STAGE 1 MEANINGFUL USE PERFORMANCE MEASURES

FOR INDIAN HEALTH SERVICE (IHS) RESOURCE AND PATIENT MANAGEMENT SYSTEM (RPMS) ELECTRONIC HEALTH RECORD (EHR) SITES

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Service Categories			
A	Ambulatory	O	Observation
S	Day Surgery	M	Telemedicine

EP Core Set Measure Name	Measure and Stage 1 Logic
1 of 15. CPOE Medication	# patients w/at least 1 med ordered w/CPOE / # unique patients w/at least 1 med on med list Denominator Inclusions: Count each patient WHERE one or more medications are present as structured data on their medication list AND with one or more face-to-face visits with the eligible professional, defined as Service Category of A, S, O or M. Denominator Exclusions: Exclude eligible Professionals who have <100 prescriptions written/entered during the EHR reporting period. Numerator Inclusions: Count each patient WHERE one or more medications have a "Date Issue" during the EHR reporting period AND the "Nature of Order" for the counted medication does not = "written"" AND the prescription was entered by a licensed healthcare professional holding the ORES or ORELSE key AND the order was entered, signed, and released to the service. Note: Transmission of the medication order is not required. Orders entered by Pharmacy or Nursing staff must be sent to the provider for review, signature, and release.
2 of 15. Drug Interaction Checks	Yes/No Attestation Measure Inclusions: Count eligible professionals who enable both the drug-drug and drug-allergy checks during the entire EHR reporting period. Note: The report will display "Yes" if the checks are turned on, or "No" if they are turned off. The eligible professional is not required to act on the checks. The system will check for this information in RPMS-EHR.
3 of 15. Maintain Problem List	# patients w at least 1 problem list entry or no problems / # unique patients seen by the EP Denominator Inclusions: Count each patient with one or more face-to-face visits with the eligible professional, defined as Service Category of A, S, O or M during the EHR reporting period. Numerator Inclusions: Count each patient in the Denominator WHERE structured data is present during the EHR reporting period specifying either an active or inactive problem on the problem list a) with an entered date on or before the end of the reporting period OR b) with a deleted date on or between the first and last days of the reporting period OR c) has structured data present during the reporting period that documents there are no active problems. Note: The list does not have to be updated at every visit.

EP Core Set Measure Name	Measure and Stage 1 Logic
4 of 15. e-Prescribing (eRx)	# Rx transmitted electronically or E-Prescribed / # Rx electronically entered and filled Denominator Inclusions: Count each prescription electronically entered by the eligible professional with an issue date during the EHR reporting period AND filled by an on-site pharmacy, off-site pharmacy or on-site COTS pharmacy AND that has a prescription number. Denominator Exclusions: 1. Any entries of any type in the outside medication component. 2. Any prescription which has a remark that contains "Administered in Clinic." 3. Any prescription for a Controlled Substance identified by DEA special handling code of 1-5. Numerator Inclusions: Count each prescription in the Denominator that has an Rx# that meets at least one of the conditions below: 1. Is numeric AND the "Nature of Order" does not = "written" 2. Starts with "X" AND the comment in the activity log contains "E-Prescribe." Measure Exclusions: Exclude eligible professionals who have <100 prescriptions entered during the EHR reporting period. Note: Successful transmission of the order is not required for this measure.
5 of 15. Active Medication List	# patients w/ medication list or no active medications / # unique patients seen by the EP Denominator Inclusions: Count each patient with one or more face-to-face visits with the eligible professional, defined as Service Category of A, S, O or M during the EHR reporting period. Numerator Inclusions: Count each patient in the Denominator WHERE: 1. There is documentation of No Active Medications on any visit during the EHR reporting period OR 2. There is a medication in the Prescription file with an Issue Date equal to or less than 365 days before the start of the reporting period AND an Issue Date on or before the end of the reporting period AND NOT a Discontinued Date before the start of the reporting period OR 3. An Outside Medication in the Pharmacy Patient file with a Documented Date on or before the end of the reporting period AND with a status of Active OR a Discontinued Date on or after the start of the reporting period. Note: Active medication list is defined as a list of medications that a given patient is currently taking. The list does not have to be updated at every visit.

EP Core Set Measure Name	Measure and Stage 1 Logic
6 of 15. Medication Allergy List	# unique patients w/medication allergy or no known allergies / # unique patients seen by the EP Denominator Inclusions: Count each patient with one or more face-to-face visits with the professional, defined as Service Category of A, S, O or M during the EHR reporting period. Numerator Inclusions: Count each patient in the Denominator WHERE structured data is present during the EHR reporting period specifying either an active adverse reaction to a medication OR has structured data present that documents there are no known allergies. Note: The list does not have to be updated at every visit.
7 of 15. Record Demographics	# patients w/ 5 demographic elements or declined to answer / # unique patients seen by the EP Denominator Inclusions: Count each patient with one or more face-to-face visits with the eligible professional, defined as Service Category of A, S, O or M during the EHR reporting period. Numerator Inclusions: Count each patient in the Denominator WHERE structured data is present during the EHR reporting period for each of the following data elements (A-E) OR a structured data element is present notating: a) that the patient declines to provide the data element information and/or b) if capturing the race and ethnicity is against state law. (A) Preferred language (B) Sex (C) Race (D) Ethnicity (E) Date of birth Note: Preferred language is captured as a preference, but the professional does not have to communicate in that language. Access to patient could be through direct patient contact or this information could be communicated as part of a referral. This report does NOT account for states where it is against the law to capture race and ethnicity. Additional CMS Final Rule Information: Race and ethnicity codes should follow current federal standards published by the OMB (http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr); if patient declines to provide the information and/or if capturing the race and ethnicity is against state law, this must be indicated as such in structured data and then would count as an entry. Preferred language is captured as a preference but the professional does not have to communicate in that language. Access to patient could be through direct patient contact or this information could be communicated as part of a referral.

