Meaningful Use Stage 1 Objectives and Measures

Meaningful Use Category Stage 1 Final	Eligible Professionals	Eligible Hospitals	Core or Menu Stage 1	Measure Brief Stage 1	Stage 1 Objectives (Effective 2014 and Onward) – Eligible Professionals	Stage 1 Objectives (Effective 2014 and Onward) – Eligible Hospitals	Stage 1 Measures (Effective 2014 and Onward)
					Blue text indicates a change from original Stage 1 language published in July 2010		
Demographics[1]	●	●	Core	> 50%	Record demographics • preferred language • gender • race • ethnicity • date of birth	Record demographics • preferred language • gender • race • ethnicity • date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
Clinical Decision Support[1]	●	●	Core	One rule	Implement one clinical decision support rule relevant to specialty or high priority area additional to that required for meaningful use	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
Implement drug-and drug-allergy interaction checks[1] (Formerly a core requirement when Stage 1 was the only Clinical Decision Support measure)	●	●	Core	Enabled	Implement drug-and drug-allergy interaction checks	Implement drug-and drug-allergy interaction checks	The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period
CPOE – Computerized Provider Order Entry[1]	●	●	Core	> 30%	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 **NEW in 2014 - Addition of an alternative measure** - More than 30 percent of medication orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE
Implement drug-formulary checks[1] (Consolidated in Stage 2 electronic prescribing objectives/measures)	●	●	Menu	One List	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
Summary of Care[1]	●	●	Menu	> 50%	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 transition of care or referral	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 transition of care or referral	The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provides a summary of care record for more than 50% of transitions of care and referrals **NEW 2014** - Replace the documented format from CCD/CCR to C-CDA using 2014 Edition Certified EHR Technology
Problem List[1] (Consolidated in Stage 2 objective for providing a summary of care for each transition of care or referral)	●	●	Core	> 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
Medication List[1] (Consolidated in Stage 2 objective for providing a summary of care for each transition of care or referral)	●	●	Core	> 80%	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
Medication Allergy List[1] (Consolidated in Stage 2 objective for providing a summary of care for each transition of care or referral)	●	●	Core	> 80%	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
Privacy / Security[6]	●	●	Core	Conduct or review Security risk analysis	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 in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process

Meaningful Use Final Stage 2 –2014 Edition Objectives and Measures

Meaningful Use Category Stage 2 Final	Base EHR, Menu Set, Menu Stage 2	Eligible Professionals	Eligible Hospitals	Numerator	Denominator	Threshold	Exclusions	2014 Edition Final Certification Language ↓
Base EHR Components								
Demographics[1]	Base	> 80%	Record the following demographics • preferred language • gender • race • ethnicity • date of birth	Record the following demographics • preferred language • gender • race • ethnicity • date of birth • date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 80 percent 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) during the EHR reporting period have demographics recorded as structured data	The number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declines to provide one or more elements) or if recording an element is contrary to state law) recorded as structured data	Number of unique patients seen by the EP or admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period	The resulting percentage must be more than 80 percent in order for an EP, eligible hospital or CAH to meet this measure	n/a	**2014 Edition EHR Certification Criterion – Revised** § 170.314(a)(3) Demographics **Standards** § 170.207(i)(HIB standards); § 170.207(q) ISO 639-2 alpha-3 codes limited to those that also have a corresponding alpha-2 code in ISO 639-1)
Clinical Decision Support[1] (Implement drug-drug and drug-allergy interaction checks now consolidated with the measure)	Base	2 Measures 5 CDS interventions related to high priority clinical quality measures Drug-Drug and drug-allergy interaction checks	Use clinical decision support to improve performance on high-priority health conditions.	