

**Meaningful Use: Stage 1 Final Rule and Proposed Objectives for Stages 2
and
Required New and/or Revised Certification Criteria**

Stage 1 Final Rule	Proposed Stage 2	New or Revised Certification Criteria Required?
Improving Quality, Safety, Efficiency & Reducing Health Disparities		
CPOE for medication orders (30%)	CPOE (by licensed professional) for at least 1 medication, and 1 lab or radiology order for 60% of unique patients who have at least 1 such order (order does not have to be transmitted electronically)	No
Drug-drug/drug-allergy interaction checks	Employ drug-drug interaction checking and drug allergy checking on appropriate evidence-based interactions	Revision likely to accommodate “evidence-based interactions”
E-prescribing (eRx) (EP) (40%)	50% of orders (outpatient and hospital discharge) transmitted as eRx	No , for EHR technology designed for an ambulatory setting Yes , for EHR technology designed for an inpatient setting
Record demographics (50%)	80% of patients have demographics recorded and can use them to produce stratified quality reports	No, subject to vocabulary standards adoption Revision may be necessary to link to stratified CQM reports
Report CQM electronically	Continue as per Quality Measures Workgroup and CMS	Revision likely to accommodate any potential CQM changes
Maintain problem list (80%)	Continue Stage 1	No, subject to vocabulary standards adoption
Maintain active med list (80%)	Continue Stage 1	No, subject to vocabulary standards adoption
Maintain active medication allergy list (80%)	Continue Stage 1	No, subject to vocabulary standards adoption
Record vital signs (50%)	80% of unique patients have vital signs recorded	No, unless additional vital signs are required
Record smoking status (50%)	80% of unique patients have smoking status recorded	No

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Implement 1 CDS rule	Use CDS to improve performance on high-priority health conditions. Establish CDS attributes for purposes of certification: 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow; 7. Integrated with EHR; 8. Presented to the appropriate party who can take action	Revision likely to accommodate additional specificity
Implement drug formulary checks *	Move current measure to core	No, subject to standards & implementation specifications adoption
Record existence of advance directives (EH) (50%)*	Make core requirement. For EP and EH: 50% of patients >=65 years old have recorded in EHR the result of an advance directive discussion and the directive itself if it exists	No , for EHR technology designed for an inpatient setting Yes , for EHR technology designed for an ambulatory setting
Incorporate lab results as structured data (40%)*	Move current measure to core, but only where results are available	No, subject to standards adoption
Generate patient lists for specific conditions *	Make core requirement. Generate patient lists for multiple patient-specific parameters	Revision likely to accommodate additional specificity
Send patient reminders (20%)*	Make core requirement.	No
(NEW)	30% of visits have at least one electronic EP note	NEW
(NEW)	30% of EH patient days have at least one electronic note by a physician, NP, or PA	NEW
(NEW)	30% of EH medication orders automatically tracked via electronic medication administration recording	NEW

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Engage Patients and Families in Their Care		
Provide electronic copy of health information, upon request (50%)	Continue Stage 1	No, subject to standards & implementation specifications adoption
Provide electronic copy of discharge instructions (EH) at discharge (50%)	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least 80% of patients (patients may elect to receive only a printed copy of the instructions)	No
EHR-enabled patient-specific educational resources (10%)	Continue Stage 1	No
(NEW for EH)	80% of patients offered the ability to view and download via a web-based portal ⁱⁱⁱ , within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in human-readable and structured forms (HITSC to define).	New, for EHR technology designed for an inpatient setting
Provide clinical summaries for each office visit (EP) (50%)	Patients have the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter. Follow-up tests that are linked to encounter orders but not ready during the encounter should be included in future summaries of that encounter, within 4 days of becoming available. Data are available in human-readable and structured forms (HITSC to define)	Revision of “timely access” certification criterion since the same initial capability (view and download) appears to be required (see next row below)

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Provide timely electronic access (EP) (10%)	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data are available in human-readable and structured forms (HITSC to define).	Revision required to accommodate additional functionality/specificity
This objective sets the measures for “Provide timely electronic access (EP)” and for “Provide clinical summaries for each office visit (EP)”	EPs: 20% of patients use a web-based portal ⁱⁱⁱ to access their information (for an encounter or for the longitudinal record) at least once. Exclusions: patients without ability to access the Internet	same capability as the two rows above
(NEW)	EPs: online secure patient messaging is in use	NEW
(NEW)	Patient preferences for communication medium recorded for 20% of patients	NEW
Improve Care Coordination		
Perform test of HIE	Connect to at least three external providers in “primary referral network” (but outside delivery system that uses the same EHR) or establish an ongoing bidirectional connection to at least one health information exchange	No, subject to standards adoption
Perform medication reconciliation (50%)*	Medication reconciliation conducted at 80% of care transitions by receiving provider (transitions from another setting of care, or from another provider of care, or the provider believes it is relevant)	NO

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Provide summary of care record (50%)*	Move to Core	No, subject to standards & implementation specifications adoption
(NEW)	List of care team members (including PCP) available for 10% of patients in HER	NEW
(NEW)	Record a longitudinal care plan for 20% of patients with high-priority health conditions	NEW
Improve Population and Public Health		
Submit immunization data*	EH and EP: Mandatory test. Some immunizations are submitted on an ongoing basis to Immunization Information System (IIS), if accepted and as required by law	No, subject to standards & implementation specifications adoption
Submit reportable lab data*	<u>EH</u> : move Stage 1 to core <u>EP</u> : lab reporting menu. For EPs, ensure that reportable lab results and conditions are submitted to public health agencies either directly or through their performing labs (if accepted and as required by law).	No, for EHR technology designed for an inpatient setting, subject to standards & implementation specifications adoption Yes, for EHR technology designed for an ambulatory setting
Submit syndromic surveillance data*	Move to core.	No, subject to standards & implementation specifications adoption
Ensure Adequate Privacy and Security Protections for Personal Health Information		
Conduct security review analysis & correct deficiencies		Undetermined