EP Core Set Measure Name	Measure and Stage 1 Logic
8 of 15. Record Vital Signs	$\frac{\text{\# patients w/ 3 vital sign elements}}{\text{\# unique patients 2+ yrs seen by the EP}}$ Denominator Inclusions: Count each patient 2 years old or older at the beginning of the EHR reporting period who has one or more face-to-face visits with the eligible professional, defined as Service Category of A, S, O or M during the EHR reporting period. Numerator Inclusions: Count each patient in the Denominator WHERE structured data is present during the EHR reporting period for each of the following data elements (A-C). (A) Height (B) Weight (C) Blood Pressure Measure Exclusions: Exclude eligible professionals who see no patients 2 years or older at the beginning of the EHR reporting period. Note: The list does not have to be updated at every visit, nor do data elements have to be recorded on the same visit. A professional who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice may be excluded from this measure and will have to attest to this in separate documentation to CMS.

EP Core Set Measure Name	Measure and Stage 1 Logic
9 of 15. Record Smoking Status	# patients 13+ yrs w/ 1 smoking status factor # unique patients 13+ yrs seen by the EP Denominator Inclusions: Count each patient 13 years old or older at the beginning of the EHR reporting period who has one or more face-to-face visits with the eligible professional, defined as Service Category of A, S, O or M during the EHR reporting period. Numerator Inclusions: Count each patient in the Denominator WHERE structured data is present during the EHR reporting period for smoking status. Measure Exclusions: Exclude eligible professionals who see no patients 13 years old or older. Note: Smoking status must be recorded with one of the following national tobacco health factors. No other health factors will count: - Current smoker, every day - Current smoker, some day - Current smoker, status unknown - Previous (former) smoker - Never smoked - Smoking status unknown Note: The list does not have to be updated at every visit.
10 of 15. Clinical Quality Measures (CQMs)	Yes/No Attestation Measure Inclusions: Count eligible professionals who successfully reported to CMS the ambulatory clinical quality measures selected by CMS in the manner specified by CMS during the EHR reporting period. Additional CMS Final Rule Information: The professional is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.

EP Core Set Measure Name	Measure and Stage 1 Logic
11 of 15. Clinical Decision Support Rule	Yes/No Attestation Measure Inclusions: Count eligible professionals who implement at least one of the following conditions during the entire EHR reporting period: 1. Clinical Reminders package installed and national reminders configured. 2. Diabetes Supplement, Pre-Diabetes Supplement, Asthma Supplement, Anti-coagulation Supplement, Women's Health Supplement, Immunization Package Forecasting, and/or Health Maintenance Reminders configured within the EHR Reports tab. Note: The report will display "Yes" if any of the above are found to be installed, or "No" if none of the above are found to be installed.
12 of 15. Electronic Copy of Health Information	$\frac{\text{\# patients who receive electronic copy of health info w/in 3 days}}{\text{\# patients who requested electronic copy of health info}}$ Denominator Inclusions: Count each patient of the eligible professional meeting ALL conditions shown below. 1. The professional will have had at least one face-to-face visit with the patient within the past 365 days from the end of the EHR reporting period. A face-to-face visit is defined as Service Category of A, S, O, or M. 2. At least once during the EHR reporting period, the patient requested an electronic copy of their health information, which is defined as the Patient/Agent Request Type value in the Release of Information (ROI) package is equal to “Electronic.” 3. The patient requested the information during the first day of the EHR reporting period through four business days prior to the end of the EHR reporting period. This is determined by checking the Date Request Initiated field in ROI. 4. Patients with multiple requests during the EHR reporting period will be counted only once. Numerator Inclusions: Count each patient in the Denominator WHERE the patient was given an electronic copy of their health information within three business days from the request date. This is determined by checking the ROI fields of Record Dissemination, where the value is “Electronic” and Disclosure Date. Measure Exclusions: Exclude eligible professionals who have no patients meeting the denominator inclusions criteria specified.

EP Core Set Measure Name	Measure and Stage 1 Logic
13 of 15. Clinical Summaries	# office visits patient wellness handout provided w/in 3 bus days --- # office visits w/ EP Denominator Inclusions: Count each patient face-to-face visit with a professional, defined as Service Category of A, S, O or M during the EHR reporting period. Count visits made the first day of the EHR reporting period through four business days prior to the end of the EHR reporting period. Numerator Inclusions: Count each patient face-to-face visit in the Denominator WHERE a Patient Wellness Handout (PWH) was generated on or after the visit date/time but within 3 business days of the visit. Measure Exclusions: Exclude eligible professionals who have no office visits during the EHR reporting period Example: (for a single patient with multiple professional visits in one day) Professional A sees the patient at 9:00 am, Professional B sees the same patient at 11:00 am and Professional C sees the same patient at 1:00 pm. Each visit will be counted in each professional's Denominator. If the PWH is generated at 9:30 am, the patient would be counted in the numerator for Professional A only. If the PWH is generated at 1:30 pm, the visit will be counted in each professional's numerator calculation. Note: All types of PWHs will be included.