5%; eligible hospitals, and CAHs must satisfy both measures in order to meet the objective. [1] Implement five clinical decision support interventions related to four or more clinical quality measures relevant to specialties or high clinical priority for the reporting period. Absent four clinical quality measures related to an EP, eligible hospital, or CAH's specialty or high clinical priority, the EP, eligible hospital, or CAH must select additional clinical quality measures that are related to high-priority health conditions. It is recommended that the five clinical decision support interventions be related to improving healthcare efficiency. [2] The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug and drug allergy interaction checks for the entire EHR reporting period	**Exclusion:** For the second **[2]** measure, any EP who writes fewer than 100 medication orders during the EHR reporting period can claim an exclusion for the implement drug-drug and drug allergy interaction checks portion of this objective. **Detail Highlights - Data Elements for EP "View, Download, and Transmit"** •Patient name •Provider's name and office contact information •Current and past problem list •Procedures •Laboratory test results •Current medication list and medication history •Current medication list and medication allergy history •Vital signs (height, weight, blood pressure, BMI, growth charts) •Smoking status •Demographic information (preferred language, sex, race, ethnicity, date of birth) •Care plan fields(s), including goals and instructions •Any known care team members including the primary care provider (PCP) of record	2014 Edition EHR Certification Criterion – Revised § 170.314(a)(8) Clinical decision support **Standard** § 170.204(a) (HL7 Version 3 Implementation Guide: Context-Aware Knowledge Retrieval (Infobutton) Service-Oriented Architecture Implementation Guide) **Implementation Specifications** (1) Configure clinical decision support. (2) Automatically and electronically interact (i) Source attributes
CPOE – Computerized Provider Order Entry[1]	Base	3 Measures Medication orders: > 60% Radiology orders: > 30% Laboratory orders: > 30%	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by an EP or authorized provider in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE	**Medication orders:** The number of orders in the denominator recorded using CPOE< **Radiology orders:** The number of orders in the denominator recorded using CPOE **Laboratory orders:** The number of orders in the denominator recorded using CPOE	**Medication orders:** Number of medication orders created by the EP or authorized provides in the eligible hospitals or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period **Radiology orders:** Number of radiology orders created by the EP or authorized provides in the eligible hospitals or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period **Laboratory orders:** Number of laboratory orders created by the EP or authorized provides in the eligible hospitals or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period	**Medication orders:** The resulting percentage must be more than 60 percent in order for an EP, eligible hospital or CAH to meet this measure **Radiology orders:** The resulting percentage must be more than 30 percent in order for an EP, eligible hospital or CAH to meet this measure **Laboratory orders:** The resulting percentage must be more than 30 percent in order for an EP, eligible hospital or CAH to meet this measure	**Medication orders:** Any EP who writes fewer than 100 medication orders during the EHR reporting period **Radiology orders:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period **Laboratory orders:** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period An EP through a combination of meeting the thresholds and/or exclusions must satisfy all three measures for this objective A hospital must meet the thresholds for all three measures.	**2014 Edition EHR Certification Criterion – Unchanged** § 170.314(a)(1) (Computerized provider order entry) § 170.314(a)(2) (Drug-drug, drug-allergy interaction checks)
Transitions of Care[4] (Summary of Care, Problem List, Medication List, and Medication Allergy List are now consolidated into this single objective)	Base*	3 Measures > 50% > 10% at least one successful test	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 provides a summary care record for each transition of care or referral.	5%; eligible hospitals, and CAHs must satisfy all three measures in order to meet the objective. [1] The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. [2] The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of transitions of care and referrals electronically transmitted using certified EHR technology to a care setting external to the eligible hospital or CAH. Summary of care records must be transmitted to a care setting that has an EHR technology that has been developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2). [3] Conducts one or more successful tests with the CMS designated test EHR during the reporting period.	[1] Number of transitions of care and referrals in the denominator where a summary of care record was provided. [2] The number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a care setting external to the eligible hospital or CAH where care record via exchange facilitated by an organization that is a Nationwide Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization. [3] Numerator not applicable to the third measure	[1] Number of transitions of care and referrals during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider. [2] Number of transitions of care and referrals during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider [3] Denominator not applicable to the third measure	[1] The percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure. [2] The percentage must be more than 10 percent in order for an EP, eligible hospital or CAH to meet this measure. [3] Threshold not applicable to the third measure	[1] Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures. [2] Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures. [3] Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.	