Core Set of Objectives and Measures Must Meet All 15 Measures		
Stage 1 Objectives	**Stage 1 Measures**	**Reporting Method**
Use Computerized Provider Order Entry (CPOE) for medication orders directly entered by any licensed health care professional who can enter orders into the medical record per state, local, and professional guidelines	More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE **Exclusion:** Any EP who writes fewer than 100 prescriptions during the EHR reporting period qualifies for an exclusion from this objective/measure	Through the EHR. Count is limited to information for patients whose records are maintained in the certified EHR
Implement drug-drug and drug-allergy checks	The EP has enabled this functionality for the entire EHR reporting period **Exclusion:** None	Attestation
Generate and transmit permissible prescriptions electronically (Note: only non-controlled substances are permissible)	More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology **Exclusion:** Any EP who writes fewer than 100 prescriptions during the EHR reporting period qualifies for an exclusion from this objective/measure	Through the EHR. Count is limited to information for patients whose records are maintained in the certified EHR
Record demographics • Preferred language • Gender • Race • Ethnicity • Date of Birth	More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data **Exclusion:** None	EHR must have ability to tabulate patient's records stored in the EHR, however, if thresholds are not met through those patient records stored in the EHR, physician would need to manually count paper records in order to meet the threshold

Maintain an up-to-date problem list of current and active diagnoses	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data **Exclusion:** None	EHR must have ability to tabulate patient's records stored in the EHR, however, if thresholds are not met through those patient records stored in the EHR, physician would need to manually count paper records in order to meet the threshold
Maintain active medication list	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data **Exclusion:** None	EHR must have ability to tabulate patient's records stored in the EHR, however, if thresholds are not met through those patient records stored in the EHR, physician would need to manually count paper records in order to meet the threshold
Maintain active medication allergy list	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data **Exclusion:** None	EHR must have ability to tabulate patient's records stored in the EHR, however, if thresholds are not met through those patient records stored in the EHR, physician would need to manually count paper records in order to meet the threshold
Record and chart changes in vital signs: • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI	For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data **Exclusion:** Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice during the EHR reporting period qualifies for an exclusion from this objective/measure	Through the EHR. Count is limited to information for patients whose records are maintained in the certified EHR

Record smoking status for patients 13 years old or older	More than 50 percent of all unique patients 13 years old or older seen by the EP have "smoking status" recorded **Exclusion:** Any EP who sees no patients 13 years or older during the EHR reporting period qualifies for an exclusion from this objective/measure	Through the EHR. Count is limited to information for patients whose records are maintained in the certified EHR
Implement one clinical decision support rule relevant to specialty or high clinical priority with the ability to track compliance to that rule	Implement one clinical decision support rule **Exclusion:** None	Attestation
Report ambulatory quality measures to CMS or the States **(Note: Refer to Attachment 2 for details)**	For 2011, provide aggregate numerator and denominator through attestation For 2012, electronically submit the measures **Exclusion:** None	EHR must have ability to tabulate patient's records stored in the EHR, however, if thresholds are not met through those patient records stored in the EHR, physician would need to manually count paper records in order to meet the threshold
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request (electronic copy must be in an electronic form---patient portal, PHR, CD, USB, etc.)	More than 50 percent of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days **Exclusion:** Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period qualifies for an exclusion from this objective/measure	Through the EHR. Count is limited to information for patients whose records are maintained in the certified EHR

Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days. An office visit is defined as any billable visit that includes: 1) Concurrent care or transfer of care visits, 2) Consultant visits and 3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider **Exclusion:** Any EP who has no office visits during the EHR reporting period qualifies for an exclusion from this objective/measure	Through the EHR. Count is limited to information for patients whose records are maintained in the certified EHR
Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective **Exclusion:** None	Attestation
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process The testing can occur prior to the beginning of the EHR reporting period A security update could be updated software for certified EHR technology to be implemented as soon as available, to changes in workflow processes, or storage methods or any other necessary corrective action that needs to take place in order to eliminate the security deficiency or deficiencies identified in the risk analysis. **Exclusion:** None	Attestation