EP Core Set Measure Name	Measure and Stage 1 Logic
14 of 15. Electronic Exchange of Clinical Information	Yes/ No Attestation Measure Inclusions: Count eligible professionals who conduct at least one test of the certified EHR technology's capacity to electronically exchange key clinical information during the EHR reporting period. Additional CMS Final Rule Information: The test of electronic exchange of key clinical information must involve the transfer of information between two different legal entities with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information are not acceptable to satisfy this objective. The transmission of actual patient information is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective. When the clinical information is available in a structured format it should be transferred in a structured format. However, if the information is unavailable in a structured format, the transmission of unstructured data is permissible. EPs can use their clinical judgment to identify what clinical information is considered key clinical information for purposes of exchanging clinical information about a patient at a particular time with other providers of care. A minimum set of information is identified in the HIT Standards and Criteria rule at 45 CFR 170.304(i), and is generally outlined in this objective as: problem list, medication list, medication allergies, and diagnostic test results. An EP's determination of key clinical information could include some or all of this information, as well as information not included here. An EP should test their ability to send the minimum information set in the HIT Standards and Criteria rule at 45 CFR 170.304(i). If the EP continues to exchange information beyond the initial test, then the professional may decide what information should be exchanged on a case-by-case basis. EPs must test their ability to electronically exchange key clinical information at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Every payment year requires its own, unique test. If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology. An unsuccessful test of electronic exchange of key clinical information will be considered valid for meeting the measure of this objective.

EP Core Set Measure Name	Measure and Stage 1 Logic
15 of 15. Protect Electronic Health Information	Yes/No Attestation Measure Inclusions: Count eligible professionals who conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies prior to or during the EHR reporting period. Additional CMS Final Rule Information: EPs must conduct or review a security risk analysis of certified EHR technology and implement updates as necessary at least once prior to the end of the EHR reporting period and attest to that conduct or review. The testing could occur prior to the beginning of the first EHR reporting period. However, a new review would have to occur for each subsequent reporting period. A security update would be required if any security deficiencies were identified during the risk analysis. A security update could be updated software for certified EHR technology to be implemented as soon as available, changes in workflow processes or storage methods, or any other necessary corrective action that needs to take place in order to eliminate the security deficiency or deficiencies identified in the risk analysis.

Service Categories			
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EP Menu Set Measure Name	Measure and Stage 1 Logic
1 of 10. Drug-Formulary Checks	Yes/No Attestation Measure Inclusions: Count eligible professionals who enable the drug-formulary check during the entire EHR reporting period. Measure Exclusion: Exclude eligible professionals who order <100 prescriptions during the EHR reporting period. Expectation is that this measure will be expanded to be counted on a transactional basis for future stages. Note: All EPs using the RPMS EHR for pharmacy CPOE meet this measure because this check is always enabled. Additional CMS Final Rule Information: The EP is not required to act on the check. An EP must have at least one formulary that can be queried. This may be an internally developed formulary or an external formulary. The formularies should be relevant for patient care during the prescribing process.
2 of 10. Clinical Lab Test Results	# lab test results with +/- or numeric format # lab tests ordered by EP w/ results Denominator Inclusions: Count each V LAB entry ordered by an eligible professional during the EHR reporting period that meets all of the following criteria: 1. The ordering professional on the V LAB entry is the professional for which the report is being run. 2. The lab test is NOT a Pap Smear, determined by using the BGP PAP SMEAR TEST lab taxonomy. 3. The result of the test is not equal to "canc" (these tests were cancelled). Numerator Inclusions: Count each test in the Denominator WHERE the status flag is RESULTED and 1. Where RESULTS does not equal "comment" OR 2. If RESULTS = "comment" THEN COMMENTS does not equal null. Denominator Exclusions: 1. An EP who orders no lab tests with results that are displayed in either a positive/negative or numeric format during the EHR reporting period. 2. All Pap smears ordered using any of the following CPT codes: [88141-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091]. The results for these orders are expressed with text; thus, they are excluded from the measure.

EP Menu Set Measure Name	Measure and Stage 1 Logic
3 of 10. Patient Lists	Yes/No Attestation Measure Inclusions: Count the generation of one Patient List Report during the EHR reporting period. If count = 1, report "Yes," if count = 0, report "No" for this measure. Note: The report could cover every patient whose records are maintained using certified EHR technology or a subset of those patients at the discretion of the EP. Conditions in the patient list should be the same definitions as used in the problem list. Note: This is a measure for which a State can submit modifications to CMS for approval.
4 of 10. Patient Reminders	$\frac{\text{\# patients 0-5 yrs or 65+ yrs printed patient wellness handout}}{\text{\# unique patients 0-5 yrs or 65+ yrs seen by EP}}$ Denominator Inclusions: Count each patient with an age of 5 years old and younger at the beginning of the EHR reporting period OR 65 years old and older at the beginning of the EHR reporting period and who do not have a date of death recorded or whose health record has not been inactivated. Numerator Inclusions: Count each patient in the Denominator WHERE one or more Patient Wellness Handouts (PWH) were generated during the EHR reporting period. Measure Exclusion: If a facility does not have any patients in the database who are 1) 5 years old or younger or 2) 65 years or older, the EP is excluded from this measure. Note: This objective is not counting patient visits during the EHR reporting period, only PWHs that were printed during the EHR reporting period. The method in which the PWH was delivered is not considered for this measure. The PWH should include at a minimum a problem list, most recent labs, a medication list, and a medication allergies list. Note: This measure is reported for the entire facility, not just for the specified EP, since the patient is not required to have a visit with the EP during the EHR reporting period.