**2014 Edition EHR Certification Criteria – Revised** § 170.314(b)(1) (Incorporate summary of care record) § 170.314(b)(2) (Create summary care record) **Standards** § 170.205(a)(3) (Consolidated CDA); § 170.207(l) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(q) ISO 639-1; (ISO 639-2 alpha-3 codes) (preferred language); § 170.207(s)(SNOMED CT® International Release January 2012); § 170.207(u)(LOINC® version 2.40); § 170.207(x)(2) (HCPCS and CPT-4) or § 170.207(bb)(4) (ICD-10-PCS); § 170.207(z)(2) (LOINC version 2.40); and § 170.207(dd)(2) (RxNorm August 5, 2012 Release)
Problem List[1] (Consolidated in Stage 2 objective for providing a summary of care for each transition of care or referral)	Base*	3 Measures > 50% > 10% at least one successful test	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 transition of care or referral	5%; eligible hospitals, and CAHs must satisfy all three measures in order to meet the objective. [1] The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. [2] The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provides of care provides a summary of care record for more than 10 percent of transitions of care and referrals electronically transmitted using certified EHR technology to a care setting external to the eligible hospital or CAH. Summary of care records must be transmitted to a care setting that has an EHR technology that has been developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2). [3] Conducts one or more successful tests with the CMS designated test EHR during the reporting period.	[1] Number of transitions of care and referrals in the denominator where a summary of care record was provided. [2] The number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a care setting external to the eligible hospital or CAH where care record via exchange facilitated by an organization that is a Nationwide Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization. [3] Numerator not applicable to the third measure	[1] Number of transitions of care and referrals during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider. [2] Number of transitions of care and referrals during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider [3] Denominator not applicable to the third measure	[1] The percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure. [2] The percentage must be more than 10 percent in order for an EP, eligible hospital or CAH to meet this measure. [3] Threshold not applicable to the third measure	[1] Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures. [2] Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures. [3] Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.	**2014 Edition EHR Certification Criterion – Revised** § 170.314(b)(3) (Transmit all three summaries) **Standards** § 170.202(a) (Applicability Statement for Secure Health Transport); § 170.202(b) (XDR and XDM for Direct Messaging Specification); and § 170.202(c) (Transport and Security Specification)
Privacy / Security[6]	Base	Conduct or review Security risk analysis	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 in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process				No exclusions to this measure	**2014 Edition EHR Certification Criterion – Revised and NEW!!** § 170.314(d)(2) Auditable events and tamper-resistance - **NEW!** § 170.314(d)(3) Audit report(s) - **Revised** § 170.314(d)(4) Amendments § 170.314(d)(5) Emergency access - **Unchanged** § 170.314(d)(7) End-user device encryption - **NEW!** § 170.314(d)(8) Integrity - **Unchanged**
Core Set EHR Components								
Clinical Quality Measures[1]				**Clinical Quality Measures eliminated from the core objective. Beginning FY/CY 2014, all participants, *regardless* of year of participation or Stage, must report an increased number of CQMs: 16 for hospitals; and 9 for EPs. Additionally, the CQMs reported must be from at least 3 National Quality Strategy Domains.**					
Vital Signs[1]	NEW!! Core	> 80%	Record and chart changes in the following vital signs: • height • weight • blood pressure • calculate and display growth charts for children 2-20 years, including BMI • Calculate and display BMI NEW in 2014 - Modification from Stage 1 criteria in that greater for EPs who believe that recording and charting vital signs is outside the scope of their practice.	Record and chart changes in vital signs: • height • weight • blood pressure • calculate and display growth charts for children 2-20 years, including BMI • Calculate and display BMI	Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and blood pressure (ages 3 and over) recorded as structured data	Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and blood pressure (ages 3 and over) recorded as structured data	The resulting percentage must be more than 80 percent in order for an EP, eligible hospital, or CAH to meet this measure.	Any EP who sees no patients 2 years or older is excluded from recording blood pressure Any EP who believes that all 2 vital signs of height/weight, weight, and blood pressure have no relevance to their scope of practice is excluded from recording this measure [3] An EP who believes that height/length and weight are relevant to their scope of practice but does not have the capacity to record a patient's height/length or weight is excluded from this measure [4] An EP who believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight. **NEW!!** These above exclusions also apply to EPs reporting Stage 1 **Measure.**	**2014 Edition EHR Certification Criterion – Revised** § 170.314(a)(6) (Vital signs, body mass index, and growth charts) **Standard** § 170.207 (Vital Signs) Standard: Clinical Genomics, Pedigree 2
