoring or alert.	NA
Element E: Implement Evidence-Based Decision Support	**The practice implements clinical decision support** + (e.g. point-of-care reminders) following evidence-based guidelines for: 1. A mental health or substance use disorder.+ 2. A chronic medical condition.+ 3. An acute condition.+ 4. A condition related to unhealthy behaviors.+ 5. Well child or adult care.+ 6. Overuse/appropriateness issues.+	**Objective 2: Clinical Decision Support** *In order for EPs to meet the objective they must satisfy both of the following measures:* **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.

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 3: Population Health Management		
		Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period. **Exclusion**: For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.
PCMH 4: Care Management and Support		
Element A: Identify Patients for Care Management	The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following: 1. Behavioral health conditions. 2. High cost/high utilization. 3. Poorly controlled or complex conditions. 4. Social determinants of health. 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver. 6. The practice monitors the percentage of the total patient population identified through its process and criteria.	NA
Element B: Care Planning and Self-Care Support	The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A: 1. Incorporates patient preferences and functional/lifestyle goals. 2. Identifies treatment goals. 3. Assesses and addresses potential barriers to meeting goals. 4. Includes a self-management plan. 5. Is provided in writing to the patient/family/caregiver.	NA
Element C: Medication Management	The practice has a process for managing medications, and systematically implements the process in the following ways: **1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions.+** 2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions. 3. Provides information about new prescriptions to more than 80 percent of patients/families/caregivers.	**Objective 7: Medication Reconciliation** **Measure**: The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP. **Exclusion**: Any EP who was not the recipient of any transitions of care during the EHR reporting period.

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 4: Care Management and Support		
	4. Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment. 5. Assesses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates of assessment. 6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates	
Element D: Use Electronic Prescribing	The practice uses an electronic prescription system with the following capabilities. **1. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies.+** **2. Enters electronic medication orders in the medical record for more than 60 percent of medications.+** **3. Performs patient-specific checks for drug-drug and drug-allergy interactions.+** 4. Alerts prescriber to generic alternatives.	**Objective 4: Electronic Prescribing** **EP Measure**: More than 50 percent of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT. **Exclusions:** Any EP who: – Writes fewer than 100 permissible prescriptions during the EHR reporting period; or – Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period. **Objective 3: Computerized Provider Order Entry** *An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective.* **Measure 1**: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Exclusion**: Any EP who writes fewer than 100 medication orders during the EHR reporting period. **Measure 2**: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Exclusion**: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. **Measure 3**: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Exclusion:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period.

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 4: Care Management and Support		
		Objective 2: Clinical Decision Support *In order for EPs to meet the objective they must satisfy both of the following measures:* **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. **Measure 2**: The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period. **Exclusion**: For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.
Element E: 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: **1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients+** 2. Provides educational materials and resources to patients. 3. Provides self-management tools to record self-care results. 4. Adopts shared decision making aids. 5. Offers or refers patients to structured health education programs such as group classes and peer support. 6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates. 7. Assesses usefulness of identified community resources.	**Objective 6: Patient Specific Education** **EP Measure**: 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. **Exclusion**: Any EP who has no office visits during the EHR reporting period.

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 5: Care Coordination and Care Transitions		
Element A: Test Tracking and Follow-Up	The practice has a documented process for and demonstrates that it: 1. Tracks lab tests until results are available, flagging and following up on overdue results. 2. Tracks imaging tests until results are available, flagging and following up on overdue results. 3. Flags abnormal lab results, bringing them to the attention of the clinician. 4. Flags abnormal imaging results, bringing them to the attention of the clinician. 5. Notifies patients/families of normal and abnormal lab and imaging test results. 6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults). **7. More than 30 percent of laboratory orders are electronically recorded in the patient record.+** **8. More than 30 percent of radiology orders are electronically recorded in the patient record.+** 9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record. 10. More than 10 percent of scans and tests that result in an image are accessible electronically.	**Objective 3: Computerized Provider Order Entry** *An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective.* **Measure 1**: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Exclusion**: Any EP who writes fewer than 100 medication orders during the EHR reporting period. **Measure 2**: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Exclusion**: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. **Measure 3**: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Exclusion:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period.
Element B: Referral Tracking and Follow-Up	The practice: 1. Considers available performance information on consultants/specialists when making referral recommendations. 2. Maintains formal and informal agreements with a subset of specialists based on established criteria. 3. Maintains agreements with behavioral healthcare providers. 4. Integrates behavioral healthcare providers within the practice site. 5. Gives the consultant or specialist the clinical question, the required timing and the type of referral. 6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan. **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.+** 8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.	**Objective 5: Health Information Exchange** **Measure:** The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals. **Exclusion**: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 5: Care Coordination and Care Transitions		
	9. Documents co-management arrangements in the patient's medical record. 10. Asks patients/families about self-referrals and requesting reports from clinicians.	
Element C: Coordinate Care Transitions	The practice: 1. Proactively identifies patients with unplanned hospital admissions and emergency department visits. 2. Shares clinical information with admitting hospitals and emergency departments. 3. Consistently obtains patient discharge summaries from the hospital and other facilities. 4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit. 5. Exchanges patient information with the hospital during a patient's hospitalization. 6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners. **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.+**	**Objective 5: Health Information Exchange** **Measure:** The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals. **Exclusion**: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.
PCMH 6: Performance Measurement and Quality Improvement		
Element A: Measure Clinical Quality Performance	At least annually, the practice measures or receives data on: 1. At least two immunization measures. 2. At least two other preventive care measures. 3. At least three chronic or acute care clinical measures. 4. Performance data stratified for vulnerable populations (to assess disparities in care).	NA
Element B: Measure Resource Use and Care Coordination	At least annually, the practice measures or receives quantitative data on: 1. At least two measures related to care coordination. 2. At least two utilization measures affecting health care costs.	NA