EP Menu Set Measure Name	Measure and Stage 1 Logic
5 of 10. Patient Electronic Access	# patients w/ access to PHR online w/in 4 business days / # unique patients seen by EP Denominator Inclusions: Count each patient with one or more face-to-face visits with the professional, defined as Service Category of A, S, O or M during the EHR reporting period. Numerator Inclusions: If eligible professional answers "Yes" to having access to the Personal Health Record (PHR), then numerator equals the denominator. If eligible professional answers "No" to having access to PHR, then the numerator equals '0.' Measure Exclusions: A professional who neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) may be excluded from this measure and will have to attest to this in separate documentation to CMS. Note: All patient information is available through the Personal Health Record patient portal as the information is entered into the EHR and can be accessed by all patients who wish to establish an account; therefore, the 4 business days requirement is met immediately. Some information may be withheld or delayed as in keeping with HIPAA and assuring optimal patient care services.
6 of 10. Patient Specific Education Resources	# patients provided education resources / # unique patients seen by the EP Denominator Inclusions: Count each patient with one or more face-to-face visits with the professional, defined as Service Category of A, S, O or M during the EHR reporting period. Numerator Inclusions: Count each patient in the Denominator WHERE the patient has one or more entries of the patient and family education subtopic of literature (L) during the EHR reporting period. Note: The patient specific education resources must use the capabilities of the certified EHR technology and the EHR must calculate the measure. The professional can decide which, if any, resources are applicable. Each professional who sees the patient during the reporting period will be given a numerator inclusion if any professional has issued literature during the EHR reporting period. This eliminates the necessity for each professional to provide duplicate literature to a patient in order to meet Meaningful Use.

EP Menu Set Measure Name	Measure and Stage 1 Logic
7 of 10. Medication Reconciliation	# transitions of care to EP when medication reconciliation completed / # transitions of care to EP Denominator Inclusions: Count each patient visit with the professional, defined as Service Category of A, S, O or M during the EHR reporting period WHERE the clinic code is NOT equal to one of the following: 09, 11, 12, 14, 18, 21, 22, 33, 34, 35, 36, 39, 40, 41, 42, 43, 45, 51, 52, 53, 54, 55, 60, 61, 66, 67, 68, 71, 74, 76, 77, 78, 82, 86, 90, 91, 93, 94, 95 or 98, A1, A3, A8, A9, B1, B2, B4, B7, C4, C5, C8, C9, D1, D2, D3, D4. Numerator Inclusions: Count each visit in the Denominator WHERE a Patient Education Code of M-MR is documented on the day of the visit. In the event the patient has multiple visits on the same day, a medication reconciliation (i.e. Patient Education Code of M-MR) needs only to occur once on the day of the visit. Measure Exclusion: Exclude eligible professionals who only had encounters during the report period for the following clinic codes: 09, 11, 12, 14, 18, 21, 22, 33, 34, 35, 36, 39, 40, 41, 42, 43, 45, 51, 52, 53, 54, 55, 60, 61, 66, 67, 68, 71, 74, 76, 77, 78, 82, 86, 90, 91, 93, 94, 95 or 98, A1, A3, A8, A9, B1, B2, B4, B7, C4, C5, C8, C9, D1, D2, D3, D4. Encounters to these clinics are not defined as a transition of care. Note: The Patient Wellness Handout (PWH) is not required to meet this measure. However, printing the PWH and providing a copy to the patient is encouraged and recommended as it will allow the EP to meet additional Performance Measures and provide a method by which EPs may produce a medication list and review it with the patient. Documentation of M-MR is the only thing that is counted by RPMS during a transition of care.
8 of 10. Transition of Care Summary	# transitions of care & referrals where summary of care printed w/in 14 days / # transitions of care & referrals by EP Denominator Inclusions: Count each of the RCIS referrals WHERE the requesting professional is the EP for which we are running the report AND the referral has a Date Initiated between the first day of the EHR reporting period through 14 days before the last day of the EHR reporting period AND the status of Referral is equal to "A" (active) or "C1" (closed completed). Denominator Exclusions: All in-house referrals. Numerator Inclusions: Count each event in the Denominator WHERE the Summary of Care (C32) was printed within 14 days of the referral initiated date. Measure Exclusion: Exclude EPs that do not have any referrals meeting the conditions described in the Denominator Inclusions statement above. Note: The printing of the Summary of Care record (C32) does NOT preclude the professional or CHS clerk from printing and/or electronically transmitting the RPMS Health Summary or any additional information or documentation that may be useful for the receiver of the patient.

EP Menu Set Measure Name	Measure and Stage 1 Logic
9 of 10. Immunization Registries Data Submission	Yes/ No Attestation Measure Inclusions: Count eligible professionals who perform at least one test of the certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test was successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically) during the EHR reporting period. Measure Exclusion: Exclude eligible professionals who do not administer one or more immunizations during the EHR reporting period or if their respective state does not have an immunization registry and/or does not have the capacity to receive the information electronically. Additional CMS Final Rule Information: Test data about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective. A failed attempt will meet the measure. Where no immunization registry exists that has the capacity to receive information electronically during the EHR reporting period, a professional may be excluded from this measure and will have to attest to this in separate documentation to CMS.
10 of 10. Syndromic Surveillance Data Submission	Yes/No Attestation Measure Inclusions: Count eligible professionals who perform at least one test of the certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies and follow-up submission if the test was successful (unless none of the public health agencies to which the EP submits such information has the capacity to receive the information electronically) during the EHR reporting period. Measure Exclusion: Exclude eligible professionals who do not collect any reportable syndromic surveillance information on patients during the EHR reporting period. Note: States may modify this objective. Additional CMS Final Rule Information: Public health agency is an entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function. Test must involve a real submission but may use test data that is identical to a fictional patient. A failed attempt will meet the measure. The test could be started before the start of the EHR reporting period and must be completed prior to the end of the EHR reporting period. Each payment year would require its own unique test. The test must be conducted with the certified EHR technology in accordance with the standards specified in the ONC rule at 45 CFR 170.302(l). Where no public health agency exists that has the capacity to receive information electronically during the EHR reporting period, an EP may be excluded from this measure and will have to attest to this in separate documentation to CMS.