Menu Set of Objectives and Measures Must Choose and Meet 5 from the Menu*		
* At least 1 public health objective must be selected		
Stage 1 Objectives	**Stage 1 Measures**	**Reporting Method**
Implement drug-formulary checks	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period **Exclusion:** None	Attestation
Incorporate clinical lab-test results into EHR as structured data	More than 40 percent of all clinical lab tests results ordered by the EP during the HER reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data **Exclusion:** An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period qualifies for an exclusion from this objective/measure	Through the EHR. Count is limited to information for patients whose records are maintained in the certified EHR
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 **Exclusion:** None	Attestation

Send reminders to patients per patient preference for preventive/ follow up care	More than 20 percent of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period **Exclusion:** An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology qualifies for an exclusion from this objective/measure	Through the EHR. Count is limited to information for patients whose records are maintained in the certified EHR
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 4 business days of the information being available to the EP	More than 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information **Exclusion:** Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) (e.g., lab test results, problem list, medication list, medication allergy list, immunizations, and procedures) during the EHR reporting period qualifies for an exclusion from this objective/measure	EHR must have ability to tabulate patient's records stored in the EHR, however, if thresholds are not met through those patient records stored in the EHR, physician would need to manually count paper records in order to meet the threshold
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10 percent of all unique patients seen by the EP are provided patient specific education resources **Exclusion:** None	EHR must have ability to tabulate patient's records stored in the EHR, however, if thresholds are not met through those patient records stored in the EHR, physician would need to manually count paper records in order to meet the threshold

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 performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP. "Relevant encounter" is an encounter during which the EP performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the EP. Essentially an encounter is relevant if the EP, judges it to be so. "Transition of care" is the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. When conducting medication reconciliation during a transfer of care, the EP, that receives the patient into their care that should conduct the medication reconciliation **Exclusion:** An EP who was not the recipient of any transitions of care during the EHR reporting period qualifies for an exclusion from this objective/measure	Through the EHR. Count is limited to information for patients whose records are maintained in the certified EHR
The EP who transitions their patient to another setting of care or refers their patient to another provider of care should provide summary care record for each transition of care and referral	The EP who transitions or refers their patient to another setting of care or provider of care should provide summary of care record for more than 50 percent of transitions of care and referrals "Transition of care" is the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another **Exclusion:** An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period qualifies for an exclusion from this objective/measure	Through the EHR. Count is limited to information for patients whose records are maintained in the certified EHR

Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice*	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically) The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective **Exclusion:** An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically qualifies for an exclusion from this objective/measure	Attestation
Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice*	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically) The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective Exclusion: An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically qualifies for an exclusion from this objective/measure	Attestation

NOTES:

(1) Colors signify reporting methods:

- Ivory = Through the EHR. Count is limited to information for patients whose records are maintained in the certified EHR.
- Gray = Attestation.
- Purple = EHR must have ability to tabulate patient's records stored in the EHR, however, if thresholds are not met through those patient records stored in the EHR, physician would need to manually count paper records in order to meet the threshold.

(2) **Unique patient** means that even if the patient is seen multiple times during the EHR reporting period they are only counted once for the measure reporting.

(3) For an exclusion to apply, the EP must meet **all** of the following requirements:
- Must ensure that the objectives list under the core and menu sets include an option for the EP to attest that the objective is not applicable;
- Meets the criteria in the applicable objective that would permit the attestation; and
- Attests that the exclusion applies.

(4) While we expect that as physicians begin to use certified EHRs and see patients, they will begin entering data for each patient into their systems, physicians should be aware that there are some situations where manual counting is needed to meet a measure. For example: A physician has seen 100 patients during the EHR reporting period. To meet a measure, the physician is required to report that 80% of his/her patients have an up-to-date problem list. However, only 60 of the 100 patient records have been recorded in the EHR with an up-to-date problem list. In this scenario, the physician would need to ensure that he/she has prepared an up-to-date problem list for an additional 20 patients whose records are not yet in the EHR, thus, requiring a manual counting process to meet the 80% threshold requirement.