Stage 1 vs. Stage 2 Comparison Table for Eligible Professionals

Last Updated: August, 2012

CORE OBJECTIVES (17 total)

Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
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 have at least one medication order entered using CPOE	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% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE
Implement drug-drug and drug-allergy interaction checks	The EP has enabled this functionality for the entire EHR reporting period	***No longer a separate objective for Stage 2***	***This measure is incorporated into the Stage 2 Clinical Decision Support measure***
Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	Generate and transmit permissible prescriptions electronically (eRx)	More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology
Record demographics • Preferred language • Gender • Race • Ethnicity • Date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data	Record the following demographics • Preferred language • Gender • Race • Ethnicity • Date of birth	More than 80% of all unique patients seen by the EP have demographics recorded as structured data
Maintain an up-to-date problem list of current	More than 80% of all unique patients seen	***No longer a separate objective for Stage 2***	***This measure is incorporated into the Stage***

and active diagnoses	by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data		***2 measure of Summary of Care Document at Transitions of Care and Referrals***
Maintain active medication list	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	***No longer a separate objective for Stage 2***	***This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals***
Maintain active medication allergy list	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data	***No longer a separate objective for Stage 2***	***This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals***
Record and chart changes in vital signs: • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI	For more than 50% of all unique patients age 2 and over seen by the EP, blood pressure, height and weight are recorded as structured data	Record and chart changes in vital signs: • Height • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI	More than 80% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data
Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status	Record smoking status for patients 13 years old or older	More than 80% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data

	recorded as structured data		
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	Use clinical decision support to improve performance on high-priority health conditions	1. Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period. 2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period
Report clinical quality measures (CQMs) to CMS or the States	Provide aggregate numerator, denominator, and exclusions through attestation or through the PQRS Electronic Reporting Pilot	***No longer a separate objective for Stage 2, but providers must still submit CQMs to CMS or the States in order to achieve meaningful use***	***Starting in 2014, all CQMs will be submitted electronically to CMS***
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request	More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days	Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP	i. More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information ii. More than 5% 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 health information
Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days	Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients within one business day for more than 50% of office visits
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	***This objective is eliminated from Stage 1 in 2013 and is no longer an objective for Stage 2***	***This measure is eliminated from Stage 1 in 2013 and is no longer a measure for Stage 2***
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	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 at rest and implement security updates as necessary and correct identified security deficiencies as part of its risk management process
Implement drug-formulary checks	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period	***No longer a separate objective for Stage 2***	***This measure is incorporated into the e-Prescribing measure for Stage 2***

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 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	Incorporate clinical lab-test results into Certified EHR Technology as structured data	More than 55% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate at least one report listing patients of the EP with a specific condition	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one report listing patients of the EP with a specific condition
Send reminders to patients per patient preference for preventive/ follow up care	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	Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care	Use EHR to identify and provide reminders for preventive/follow-up care for more than 10% of patients with two or more office visits in the last 2 years
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP	More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information	***This objective is eliminated from Stage 1 in 2014 and is no longer an objective for Stage 2***	***This measure is eliminated from Stage 1 in 2014 and is no longer a measure for Stage 2***

Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients seen by the EP are provided patient-specific education resources	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	Patient-specific education resources identified by CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	1. The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals 2. The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record either a) electronically transmitted to a recipient using CEHRT or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or is validated through an

			ONC-established governance mechanism to facilitate exchange for 10% of transitions and referrals 3. The EP who transitions or refers their patient to another setting of care or provider of care must either a) conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the sender's, or b) conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period
Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice	Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period
NEW	**NEW**	Use secure electronic messaging to	A secure message was sent using the electronic

		communicate with patients on relevant health information	messaging function of Certified EHR Technology by more than 5% of unique patients seen during the EHR reporting period

MENU OBJECTIVES (EPs must select 3 of 6 menu objectives)

Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period
NEW	**NEW**	Record electronic notes in patient records	Enter at least one electronic progress note created, edited and signed by an EP for more than 30% of unique patients
NEW	**NEW**	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT	More than 10% of all scans and tests whose result is an image ordered by the EP for patients seen during the EHR reporting period are incorporated into or accessible through Certified EHR Technology
NEW	**NEW**	Record patient family health history as structured data	More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives or an indication that family health history has been

			reviewed
NEW	**NEW**	Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period
NEW	**NEW**	Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period