Service Categories			
A	Ambulatory	O	Observation
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EH/CAHs Core Set Measure Name	Measure and Stage 1 Logic
1 of 14. CPOE Medication	# patients w/at least 1 medication ordered w/CPOE --- # unique patients w/at least 1 medication on medication list Denominator Inclusions: Count each patient WHERE one or more medications are present as structured data on their medication list AND one or more of the following types of services occurred during the EHR reporting period: 1. A hospitalization, defined as Service Category of H. 2. An emergency department visit defined as clinic code of Emergency Department-30 AND a Service Category of A. Numerator Inclusions: Count each patient in the Denominator that has a medication order date during the EHR reporting period AND the "Nature of Order" for the medication order does not = "written" AND the medication order was entered by a licensed healthcare professional holding the ORES or ORELSE key. Note: Medication orders are defined in ADT as Admission Type UB-04 of 1-Emergency and Admission Source UB-04 of 7-Emergency. All medication orders for the eligible hospital's entire patient population will be counted; not just for Medicare and Medicaid patients. Transmission of the medication order is not required.
2 of 14. Drug-Interaction Checks	Yes/No Attestation Measure Inclusions: Count eligible hospitals and CAHs that enable both the drug-drug and drug-allergy checks during the entire EHR reporting period. Note: The report will display "Yes" if the checks are turned on, or "No" if they are turned off. The eligible professional is not required to act on the checks. The system will check for this information in RPMS-EHR.

EH/CAHs Core Set Measure Name	Measure and Stage 1 Logic
3 of 14. Maintain Problem List	# patients w/at least 1 problem list entry or no problems # unique patients admitted Denominator Inclusions: Count each patient with one or more of the following during the EHR reporting period: 1. A hospitalization, defined as Service Category of H. 2. An emergency department visit defined as clinic code of Emergency Department-30 AND a Service Category of A. Numerator Inclusions: Count each patient in the Denominator WHERE structured data is present during the reporting period specifying either an active or inactive problem on the problem list a) with an entered date on or before the end of the reporting period OR b) with a deleted date on or between the first and last days of the reporting period OR c) has structured data present during the reporting period that documents there are no active problems. Note: The list does not have to be updated at every visit to be up-to-date.
4 of 14. Active Medication List	# patients w/ medication list or no active medications # unique patients admitted Denominator Inclusions: Count each patient with one or more of the following during the EHR reporting period: 1. A hospitalization, defined as Service Category of H. 2. An emergency department visit defined as clinic code of Emergency Department-30 AND a Service Category of A. Numerator Inclusions: Count each patient in the Denominator WHERE: 1. There is documentation of No Active Medications on any visit during the EHR reporting period OR 2. There is a medication in the Prescription file with an Issue Date equal to or less than 365 days before the start of the reporting period AND an Issue Date on or before the end of the reporting period AND NOT a Discontinued Date before the start of the reporting period OR 3. An Outside Medication in the Pharmacy Patient file with an Documented Date on or before the end of the reporting period AND with a status of Active OR a Discontinued Date on or after the start of the reporting period. Note: Active medication list is defined as a list of medications that a given patient is currently taking. The list does not have to be updated at every visit to be up-to-date.

EH/CAHs Core Set Measure Name	Measure and Stage 1 Logic
5 of 14. Medication Allergy List	$\frac{\text{\# unique patients w/medication allergy or no known allergies}}{\text{\# unique patients admitted}}$ Denominator Inclusions: Count each patient with one or more of the following during the EHR reporting period: 1. A hospitalization, defined as Service Category of H. 2. An emergency department visit defined as clinic code of Emergency Department-30 AND a Service Category of A. Numerator Inclusions: Count each patient in the Denominator WHERE structured data is present during the EHR reporting period specifying either an active adverse reaction to a medication OR has structured data present that documents there are no known allergies. Note: The list does not have to be updated at every visit to be up-to-date.

EH/CAHs Core Set Measure Name	Measure and Stage 1 Logic
6 of 14. Record Demographics	$\frac{\text{\# patients w/ 5 demographic elements or declined to answer}}{\text{\# unique patients admitted}}$ Denominator Inclusions: Count each patient that has one or more of the following during the EHR reporting period: 1. A hospitalization, defined as Service Category of H. 2. An emergency department visit defined as clinic code of Emergency Department-30 AND a Service Category of A. Numerator Inclusions: Count each patient in the Denominator WHERE structured data is present during the EHR reporting period for each of the following data elements (A-F) OR a structured data element is present notating: a) that the patient declines to provide the data element information and/or b) if capturing the race and ethnicity is against state law. (A) Preferred language (B) Sex (C) Race (D) Ethnicity (E) Date of birth (F) Date and preliminary cause of death if the patient died in the eligible hospital or CAH Note: Preferred language is captured as a preference, but the hospital or CAH does not have to communicate in that language. Cause of death is the preliminary cause as indicated by the hospital, not on the death certificate issued by the DOH or coroner's office. Access to patient could be through direct patient contact or this information could be communicated as part of a referral. This report does NOT account for states where it is against the law to capture race and ethnicity. Additional CMS Final Rule Information: Race and ethnicity codes should follow current federal standards published by the OMB (http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr); if patient declines to provide the information and/or if capturing the race and ethnicity is against state law, this must be indicated as such in structured data and then would count as an entry. Preferred language is captured as a preference but the professional does not have to communicate in that language. Access to patient could be through direct patient contact or this information could be communicated as part of a referral.