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 6: Performance Measurement and Quality Improvement		
Element C: **Measure Patient/Family Experience**	At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care. 1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: • Access. • Communication. • Coordination. • Whole Person Care/Self-Management Support. 2. The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool. 3. The practice obtains feedback on experiences of vulnerable patient groups. 4. The practice obtains feedback from patients/families through qualitative means.	NA
Element D: Implement Continuous Quality Improvement	The practice uses an ongoing quality improvement process to: 1. Set goals and analyze at least three clinical quality measures from Element A. 2. Act to improve at least three clinical quality measures from Element A. 3. Set goals and analyze at least one measure from Element B. 4. Act to improve at least one measure from Element B. 5. Set goals and analyze at least one patient experience measure from Element C. 6. Act to improve at least one patient experience measure from Element C. 7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations.	NA
Element E: Demonstrate Continuous Quality Improvement	The practice demonstrates continuous quality improvement by: 1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D. 2. Achieving improved performance on at least two clinical quality measures. 3. Achieving improved performance on one utilization or care coordination measure. 4. Achieving improved performance on at least one patient experience measure.	NA
Element F: Report Performance	The practice produces performance data reports using measures from Elements A, B and C and shares: 1. Individual clinician performance results with the practice. 2. Practice-level performance results with the practice. 3. Individual clinician or practice-level performance results publicly. 4. Individual clinician or practice-level performance results with patients.	NA

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 6: Performance Measurement and Quality Improvement		
Element G: **Use Certified EHR Technology**	The practice uses a certified EHR system. 1. **The practice uses an EHR system (or modules) that has been certified and issued a CMS certification ID.++** **2. The practice to conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies.+** **3. The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically.+** **4. The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically.+** **5. The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically.+** 6. **The practice reports clinical quality measures to Medicare or Medicaid agency, as required for Meaningful Use.++** **7. The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically.+** 8. The practice has access to a Health Information Exchange. 9. The practice has bi-directional exchange with a Health Information Exchange. 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.	**Objective 1: Protect Patient Health Information** **Measure**: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process. **Objective 10: Public Health Reporting** An EP scheduled to be in Stage 2 in 2015 must meet 2 measures. **Measure Option 1 – Immunization Registry Reporting**: The EP is in active engagement with a public health agency to submit immunization data. **Exclusions**: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP-- - Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period; – Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; **or** – Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 6: Performance Measurement and Quality Improvement		
Element G: **Use Certified EHR Technology *continued***		**Measure Option 2—Syndromic Surveillance Reporting:** The EP is in active engagement with a public health agency to submit syndromic surveillance data. **Exclusion for EPs:** Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP: – Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system; – Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or – Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period. **Measure Option 3—Specialized Registry Reporting:** The EP is in active engagement to submit data to a specialized registry. **Exclusions**: Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP— – Does not diagnose or treat any disease or condition associated with, or collect relevant data that is collected by, a specialized registry in their jurisdiction during the EHR reporting period; – Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or – Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period. **++ CMS Requirement** **Clinical Quality Measures (CQM)** Eligible professionals must report clinical quality measures to CMS. Six measure domains were specified: patient and family engagement, patient safety, care coordination, population and public health, efficient use of healthcare resources and clinical processes/effectiveness with 64 potential measures.

PCMH 2014 Standards, Elements and Factors +Modified Stage 2 Alignment		Meaningful Use Modified Stage 2 Requirements
PCMH 6: Performance Measurement and Quality Improvement		
		Eligible professionals have three reporting options: 1) Select and submit 9 measures from the list of 64 measures; one measure from at least three National Quality Strategy Domains is required. If a provider's EHR doesn't include information for 9 measures in three domains, they must submit all of the measures they can. 2) Submit and satisfactorily report CQM under the Physician Quality Reporting System's (PQRS) EHR Reportion Option (both individual EPs and EPs in group practices) 3) Eligible professionals that are part of an ACO (Medicare Shared Savings program, or Pioneer ACO) and satisfy CMS' quality reporting requirements via CEHRT (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html)