

Core Objectives/Measures (Mandatory)

Interim Rule Objective	Final Rule Objective	Interim Rule Measure	Final Rule Measure	Major Changes
1. Use CPOE	CPOE for medication orders	For EPs, CPOE is used for at least 80% of all orders	More than 30% of unique patients with at least 1 medication in their medication list have at least 1 order entered using CPOE	<ul style="list-style-type: none"> Reduced from 80% to 30% Changed from “all orders” to at least 1 order per patient.
2. Implement drug-drug, drug-allergy, drug-formulary checks	Drug-drug and drug-allergy interaction checks	The EP has enabled this functionality	Functionality is enabled for these checks for the entire EHR reporting period	<ul style="list-style-type: none"> Original objective changed. “Drug-formulary checks” is now a separate menu measure.
3. Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®	Maintain up-to-date problem list of current and active diagnoses	At least 80% of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data	More than 80% of all unique patients have at least one entry or an indication that no problems are known for the patient recorded as structured data	No changes
4. Generate and transmit permissible prescriptions electronically (eRx)	Generate and transmit permissible prescriptions electronically (eRx)	At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	More than 40% of all permissible prescriptions are transmitted electronically using certified EHR technology	<ul style="list-style-type: none"> Reduced from 75% to 40%
5. Maintain active medication list	Maintain active medication list	At least 80% of all unique patients seen by the EP have at least one entry (or an indication of “none” if the patient is not currently prescribed any medication) recorded as structured data	More than 80% of all unique patients have at least one entry (or an indication that the patient is not currently prescribe any medication) recorded as structured data	No changes
6. Maintain active medication allergy list	Maintain active medication allergy list	At least 80% of all unique patients seen by the EP have at least one entry or (an indication of “none” if the patient has no medication allergies) recorded as structured data	More than 80% of all unique patients have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data	No changes

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7. Record demographics: <ul style="list-style-type: none"> • preferred language • insurance type • gender • race • ethnicity • date of birth 	Record patient demographics, including: preferred language, gender, race, ethnicity, date of birth	At least 80% of all unique patients seen by the EP have demographics recorded as structured data	More than 50% of all unique patients have demographics recorded as structured data	<ul style="list-style-type: none"> • Reduced from 80% to 50%.
8. Record and chart changes in vital signs: <ul style="list-style-type: none"> • height • weight • blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI. 	Record and chart changes in vital signs: <ul style="list-style-type: none"> • height • weight • blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI. 	For at least 80% of all unique patients age 2 and over seen by the EP, record blood pressure and BMI; additionally plot growth chart for children age 2-20	For more than 50% of all unique patients age 2 and over, height, weight, and BP are recorded as structured data	<ul style="list-style-type: none"> • Reduced from 80% to 50%.
9. Record smoking status for patients 13 years old or older	Smoking status – recorded for patients 13 years of age or older	At least 80% of all unique patients 13 years old or older seen by the EP have “smoking status” recorded	More than 50% of all unique patients age 13 or over have smoking status recorded as structured data	<ul style="list-style-type: none"> • Reduced from 80% to 50%.
10. Report ambulatory quality measures to CMS or the States	Report ambulatory clinical quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of the proposed rule. For 2012, electronically submit the measures as discussed in section II(A)(3) of the proposed rule	For 2011, provide aggregate numerator, denominator, and exclusions through attestation. For 2012, submit clinical quality measures electronically.	No changes
11. Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 1 clinical decision support rule relevant to specialty or high clinical priority, along with ability to track compliance with that rule	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP is responsible for as described further in section II(A)(3) of the proposed rule.	Implement 1 clinical decision support rule	<ul style="list-style-type: none"> • Reduced from 5 decision support rules to 1.

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12. Check insurance eligibility electronically from public and private payers	N/A	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP	N/A	<ul style="list-style-type: none"> Objective eliminated
13. Submit claims electronically to public and private payers.	N/A	At least 80% of all claims filed electronically by the EP	N/A	<ul style="list-style-type: none"> Objective eliminated
14. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request	Provide patients with an electronic copy of their health information (including test results, problem list, medication lists, medication allergies) upon request	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours	More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days	<ul style="list-style-type: none"> Reduced from 80% to 50%. Reduced from 2 business days to 3.
15. Provide clinical summaries for patients for each office visit	Provide clinical summaries for patients for each office visit	Clinical summaries are provided for at least 80% of all office visits	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days	<ul style="list-style-type: none"> Reduced from 80% to 50%. Defined time limit to provide summaries (3 days).
16. 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	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	Perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information	No changes
17. 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	Conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	<ul style="list-style-type: none"> Specifically identified a "risk management process."

Menu Objectives/Measures (Choose 5)

Interim Rule Objective	Final Rule Objective	Interim Rule Measure	Final Rule Measure	Major Changes
1. Incorporate clinical lab-test results into EHR as structured data	Incorporate clinical lab-test results into certified EHR structured data	At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	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	<ul style="list-style-type: none"> • Changed to a menu objective • Reduced from 50% to 40%
2. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least 1 report listing patients of the EP with a specific condition.	Generate at least 1 report listing patients with a specific condition	<ul style="list-style-type: none"> • Changed to a menu objective
3. Send reminders to patients per patient preference for preventive/ follow up care	Send reminders to patients per patient preference for preventive/follow up care	Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over	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	<ul style="list-style-type: none"> • Changed to a menu objective • Reduced from 50% to 20% • Age increased from 50 to 65
4. Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4 business days of the information being available to the EP	At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information	More than 10% of all unique patients are provided timely (available to the patient within 4 business days of being updated in the EHR) electronic access to their health information, subject to the EP's discretion to withhold certain information	<ul style="list-style-type: none"> • Changed to a menu objective
5. Perform medication reconciliation at relevant encounters and each transition of care	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	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care	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	<ul style="list-style-type: none"> • Changed to a menu objective • Reduced from 80% to 50%

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6. Provide summary care record for each transition of care and referral	Transition/referral of patient to another setting or provider of care – EP should provide summary of care record for each transition of care or referral	Provide summary of care record for at least 80% of transitions of care and referrals	Summary of care record provided for more than 50% of transitions of care and referrals	<ul style="list-style-type: none"> • Changed to a menu objective • Reduced from 80% to 50%
7. Capability to submit electronic data to immunization registries and actual submission where required and accepted	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	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)	<ul style="list-style-type: none"> • Changed to a menu objective • Defined “test is successful” criteria
8. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to 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 (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)	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)	<ul style="list-style-type: none"> • Changed to a menu objective • Defined “test is successful” criteria
9. N/A	Implement drug-formulary checks (new measure, split from original core measure)	The EP has enabled this functionality	This functionality is enabled and the EP has access to at least 1 internal or external drug formulary for the entire EHR reporting period	New objective/measure
10. N/A	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate (new measure)	N/A	More than 10% of all unique patients are provided patient-specific education resources	New objective/measure