

Crosswalk of National Quality Strategy with Future MU Stages, ACO NPRM & Related National Priorities

Notes:

1. "CORE" means it is an objective in Stage 1 MU menu set (proposal to move it to the core set would be aligned with the NQS principle).
2. "Raise threshold" means that proposed increased threshold would help align with NQS principle.
3. "Stage 3" indicates a current HITPC-proposed stage 3 change.

National Quality Strategy	Future MU Requirement	ACO NPRM	Other Key Priorities (Partnership for Patients (PP), PCMH, CV Disease Focus (CVD), Bend the Cost Curve (Cost), etc.)
Person-centeredness	New CQMs in development Secure messaging View & download Recording patient preferences Record advanced directives Stage 3: Report experience of care Incorporate patient data Exchange data with PHR	Patient-reported measures Patient-provider communication Patient access to records Health literacy/disparities Shared decision making Patient involvement governance Privacy and Security * ACO #1-7: Patient/Care Giver Experience Surveys *ACO #11: Care Transition Measure	P4P: Fixing errors in the record Family access to record during hospital stay CVD: Chronic care management PCMH: Enhance access and continuity Plan and manage care Provide self-care and community support Track and coordinate care
Specific health considerations, starting with CV disease	Registries/generate patient lists for specific conditions (CORE)	Identifying & managing high-risk populations Evaluation of population health needs and consideration of diversity Implementation of individualized care plans Integration of community resources *ACO #31Adult Weight Screening And Follow-up *ACO #32 Blood Pressure Measurement * ACO #58: Hypertension: Blood	CV disease emphasis Bending the cost curve PCMH: Identify and manage patient populations Plan and manage care Provide self-care and community support

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		Pressure Control * ACO #33: Tobacco Use Assessment and Tobacco Cessation Intervention * ACO #23: Patient Registry Use	
Reduce disparities	Record demographics (raise threshold 50→80%; Stage 3: make more granular categories) Discharge instructions in common primary languages	Patient access to records Health literacy/disparities Identifying & managing high-risk populations Implementation of individualized care plans Integration of community resources Evaluation of population health needs and consideration of diversity *ACO #59: Hypertension: Plan of Care	PCMH: Enhance access and continuity Provide self-care and community support
Public-private sector alignment	[Working with health plans on MU alignment strategies]	Partner with community stakeholders (governance)	
Supporting innovation	Greater focus on outcomes in future CQMs CDS but not overly prescriptive Structured data (to support comparative measurement)— Structured lab data (CORE)	Focus more on getting there than on how to get there Innovation Center initiatives *ACO #21: % of PCPs Using CDS ^See full MU/ACO CQM Crosswalk	Bundled payments Partnership for Patients (outcome goals, collaboration, innovation)
National standards but state-level needs	Stage 1 currently allows for states to raise bar for public health	Integration of community resources Effectively integrate Medicare and Medicaid Coordination between the Federal	

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		government and States for individuals eligibility	
Primary care emphasis	[Stage 1 MU]	[ACO core principle]	PCMH
Care coordination	HIE List of care team members Longitudinal care plan Medication reconciliation (CORE) Share summary care record (CORE)	HIE Sharing summary care record Define processes to promote care Coordination * ACO #10: Medication Reconciliation * ACO #59: Hypertension: Plan of Care *ACO #11: Care Transition Measure	Partnership for Patients: Care transitions Bundled payments PCMH: Plan and manage care Track and coordinate care Bending the cost curve
Population health management & planning	Public health objectives (CORE) Stage 3: Public health button & patient-reported data	Shared data related to prescription drug use	
Providing all stakeholders with information needed for personalized choices	View & download Electronic progress notes Patient-specific education resources (CORE) Patient reminders (CORE) Drug formulary checks (CORE) Stage 3: Self-management tools	Public reporting on savings *ACO #48: Heart Failure: Patient Education * ACO #59: Hypertension: Plan of Care	PCMH: Identify and manage patient populations Provide self-care and community support
Affordable care	CPOE (extend to radiology) Electronic administrative transactions (claims/eligibility) Drug formulary checks (CORE)		
Safer care	Electronic medication administration record CPOE (broaden definition/raise thresholds)	% of PCPs who are successful electronic prescribers (*ACO #20)	

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	Medication reconciliation (CORE)		

* See “MU_ACO Measure Crosswalk” for more detailed alignment of the MU functional objectives and the quality measures from the ACO NPRM.

^ See “Quality Measures Cross Walk” for more detailed information on the alignment of the MU CQMs and ACOs NPRM quality measures with associated NQF #,