Redwood MedNet NHIN Direct x MU Crosswalk

MU#	Care Goals	Stage 1 Objectives - Ambulatory	VIA PUSH
1	*Provide access to comprehensive patient health data for patient's health care team Use evidence-based order sets and CPOE Apply clinical decision support at the point of care Generate lists of patients who need care and use them to reach out to patients Report information for quality improvement and public reporting*	Use CPOE	
2		Implement drug-drug, drug-allergy, drug-formulary checks	
3		Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	
4		Generate and transmit permissible prescriptions electronically (eRx)	
5		Maintain active medication list	
6		Maintain active medication allergy list	
7		Record demographics o preferred language o insurance type o gender o race o ethnicity o date of birth	
8		Record and chart changes in vital signs: o height o weight o blood pressure o Calculate and display: BMI o Plot and display growth charts for children 2-20 years, including BMI.	
9		Record smoking status for patients 13 years old or older	
10		Incorporate clinical lab-test results into EHR as structured data	PUSH
11		Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	
12		Report ambulatory quality measures to CMS or the States	PUSH
13		Send reminders to patients per patient preference for preventive/ follow up care	PUSH
14		Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	
15		Check insurance eligibility electronically from public and private payers	
16		Submit claims electronically to public and private payers.	
17	*Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health*	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request	PUSH
18		*no measure*	
19		Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP	PUSH
20		Provide clinical summaries for patients for each office visit	PUSH
21	*Exchange meaningful clinical information among professional health care team*	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	PUSH
22		Perform medication reconciliation at relevant encounters and each transition of care	
23		Provide summary care record for each transition of care and referral	PUSH
24	*Improve population and public health*	Capability to submit electronic data to immunization registries and actual submission where required and accepted	PUSH
25		*no measure*	
26		Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	PUSH
27	*Ensure adequate privacy and security protections for personal health information*	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	

n = 10

Redwood MedNet NHIN Direct x MU Crosswalk

MU#	Care Goals	Stage 1 Objectives - Inpatient	VIA PUSH
1	*Provide access to comprehensive patient health data for patient's health care team Use evidence-based order sets and CPOE Apply clinical decision support at the point of care Generate lists of patients who need care and use them to reach out to patients Report information for quality improvement and public reporting*	Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	
2		Implement drug-drug, drug-allergy, drug-formulary checks	
3		Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	
4		*no measure*	
5		Maintain active medication list	
6		Maintain active medication allergy list	
7		Record demographics o preferred language o insurance type o gender o race o ethnicity o date of birth o date and cause of death in the event of mortality	
8		Record and chart changes in vital signs: o height o weight o blood pressure o Calculate and display: BMI o Plot and display growth charts for children 2-20 years, including BMI.	
9		Record smoking status for patients 13 years old or older	
10		Incorporate clinical lab-test results into EHR as structured data	PUSH
11		Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	
12		Report hospital quality measures to CMS or the States	PUSH
13		*no measure*	
14		Implement 5 clinical decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules	
15		Check insurance eligibility electronically from public and private payers	
16		Submit claims electronically to public and private payers.	
17	*Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health*	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request	PUSH
18		Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	PUSH
19		*no measure*	
20		*no measure*	
21	*Exchange meaningful clinical information among professional health care team*	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	PUSH
22		Perform medication reconciliation at relevant encounters and each transition of care	
23		Provide summary care record for each transition of care and referral	PUSH
24	*Improve population and public health*	Capability to submit electronic data to immunization registries and actual submission where required and accepted	PUSH
25		Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	PUSH
26		Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	PUSH
27	*Ensure adequate privacy and security protections for personal health information*	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	

n = 9