EH/CAHs Core Set Measure Name	Measure and Stage 1 Logic
7 of 14. Record Vital Signs	$\frac{\text{\# patients w/ 3 vital sign elements}}{\text{\# unique patients 2+ yrs admitted}}$ Denominator Inclusions: Count each patient 2 years or older at the beginning of the EHR reporting period who has one or more of the following during the EHR reporting period: 1. A hospitalization, defined as Service Category of H. 2. An emergency department visit defined as clinic code of Emergency Department-30 AND a Service Category of A. Numerator Inclusions: Count each patient in the Denominator WHERE structured data is present during the EHR reporting period for each of the following data elements (A-C). (A) Height (B) Weight (C) Blood Pressure Note: The list does not have to be updated at every visit to be up-to-date, nor do data elements have to be recorded on the same visit.

EH/CAHs Core Set Measure Name	Measure and Stage 1 Logic
8 of 14. Record Smoking Status	# patients 13+ yrs w/ 1 smoking status factor --- # unique patients 13+ yrs admitted Denominator Inclusions: Count each patient 13 years old or older at the beginning of the EHR reporting period who has one or more of the following during the EHR reporting period: 1. A hospitalization, defined as Service Category of H. 2. An emergency department visit defined as clinic code of Emergency Department-30 AND a Service Category of A. Numerator Inclusions: Count each patient in the Denominator WHERE structured data is present during the EHR reporting period for smoking status. Note: Smoking status must be recorded with one of the following national tobacco health factors. No other health factors will count: - Current smoker, every day - Current smoker, some day - Current smoker, status unknown - Previous (former) smoker - Never smoked - Smoking status unknown. Measure Exclusion: Exclude eligible hospitals or CAHs that admit no patients 13 years old or older to their inpatient or emergency department (POS 21 or 23). Note: The list does not have to be updated at every visit to be up-to-date.
9 of 14. Clinical Quality Measures (CQMs)	Yes/No Attestation Measure Inclusions: Count eligible hospitals and CAHs that successfully report to CMS the hospital clinical quality measures selected by CMS and in the manner specified by CMS during the EHR reporting period. Additional CMS Final Rule Information: The professional is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.

EH/CAHs Core Set Measure Name	Measure and Stage 1 Logic
10 of 14. Clinical Decision Support Rule	Yes/No Attestation Measure Inclusions: Count eligible hospitals and CAHs that implement conditions (#1 and #3) OR (#2 and #3) below during the EHR reporting period: 1. Clinical Reminders package installed and national reminders configured. 2. Diabetes Supplement, Pre-Diabetes Supplement, Asthma Supplement, Anti-coagulation Supplement, Women's Health Supplement, Immunization Package Forecasting, and/or Health Maintenance Reminders configured within the EHR Reports tab. 3. Implemented at least one disease-specific admission menu. Note: The report will display "Yes" if any of the above are found to be installed, or "No" if none of the above are found to be installed.
11 of 14. Electronic Copy of Health Information	$\frac{\text{\# patients who receive electronic copy of health info w/in 3 days}}{\text{\# patients who requested electronic copy of health info}}$ Denominator Inclusions: Count each patient of the eligible hospital or CAH meeting ALL conditions shown below. 1. The patient will have at least one hospitalization or emergency department visit within the past 365 days from the end of the EHR reporting period. A hospitalization is defined with a Service Category of H. An emergency department visit defined as clinic code of Emergency Department-30 AND a Service Category of A. 2. At least once during the EHR reporting period, the patient requested an electronic copy of their health information, which is defined as the Patient/Agent Request Type value in the Release of Information (ROI) package is equal to “Electronic.” 3. The patient requested the information during the first day of the EHR reporting period through four business days prior to the end of the EHR reporting period. This is determined by checking the Date Request Initiated field in ROI. 4. Patients with multiple requests during the EHR reporting period will be counted only once. Numerator Inclusions: Count each patient in the Denominator WHERE the patient was given an electronic copy of the health information within three business days from the request date. This is determined by checking the ROI fields of Record Dissemination, where the value is “Electronic” and Disclosure Date. Measure Exclusion: Exclude eligible hospitals that have no patients meeting the denominator inclusions criteria specified above.

EH/CAHs Core Set Measure Name	Measure and Stage 1 Logic
12 of 14. Electronic Copy of Discharge Instructions	$\frac{\text{\# patients who are provided electronic copy of discharge instructions}}{\text{\# discharged patients who requested electronic copy of discharge instructions}}$ Denominator Inclusions: Count each patient of the eligible hospital or CAH meeting ALL conditions shown below. 1. The patient will have at least one hospitalization with a Discharge Date during the EHR reporting period defined as Service Category of H AND a Discharge Type of a) Regular Discharge, b) Transferred, or c) Irregular Discharge OR an emergency department visit defined as clinic code of Emergency Department-30 AND a Service Category of A. 2. A patient request for an electronic copy of discharge instructions, indicated by the presence of a TIU note titled "E-copy discharge instr received" OR "E-copy discharge instr not received" in the visit file with an Entry Date/Time stamp on the day of or the day after the discharge. (The presence of a "received" or "not received" note IS the indication of the request. The type of note is the indicator of fulfilling the request.) 3. Patients with multiple requests during the EHR reporting period will be counted only once. Numerator Inclusions: Count each patient in the Denominator WHERE a TIU note title of "E-copy discharge instr received" is present. Measure Exclusion: Exclude eligible hospitals and CAHs that have no requests from patients for an electronic copy of discharge instructions during the EHR reporting period. Note: Selecting the TIU note title of "E-copy discharge instr received" does NOT generate the discharge instructions. In order to meet the measure, the hospital or emergency department must generate an electronic copy of the discharge instructions and provide those instructions in an electronic format to the patient. One option, for example, would be to print the instructions to a PDF document and e-mail the document to the patient. Note: TIU note titles are NOT available unless your facility is utilizing the ER Package. The note documents the patient's request and the results of that request. The time frame for this accounts for discharge instructions that may be documented near midnight, but may not be saved to the system until the date changes. There is no standard electronic form for the discharge instructions that is to be provided to the patient. Rather, this measure is reporting that the patient requested an electronic copy of their discharge instructions and they received it.

