

| Final Objectives | Final Measure | Exclusions |
|------------------|---------------|------------|
|------------------|---------------|------------|

Core Set

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Use computerized provider order entry for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines. | Subject to paragraph [c] of this section, 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. | Any EP who writes fewer than 100 prescriptions during the EHR reporting period. |
| Implement drug-drug and drug-allergy interaction checks. (formulary removed) | The EP has enabled this functionality for the entire EHR reporting period. | |
| Maintain an up-to-date problem list of current and active diagnoses. | More than 80% 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. | |
| Generate and transmit permissible prescriptions electronically (eRx). | Subject to paragraph [c] of this section, more than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. | Any EP who writes fewer than 100 prescriptions during the EHR reporting period. |
| Maintain active medication list | More than 80% of all unique patient's 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. | |
| Maintain active medication allergy list | More than 80% of all unique patient's seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data. | |
| Record all of the following demographics: Preferred language, Gender, Race, Ethnicity, Date of Birth (Insurance Type removed) | More than 50% of all unique patients seen by the EP have demographics recorded as structured data. | |
| 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 | Subject to paragraph [c] of this section, more than 50% of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data. | Any EP who either sees 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. |
| Record smoking status for patients 13 years old or older | Subject to paragraph [c] of this section, more than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data. | Any EP who sees no patient 13 years or older. |
| Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States. | Subject to paragraph [c] of this section, successfully report to CMS (or, in the case of Medicaid EPs, the States) ambulatory clinical quality measures selected by CMS in the manner specified by CMS (or in the case of Medicaid EPs, the States). | |

| Final Objectives | Final Measure | Exclusions |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| Implement one clinical decision support rule | Implement one clinical decision support rule | |
| Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request. | Subject to paragraph [c] of this section, more than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days . | Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period. |
| Provide clinical summaries for patient for each office visit | Subject to paragraph [c] of this section, clinical summaries provided to patients for more than 50% of all office visits within 3 business days. | Any EP who has no office visits during the EHR reporting period |
| Capability to exchange key clinical information (for example, problem list, medication list, allergies, and 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 | |
| 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. | |

| Final Objectives | Final Measure | Exclusions |
|------------------|---------------|------------|
|------------------|---------------|------------|

Menu Set

| | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Implement drug-formulary checks. | The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period. | |
| Incorporate clinical lab-test results into EHR as structured data. | Subject to paragraph [c] of this section, more than 40% of all clinical lab tests results ordered by the EP 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. | An EP who orders no lab tests whose results are either in a positive/ negative or numeric format during the EHR reporting period. |
| Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach | Subject to paragraph [c] of this section, generate at least one report listing patients of the EP with a specific condition | |
| Send reminders to patients per patient preference for preventive/ follow up care | Subject to paragraph [c] of this section, more than 20% of all patients 65 years old or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. | An EP who has no patients 65 years old or older or 5 years old or younger with recorded maintained using certified EHR technology. |
| 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 eligible professional | At least 10% of all unique patients seen by the EP are provided timely (available to the patient within 4 business days of the information being updated in the certified EHR technology) electronic access to their health information, subject to the EP's discretion to withhold certain information. | Any EP that neither orders nor creates any of the information listed at 45 CFR 17-.304(g) during the EHR reporting period. |
| 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. | Subject to paragraph [c] of this section, the EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP | An EP who was not the recipient of any transitions of care during the EHR reporting period. |
| 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 has the capacity to receive the information electronically). | An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically. |

| Final Objectives | Final Measure | Exclusions |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Capability to submit 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 or eligible hospital submits such information have the capacity to receive the information electronically) | 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. |
| Use certified EHR 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. | |
| The EP 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 care record for each transition of care or referral | Subject to paragraph [c] of this section, the EP 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. | An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period. |