View, Download, and Transmit to 3rd Party[2] (EP version)	NEW!! Core	2 Measures > 50% > 5%	Provide patients the ability to view online, download, and transmit their information within 4 business days of the information being available to the EP	There are 2 measures for this objective, both of which must be satisfied to meet the objective. [1] More than 50 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their information. [2] More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their information.	n/a	[1] The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information online. [2] Number of unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party the patient's health information.	[1] Number of unique patients seen by the EP during the EHR reporting period [2] Number of unique patients seen by the EP during the EHR reporting period	[1] The resulting percentage must be more than 50 percent in order for an EP to meet this measure. [2] The resulting percentage must be more than 5 percent in order for an EP to meet this measure	Any EP who neither orders nor creates any of the information listed for view, download, and transmit to 3rd party during the EHR reporting period may exclude only the second measure. Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with **3Mbps** broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude only the second measure.	**2014 Edition EHR Certification Criterion – Revised** § 170.314(e)(1) View, download, and transmit to 3rd party **Standards** § 170.202(a) (Direct Project); § 170.202(b) (XDR and XDM for Direct Messaging Specification); and § 170.202(d) (Synchronized clocks)
View, Download, and Transmit to 3rd Party[2] (EH and CAH version)	NEW!! Core	2 Measures > 50% > 5%	n/a	There are 2 measures for this objective, both of which must be satisfied to meet the objective. [1] More than 50 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their information. [2] More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their information during the reporting period.	[1] The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information. [2] The number of unique patients for (or their authorized representatives) in the denominator who have viewed online or downloaded or transmitted to a third party the patient's health information.	[1] Number of unique patients seen by the EP during the EHR reporting period [2] Number of unique patients seen by the EP during the EHR reporting period	[1] The resulting percentage must be more than 50 percent in order for an EP to meet this measure. [2] The resulting percentage must be more than 5 percent in order for an EP to meet this measure	Any eligible hospital or CAH will be excluded from the second measure (view, download or transmit to 3rd party) if it can demonstrate that no more than 50 percent of its inpatient or emergency department (POS 21 or 23) during the prior reporting period is excluded from recording height/length and weight as not in accordance with standard practice. This exclusion must be based on the same methodology as the EP who believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight. **NEW!!** These above exclusions also apply to EPs reporting Stage 1 **Measure.**	**2014 Edition EHR Certification Criterion – Revised** § 170.314(e)(1) View, download, and transmit to 3rd party **Standards** § 170.202(a) (Direct Project); § 170.202(b) (XDR and XDM for Direct Messaging Specification); and § 170.202(d) (synchronized clocks)
ePrescribing[1] (EP only) (Formerly part of Clinical Decision Support Stage 1 menu list)	NEW!! Menu*	> 50%	Generate and transmit permissible prescriptions electronically (erx)	Number of more than 50 percent of all permissible prescriptions, or prescriptions written by the EP and queried for a drug formulary and transmitted electronically using CEHRT	The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period, or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.	The resulting percentage must be more than **50** percent in order for an EP to meet this measure.	Any EP who: (a) prescribes fewer than 100 prescriptions during the EHR reporting period or (b) does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.	**2014 Edition EHR Certification Criterion – Revised** § 170.314(b)(3) Electronic prescribing **Standards** § 170.205(a)(2) (NCPDP SCRIPT version 10.6) (corrected information in this version of the poster; previously indicated as "not finalized and deleted", which was incorrect) and § 170.207(d)(2) (Refworm August 5, 2012 Release)