EH/CAHs Core Set Measure Name	Measure and Stage 1 Logic
13 of 14. Electronic Exchange of Clinical Information	Yes/No Attestation Measure Inclusions: Count eligible hospitals and CAHs that conduct at least one test of the certified EHR technology's capacity to electronically exchange key clinical information during the EHR reporting period. Additional CMS Final Rule Information: The test of electronic exchange of key clinical information must involve the transfer of information between two different legal entities with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information are not acceptable to satisfy this objective. The transmission of actual patient information is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective. When the clinical information is available in a structured format it should be transferred in a structured format. However, if the information is unavailable in a structured format, the transmission of unstructured data is permissible. Professionals can use their clinical judgment to identify what clinical information is considered key clinical information for purposes of exchanging clinical information about a patient at a particular time with other providers of care. A minimum set of information is identified in the HIT Standards and Criteria rule at 45 CFR 170.306(f): diagnostic test results, problem list, medication list, medication allergy list. An eligible hospital or CAH should test their ability to send the minimum information set in the HIT Standards and Criteria rule at 45 CFR 170.306(f). If the eligible hospital or CAH continues to exchange information beyond the initial test, then the professional may decide what information should be exchanged on a case-by-case basis. Eligible hospitals and CAHs must test their ability to electronically exchange key clinical information at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Every payment year requires its own, unique test. An unsuccessful test of electronic exchange of key clinical information will be considered valid for meeting the measure of this objective.
14 of 14. Protect Electronic Health Information	Yes/No Attestation Measure Inclusions: Count eligible hospitals and CAHs that conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies prior to or during the EHR reporting period. Additional CMS Final Rule Information: Eligible hospitals and CAHs must conduct or review a security risk analysis of certified EHR technology and implement updates as necessary at least once prior to the end of the EHR reporting period and attest to that conduct or review. The testing could occur prior to the beginning of the EHR reporting period. A security update would be required if any security deficiencies were identified during the risk analysis. A security update could be updated software for certified EHR technology to be implemented as soon as available, changes in workflow processes or storage methods, or any other necessary corrective action that needs to take place in order to eliminate the security deficiency or deficiencies identified in the risk analysis.

Service Categories			
A	Ambulatory	O	Observation
S	Day Surgery	M	Telemedicine

EH/CAHs Menu Set Measure Name	Measure and Stage 1 Logic
1 of 10. Drug-Formulary Checks	Yes/No Attestation Measure Inclusions: Count eligible hospitals and CAHs that enable the drug-formulary check during the entire EHR reporting period. Note: All hospitals and CAHs using the RPMS EHR for pharmacy CPOE meet this measure because this check is always enabled. Additional CMS Final Rule Information: The eligible hospital or CAH is not required to act on the check. The hospital or CAH must have at least one formulary that can be queried. This may be an internally developed formulary or an external formulary. The formularies should be relevant for patient care during the prescribing process.
2 of 10. Advance Directives	# patients admitted with advance directives # unique patients 65+ yrs admitted Denominator Inclusions: Count each patient WITH an age of 65 years or older on date of admission AND one or more admission dates to a hospital's or CAH's inpatient department (POS 21) during the EHR reporting period, defined as Service Category of H. Numerator Inclusions: Count each patient in the Denominator WHERE structured data is present indicating one or more of the following conditions: 1. There is a note title in the TIU Document Class of "Advance Directive." 2. Have an Advance Directive value of "Yes" or "No." Measure Exclusions: Exclude eligible hospitals and CAHs who have no patient admissions for patients with an age of less than or equal to 65 years on date of admission during the EHR reporting period.

EH/CAHs Menu Set Measure Name	Measure and Stage 1 Logic
3 of 10. Clinical Lab Test Results	# lab test results with +/- or numeric format --- # lab tests ordered w/ results Denominator Inclusions: Count each V LAB entry ordered during one or more of the following events occurring during the EHR reporting period: 1. A hospitalization, defined as Service Category of H. 2. An emergency department visit, defined as clinic code of Emergency Department-30 AND a Service Category of A. Each event must meet all of the following criteria: 1. The lab test is NOT a Pap Smear, determined by using the BGP PAP SMEAR TEST lab taxonomy. 2. The result of the test is not equal to "canc" (these tests were cancelled). Numerator Inclusions: Count each test in the denominator WHERE the status flag is RESULTED and 1. Where RESULTS does not equal "comment" OR 2. If RESULTS = "comment" THEN COMMENTS does not equal null. Denominator Exclusions: All Pap smears ordered using any of the following CPT codes: [88141-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091]. The results for these orders are expressed with text; thus, they are excluded from the measure.
4 of 10. Patient Lists	Yes/No Attestation Measure Inclusions: Count the generation of one Patient List Report during the EHR reporting period. If count = 1, report "Yes," if count = 0, report "No" for this measure. Note: The report could cover every patient whose records are maintained using certified EHR technology or a subset of those patients at the discretion of the eligible hospital or CAH. Conditions in the patient list should be the same definitions as used in the problem list. Note: This is a measure for which a State can submit modifications to CMS for approval.

