CORE SET (all required)

Health Outcomes Policy Priority	Stage 1 Objectives		Stage 1 Measures	Comments
	Eligible Professionals	**Eligible Hospitals**		
Improving quality, safety, efficiency, and reducing health disparities	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE	• Will increase to 60% for Stage 2 • Meds only (and not labs, imaging,etc) • Electronic transmission of orders is not required for Stage 1 • Was decreased from 80%
	Implement drug-drug and drug-allergy interaction checks	Implement drug-drug and drug-allergy interaction checks	The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period	• Yes/No Attestation
	Record demographics • preferred language • gender • race • ethnicity • date of birth	Record demographics • preferred language • gender • race • ethnicity • date of birth • date & preliminary cause of death in the event of mortality in the eligible hospital	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data	• May enter "Denied" as a structured entry if patient refuses to answer questions • Was decreased from 80%
	Maintain an up-to-date problem list of current and active diagnoses	Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data	• ICD-9 / SNOMED CT terminology requirement dropped; may simply use terms entered as structured data

	Maintain active medication List	Maintain active medication List	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	• May enter "None" as a structured entry if patient denies taking any meds.
	Maintain active medication allergy list	Maintain active medication allergy list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data	• May enter "NKDA" as a structured entry if patient denies having any drug allergies.
	Record & 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	Record & 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% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data	• EP's or hospitals with all patients younger than 2 years old are exempt from this requirement • Decreased from 80%
	Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded	• EP's or hospitals with all patients younger than 13 years old are exempt from this requirement • Decreased from 80%

			as structured data	
	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule	Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Implement one clinical decision support rule	• Yes/No Attestation • Decreased from requirement of five CDS rules to ensure better initial implementation success • Additional rules will be required in Stages 2 and 3
	Report ambulatory clinical quality measures to CMS or the States	Report hospital clinical quality measures to CMS or the States	For 2011, provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of this final rule	• Final Rule: EPs see pp. 272 to 282 for eligible CQM; Hospitals see pp. 296 to 305
			For 2012, electronically submit the clinical quality measures as discussed in section II(A)(3) of this final rule	
	Generate and transmit permissible prescriptions electronically (eRx)		More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	• Meds only • No controlled substances, durable medical equipment or supplies
Engage patients and families in their health care	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request	More than 50% of all patients of the EP or the inpatient or emergency depts. of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days	• Reduced from fulfillment of 80% requests within 48 hours.
	Provide clinical summaries for patients for each office visit		Clinical summaries provided to patients for more than 50% of	• Reduced from fulfillment of 80%

			all office visits within 3 business days	requests at time of visit
		Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency dept. (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it	• Reduced from fulfillment of 80% requests
Improve care coordination	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication 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	• Yes/No Attestation
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	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	• Yes/No Attestation

MENU SET (5 of 10 required)				
Health Outcomes Policy Priority	**Stage 1 Objectives**		**Stage 1 Measures**	**Comments**
	Eligible Professionals	**Eligible Hospitals**		
Improving quality, safety, efficiency, and reducing health disparities	Implement drug-formulary checks	Implement drug-formulary checks	The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period	• Yes/No Attestation
	Incorporate clinical lab-test results into certified EHR technology as structured data	Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	• Reduced from 50% of all ordered lab tests • Results can be entered manually, but will likely be impossible to reach 40% ; an electronic, HL7 lab interface is highly suggested
	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	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, eligible hospital or CAH with a specific condition	• Yes/No Attestation
	Send reminders to patients per patient preference for preventive/ follow up care		More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period	• Reminders must be sent in paper or electronic form as per patient preference • If EP has no patients in this age range, they're exempt.
		Record advance directives for	More than 50% of all unique	

		patients 65 years old or older	patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded	
Engage patients and families in their health care	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	Use certified HER technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources	
	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP		More than 10% 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	• Decreased from fulfillment of 30% of all requests within 96 hours
Improve care coordination	The EP, eligible hospital or CAH 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, eligible hospital or CAH 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, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)	• Decreased from 80%
	The EP, eligible hospital or CAH 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 of care record for each	The EP, eligible hospital or CAH 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 of care record for each	The EP, eligible hospital or CAH 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% of transitions of care and referrals	

	transition of care or referral	transition of care or referral		
Improve population and public health	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with 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, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	• Yes/No Attestation
		Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically)	• Yes/No Attestation
	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with 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, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	• Yes/No Attestation