Clinical Summaries for Each Office Visit[1] (EP only)	●	n/a	Core	> 50%	Provide clinical summaries for patients for each office visit	n/a	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days	Clinical summaries provided to patients or patient-authorized representatives within **3 business day** for more than 50 percent of office visits	Number of office visits in the denominator where the patient or patient-authorized representative is provided a clinical summary of their visit within 1 business day	Number of office visits conducted by the EP during the EHR reporting period	The resulting percentage must be more than 50 percent in order for an EP to meet this measure.	Any EP who has no office visits during the EHR reporting period.	**2014 Edition EHR Certification Criterion – Revised** § 170.314(e)(2) Ambulatory setting only – clinical summaries) **Standards** § 170.205(a)(3) (Consolidated CDA); § 170.207(l) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(q) ISO 639-1; (ISO 639-2 alpha-3 codes) (preferred language); § 170.207(r) (smoking status types); § 170.207(s)(SNOMED CT® International Release January 2012); § 170.207(u)(LOINC® version 2.40); § 170.207(x)(2) (HCPCS and CPT-4) or § 170.207(bb)(4) (ICD-10-PCS); § 170.207(z)(2) (LOINC version 2.40); and § 170.207(dd)(2) (RxNorm August 5, 2012 Release)
Lab Results into EHR[1]	●	●	Menu	> 40%	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 in 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	More than 50 percent of all clinical lab tests results ordered by the EP or by an authorized provider in 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	Number of lab tests results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT as structured data	Number of lab tests ordered during the EHR reporting period for which a positive or negative affirmation or a numeric result is expressed in a positive or negative affirmation or as a number	The resulting percentage must be more than 55 percent in order for an EP, eligible hospital, or CAH to meet this measure.	Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period. There is no exclusion available for eligible hospitals or CAHs because we do not believe any hospital will not be in a situation where its authorized providers have not ordered any lab tests for admitted patients during an EHR reporting period.	**2014 Edition EHR Certification Criterion – Unchanged** § 170.314(a)(4) Ambulatory setting only – patient lab creation **Standards and Implementation Specifications** § 170.205(j) (Electronic incorporation and transmission of lab results. Standard: HL7 Version 2.5.1 Implementation Guide: S&I Framework Lab Results Interface); and § 170.207(z)(2) (LOINC version 2.40)
Patient Reminders[1] (EP only)	●	n/a	Menu	> 20%	Send reminders to patients per patient preference for preventive/ follow up care	n/a	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	More than 20 percent of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period	Number of patients in the denominator who were sent a reminder per patient preference during the EHR reporting period	Number of unique patients who have had an office visit with the EP in the 24 months prior to the beginning of the EHR reporting period	The resulting percentage must be more than 10 percent in order for an EP to meet this measure.	Any EP who has had no office visits in the 24 months before the EHR reporting period.	Any EP who has had no office visits in the 24 months before the EHR reporting period. **Standard** § 170.314(a)(14) Ambulatory setting only – patient lab creation
Patient Specific Education[1]	●	●	Menu	10%	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	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	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	[SUM] Patient specific education resources identified by Certified EHR Technology [CHAR] Patient specific education resources identified by Certified EHR Technology [DENEX] More than 10 percent of all unique patients admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are identified as exclusions by certified EHR Technology	[SUM] Number of unique patients with office visits seen by the EP during the EHR reporting period [DENEX] Number of unique patients admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period	[SUM] The resulting percentage must be more than 10 percent in order for an EP to meet this measure. [DENEX] The resulting percentage must be more than 10 percent in order for an eligible hospital or CAH to meet this measure.	**[SUM]** Any EP who has no office visits during the EHR reporting period **[DENEX]** There is no exclusion to this measure for EH and CAH.	**2014 Edition EHR Certification Criterion – Revised** § 170.314(a)(15) (Patient specific education resources) **Standard** § 170.204(a) (HL7 Version 3 Implementation Guide: Context-Aware Knowledge Retrieval (Infobutton) Service-Oriented Architecture Implementation Guide)
Medication Reconciliation[1]	●	●	Menu	50%	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)	The EP, eligible hospital or CAH performs medication reconciliation for more than 50 percent 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)	The number of transitions of care in the denominator where medication reconciliation was performed	The number of transitions of care in the denominator where medication reconciliation was performed	The resulting percentage must be more than **50** percent in order for an EP, eligible hospital or CAH to meet this measure.	Any EP who did not receive the recipient of any transitions of care during the EHR reporting period.	**2014 Edition EHR Certification Criterion–Revised** § 170.314(b)(4) Clinical information reconciliation	
