EP	H	D		Required Set	Stage 1 Measure
			CPOE	Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the hospital's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE
			Drug x Drug	Implement drug-drug, drug-allergy, drug-formulary checks	Facility has enabled this functionality for the entire EHR reporting period
			eRx	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
			Demographics	Record demographics: preferred language; insurance type; gender; race; ethnicity; DOB; date and cause of death	More than 50% of all unique patients seen by the EP or admitted to the hospital's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
			Problem List	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	More than 80% of all unique patients seen by the EP or admitted to the hospital'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
			Medication List	Maintain active medication list	More than 80% of all unique patients seen by the EP or admitted to the hospital'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
			Medication Allergy List	Maintain active medication allergy list	More than 80% of all unique patients seen by the EP or admitted to the hospital'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
			Vital Signs	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 and over seen by the EP or admitted to hospital's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data
			Smoking Status	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 hospital's inpatient or emergency department (POS 21 or 23) have smoking status recorded
			Decision Support	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
			CMS Quality Measures	Report ambulatory clinical quality measures to CMS or the States	For 2011, provide aggregate numerator, denominator, and exclusions through attestation per section II(A)(3) of final rule. For 2012, electronically submit the clinical quality measures per section II(A)(3) of final rule.
			Copy to Patients	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request	More than 50% of all patients of the EP or the inpatient or emergency departments of the hospital (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days
			Discharge Instrutions	Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	More than 50% of all patients who are discharged from a hospital's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it
			Clinical Summaries	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
			Exchange Clinical Info	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test
			Privacy / Security	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

EP	H	D		Menu Set	Stage 1 Measure
			Drug : Formulary Check	Implement drug-formulary checks	The EP or hospital has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period
			Advance Directives	Record advance directives for patients 65 years old or older **[Hospital only]**	More than 50% of all unique patients 65 years old or older admitted to the hospital's inpatient department (POS 21) have an indication of an advance directive status recorded
			Lab into EHR	Incorporate clinical lab-test results into EHR as structured data	More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the hospital 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
			Patient List	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate at least one report listing patients of the EP or hospital with a specific condition
			Patient Reminders	Send reminders to patients per patient preference for preventive/ follow up care **[EP only]**	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
			Patient Access	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 **[EP only]**	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
			Patient Education	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 hospital's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources
			Medication Reconciliation	The EP or hospital 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 or hospital 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 hospital's inpatient or emergency department (POS 21 or 23)
			Summary of Care	The EP or hospital 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 or hospital 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
			Immunization Registries	Capability to submit electronic data to immunization registries and actual submission where required and accepted	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 or hospital submits such information have the capacity to receive the information electronically)
			Report to Public Health	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 **[Hospital only]**	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 hospital submits such information have the capacity to receive the information electronically)
			Syndromic Surveillance	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 or hospital submits such information have the capacity to receive the information electronically)

EP Eligible Provider
H Hospital
D Can be met with NHIN Direct push message