

**TABLE 2: Stage 1 Criteria for Meaningful Use**

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
Improving quality, safety, efficiency, and reducing health disparities	Provide access to comprehensive patient health data for patient's health care team	Use CPOE	Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	For EPs, CPOE is used for at least 80% of all orders  For eligible hospitals, CPOE is used for 10% of all orders
	Use evidence-based order sets and CPOE	Implement drug-drug, drug-allergy, drug-formulary checks	Implement drug-drug, drug-allergy, drug-formulary checks	The EP/eligible hospital has enabled this functionality
	Apply clinical decision support at the point of care	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data
	Generate lists of patients who need care and use them to reach out to patients			
	Report information for quality improvement and public reporting	Generate and transmit permissible prescriptions electronically (eRx)		At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
		Maintain active medication list	Maintain active medication list	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data
		Maintain active medication allergy list	Maintain active medication allergy list	At least 80% of all unique patients seen, by the EP or admitted to the eligible hospital have at least one entry or (an indication of "none" if the patient has no medication allergies) recorded as structured data

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		Record demographics <ul style="list-style-type: none"> <li>○ preferred language</li> <li>○ insurance type</li> <li>○ gender</li> <li>○ race</li> <li>○ ethnicity</li> <li>○ date of birth</li> </ul>	Record demographics <ul style="list-style-type: none"> <li>○ preferred language</li> <li>○ insurance type</li> <li>○ gender</li> <li>○ race</li> <li>○ ethnicity</li> <li>○ date of birth</li> <li>○ date and cause of death in the event of mortality</li> </ul>	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data
		Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>○ height</li> <li>○ weight</li> <li>○ blood pressure</li> <li>○ Calculate and display: BMI</li> <li>○ Plot and display growth charts for children 2-20 years, including BMI.</li> </ul>	Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>○ height</li> <li>○ weight</li> <li>○ blood pressure</li> <li>○ Calculate and display: BMI</li> <li>○ Plot and display growth charts for children 2-20 years, including BMI.</li> </ul>	For at least 80% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital, record blood pressure and BMI; additionally plot growth chart for children age 2-20
		Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	At least 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital have “smoking status” recorded
		Incorporate clinical lab-test results into EHR as structured data	Incorporate clinical lab-test results into EHR as structured data	At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
		Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate at least one report listing patients of the EP or eligible hospital with a specific condition.

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		Report ambulatory quality measures to CMS or the States	Report hospital quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule
		Send reminders to patients per patient preference for preventive/ follow up care		Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over
		Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP/Eligible Hospital is responsible for as described further in section II(A)(3).
		Check insurance eligibility electronically from public and private payers	Check insurance eligibility electronically from public and private payers	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital
		Submit claims electronically to public and private payers.	Submit claims electronically to public and private payers.	At least 80% of all claims filed electronically by the EP or the eligible hospital
<b>Engage patients and families in their health care</b>	Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours

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			Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it
		Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP		At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information
		Provide clinical summaries for patients for each office visit		Clinical summaries are provided for at least 80% of all office visits
<b>Improve care coordination</b>	Exchange meaningful clinical information among professional health care team	Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information
		Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care
		Provide summary care record for each transition of care and referral	Provide summary care record for each transition of care and referral	Provide summary of care record for at least 80% of transitions of care and referrals

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<b>Improve population and public health</b>	Communicate with public health agencies	Capability to submit electronic data to immunization registries and actual submission where required and accepted	Capability to submit electronic data to immunization registries and actual submission where required and accepted	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries
			Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	Performed at least one test of the EHR system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically)
		Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically)

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<b>Ensure adequate privacy and security protections for personal health information</b>	<p>Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law.</p> <p>Provide transparency of data sharing to patient.</p>	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary

e. Request for Public Comment on Potential Health IT Functionality Measures for Eligible Professionals and Eligible Hospitals in 2013 Payment Year and Subsequent Years

As noted previously, we are cognizant that in most areas of the country, the infrastructure necessary to support such the electronic exchange of structured information is not yet currently available. For that reason, we excluded the electronic exchange of structured information from many Stage 1 objectives or set relatively low performance thresholds for measures that do rely on the electronic exchange of structured data. For example, we set the threshold at 50 percent for the incorporation of lab data in structured format, and we excluded other types of diagnostic test data (for example, radiology reports, pathology reports, etc.) from that measure. We also excluded the transmission of orders from the definition of “CPOE use” for Stage 1 criteria.

In future rulemaking (for example, for Stage 2 and Stage 3 criteria), however, we anticipate raising the threshold for these objectives as the capabilities of HIT