

Objectives	Measures	Exclusions
Use computerized physician order entry (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 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	The EP has enabled this functionality for the entire EHR reporting period	None
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	Any EP who writes fewer than 100 prescriptions during the EHR reporting period
Record demographics: preferred language, gender, race, ethnicity, date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data	None
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	None
Maintain active medication list	More than 80% 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	None
Maintain active medication allergy list	More than 80% 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	None
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% of all unique patients age 2 or 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 or older	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded	Any EP who sees no patients 13 years or older
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Implement one clinical decision support rule	None
Report ambulatory 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 the Final Rule	None
	For 2012, electronically submit the clinical quality measures discussed in section II(A)(3) of the Final Rule	None
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request	More than 50% of all patients of the EP 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 patients for each office visit	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, 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	None
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) of the Final Rule and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	None



Objectives

Measures

Exclusions

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

None

Incorporate clinical lab-test results into certified EHR technology as structured data

More than 40% of all clinical lab-test 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

Any EP who orders no lab tests whose results are either in 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, research or outreach

Generate at least one report listing patients of the EP with a specific condition

None

Send reminders to patients per patient preference for preventive/follow-up care

More than 20% of all unique patients 65 years old or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period

Any EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology

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

Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) in the July 13, 2010 Final Rule during the EHR reporting period

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 are provided patient-specific education resources

None

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% of transitions of care in which the patient is transitioned into the care of the EP

Any EP who was not the recipient of any transitions of care during the EHR reporting period

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 of care record for each transition of care or referral

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

Any EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period

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 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)

Any EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically

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 capacity to submit 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 information have the capacity to receive the information electronically)

Any 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