EH/CAHs Menu Set Measure Name	Measure and Stage 1 Logic
5 of 10. Patient Specific Education Resources	# patients provided education resources / # unique patients admitted Denominator Inclusions: Count each patient that has one or more of the following during the EHR reporting period: 1. A hospitalization, defined as Service Category of H. 2. An emergency department visit, defined as clinic code of Emergency Department-30 AND a Service Category of A. Numerator Inclusions: Count each patient in the Denominator WHERE the patient has one or more entries of the patient and family education subtopic of literature (L) during the EHR reporting period. Note: The patient specific education resources must use the capabilities of the certified EHR technology and the EHR must calculate the measure. The facility can decide which, if any, resources are applicable.
6 of 10. Medication Reconciliation	# transitions of care to EP when medication reconciliation completed / # transitions of care to EP Denominator Inclusions: Count each patient event of the following types during the EHR reporting period: 1. A hospitalization, defined as Service Category of H AND an admission type of: (A) Trans-Non IHS Admission (B) Trans-IHS Admission (C) Referred Admission OR 2. An emergency department visit, defined as clinic code of Emergency Department-30 AND a Service Category of A with a "Yes" value in the "Was the patient transferred from another facility" field in the ER Visit file. (This field follows the Visit Type in the ER admission process.) Numerator Inclusions: Count each visit in the Denominator WHERE a Patient Education Code of M-MR is documented on the day of the hospital admission or emergency department visit through the second day. Note: The Patient Wellness Handout (PWH) is not required to meet this measure. However, printing the PWH and providing a copy to the patient is encouraged and recommended as it will allow the EH/CAH to meet additional Performance Measures and provide a method by which the provider may produce a medication list and review it with the patient. Documentation of M-MR is the only thing that is counted by RPMS during a transition of care.

EH/CAHs Menu Set Measure Name	Measure and Stage 1 Logic
7 of 10. Transition of Care Summary	# transitions of care & referrals where summary of care printed w/in 14 days # transitions of care & referrals by Hospital/CAH Denominator Inclusions: Count each of the RCIS referrals WHERE the referral has an Initiated Date occurring from the date of admission through the date of discharge for the conditions shown below where the status of Referral is equal to "A" (active) or "C1" (closed completed). 1. A hospitalization during the EHR reporting period defined as Service Category of H and a Discharge Type of Transferred. 2. An emergency department visit during the EHR reporting period defined as clinic code of Emergency Department-30 AND a Service Category of A with an ERS Disposition value of Referred to Another Service or Transferred to Another Facility. Denominator Exclusions: All in-house referrals. Numerator Inclusions: Count each event in the Denominator WHERE the Summary of Care (C32) was printed: 1. One day before through the day of discharge for hospitalizations. 2. On emergency department visit through the date of the discharge for the ER visit. If a discharge date is available in the V Emergency Room file it is used, otherwise the visit date is used. Measure Exclusions: Exclude eligible hospitals and CAHs that have no referrals during the EHR reporting period. Note: A transition of care from one IHS facility to another IHS facility is included as long as a referral was created. This logic allows for the printing of the C32 the day prior to a discharge/transfer for hospitalizations and printing the day after an emergency department visit where a visit extends past midnight.
8 of 10. Immunization Registries Data Submission	Yes/No Attestation Measure Inclusions: Count eligible hospitals and CAHs that perform at least one test of the certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test was successful (unless none of the immunization registries to which the hospital or CAH submits such information has the capacity to receive the information electronically) during the EHR reporting period. Measure Exclusions: Exclude eligible hospitals and CAHs that do not administer one or more immunizations during the EHR reporting period. Additional CMS Final Rule Information: Test data about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective. A failed attempt will meet the measure. Where no immunization registry exists that has the capacity to receive information electronically during the EHR reporting period, a hospital or CAH may be excluded from this measure and will have to attest to this in separate documentation to CMS.

EH/CAHs Menu Set Measure Name	Measure and Stage 1 Logic
9 of 10. Reportable Lab Results to Public Health Agencies	Yes/No Attestation Measure Inclusions: Count eligible hospitals and CAHs that perform at least one test of the certified EHR technology's capacity to submit electronic data on reportable lab results to public health agencies (unless none of the public health agencies to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically) during the EHR reporting period. Additional CMS Final Rule Information: Test data that is identical in form to actual data may be used. A failed attempt will meet the measure. Where no public health agency exists that has the capacity to receive lab results electronically during the EHR reporting period, a hospital or CAH may be excluded from this measure and will have to attest to this in separate documentation to CMS.
10 of 10. Syndromic Surveillance Data Submission	Yes/No Attestation Measure Inclusions: Count eligible hospitals and CAHs that perform at least one test of the certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically) during the EHR reporting period. Note: States may modify this objective. Additional CMS Final Rule Information: Public health agency is an entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function. Test must involve a real submission but may use test data that is identical to a fictional patient. A failed attempt will meet the measure. The test could be started before the start of the EHR reporting period and must be completed prior to the end of the EHR reporting period. Each payment year would require its own unique test. The test must be conducted with the certified EHR technology in accordance with the standards specified in the ONC rule at 45 CFR 170.302(l). Where no public health agency exists that has the capacity to receive information electronically during the EHR reporting period, a hospital or CAH may be excluded from this measure and will have to attest to this in separate documentation to CMS.