Patient List[1]	●	●	Menu	One List	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	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	n/a	n/a	n/a	No exclusions to this measure.	**2014 Edition EHR Certification Criterion – Unchanged** § 170.314(a)(14) Patient list creation
Immunization Registries[4]	●	●	Menu	One Test	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 **Change in 2013 and onward:** Addition of "except where prohibited" to the objective regulation text for the public health objectives under § 495.6	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 public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically)	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 public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically)	Any EP, eligible hospital or CAH that meets one or more of the following criteria may be excluded from this objective: [1] The EP, eligible hospital or CAH does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period. [2] the EP, eligible hospital or CAH operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period [3] the EP, eligible hospital or CAH operates in a jurisdiction in which no immunization registry or immunization information system has the capacity to receive immunization data, or [4] the EP, eligible hospital or CAH operates in a jurisdiction for which no immunization registry or immunization information system has the capacity to accept the specific standards required by CEHRT at the time their EHR reporting period can enroll additional EPs, eligible hospitals or CAHs. The second exclusion will not apply if an entity registered to participate in an immunization registry or immunization information system can receive electronic immunization data directly or via the standards required by CEHRT, but if it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion	**2014 Edition EHR Certification Criteria – Revised** § 170.314(b)(5) (Immunization registries and immunization information systems) **Standards and Implementation Specifications** § 170.202(g) (PHIN Messaging Guide for Immunization Messaging Release 1.3); and § 170.205(d)(2) (HL7 Standard Code Set CVX – Vaccines Administered, updates through July 11, 2011)	
Lab Results to Public Health Agencies[1] (EH only)	n/a	●	Menu	One Test	n/a	Capability to submit electronic laboratory 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) **Change in 2013 and onward:** Addition of "except where prohibited" to the objective regulation text for the public health objectives under § 495.6	Performed at least one test of certified EHR technology's capacity to submit electronic laboratory 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)	Number of unique patients with one or more of the following criteria may be excluded from this objective: [1] Laboratory tests are not ordered by the EP, eligible hospital or CAH for any patient in the EP, eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period [2] the EP, eligible hospital or CAH operates in a jurisdiction for which no public health agency is capable of receiving electronic laboratory results in the specific standards required by CEHRT at the start of their EHR reporting period [3] the EP, eligible hospital or CAH operates in a jurisdiction in which no public health agency has the capacity to receive electronic laboratory results [4] the EP, eligible hospital or CAH operates in a jurisdiction for which no public health agency is capable of accepting the specific standards required by CEHRT, if it has designated a Health Information Exchange to do so on behalf of the EP, eligible hospital or CAH, the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion	[1] The eligible hospital or CAH that meets one or more of the following criteria may be excluded from this objective: [1] the eligible hospital or CAH does not perform laboratory tests routinely for its patients in the inpatient or emergency department (POS 21 or 23) [2] operates in a jurisdiction where no public health agency provides information timely on capability to receive electronic reportable laboratory results or [3] the eligible hospital or CAH operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.	The eligible hospital or CAH that meets one or more of the following criteria may be excluded from this objective: [1] the eligible hospital or CAH does not perform laboratory tests routinely for its patients in the inpatient or emergency department (POS 21 or 23) [2] operates in a jurisdiction where no public health agency provides information timely on capability to receive electronic reportable laboratory results or [3] the eligible hospital or CAH operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.	The resulting percentage must be more than 50 percent in order for an EP, eligible hospital or CAH to meet this measure.	Any EP, eligible hospital, or CAH that neither sees nor admits any patients 13 years old or older.	**2014 Edition EHR Certification Criteria – Revised**