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	The EP has enabled this functionality for	No longer a separate objective for Stage 2	This measure is incorporated into the Stage
interaction checks	the entire EHR reporting period		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		2 measure of Summary of
	one entry or an indication that no		Care Document at Transitions of Care and
	problems are known for the patient recorded as structured		Referrals
	data		
Maintain active medication list	More than 80% of all unique patients seen	No longer a separate objective for Stage 2	This measure is incorporated into the Stage
	by the EP have at least one entry (or an indication that the		2 measure of Summary of Care Document at Transitions of Care and
	patient is not currently prescribed any medication) recorded as structured data		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	 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. The EP, eligible hospital, or CAH has enabled the functionality for drug- drug and drug-allergy interaction checks for the entire EHR reporting period
Depart aliginal quality	Duo vido o garagato		•
Report clinical quality	Provide aggregate	No longer a separate	Starting in 2014, all CQMs
measures (CQMs) to	numerator,	objective for Stage 2,	will be submitted
CMS or the States	denominator, and	but providers must still	electronically to CMS
	exclusions through	submit CQMs to CMS or	
	attestation or through	the States in order to	
	the PQRS Electronic Reporting Pilot	achieve meaningful use	
Provide patients with an	More than 50% of all	Provide patients the	i. More than 50% of all
electronic copy of their	patients of the EP who	ability to view online,	unique patients seen by
health information	•	download and transmit	
	request an electronic		the EP during the EHR
(including diagnostic	copy of their health	their health information	reporting period are
test results, problem	information are	within four business days	provided timely
list, medication lists,	provided it within 3	of the information being	(available to the patient
medication allergies),	business days	available to the EP	within 4 business days
upon request			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
			the EP during the EHR reporting period (or





Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3	Provide clinical summaries for patients for each office visit	representatives) view, download, or transmit to a third party their health information Clinical summaries provided to patients within one business day for more than 50% of office visits
	business days		
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-	More than 40% of all	Incorporate clinical lab-	More than 55% of all clinical
test results into certified	clinical lab tests results	test results into Certified	lab tests results ordered by
EHR technology as	ordered by the EP	EHR Technology as	the EP during the EHR
structured data	during the EHR	structured data	reporting period whose
	reporting period		results are either in a
	whose results are		positive/negative or
	either in a		numerical format are
	positive/negative or		incorporated in Certified
	numerical format are		EHR Technology as
	incorporated in		structured data
	certified EHR		
	technology as		
	structured data		
Generate lists of	Generate at least one	Generate lists of patients	Generate at least one
patients by specific	report listing patients	by specific conditions to	report listing patients of the
conditions to use for	of the EP with a	use for quality	EP with a specific condition
quality improvement,	specific condition	improvement, reduction	
reduction of disparities,		of disparities, research,	
research or outreach		or outreach	
Send reminders to	More than 20% of all	Use clinically relevant	Use EHR to identify and
patients per patient	unique patients 65	information to identify	provide reminders for
preference for	years or older or 5	patients who should	preventive/follow-up care
preventive/ follow up	years old or younger	receive reminders for	for more than 10% of
care	were sent an	preventive/follow-up	patients with two or more
	appropriate reminder	care	office visits in the last 2
	during the EHR		years
	reporting period		
Provide patients with	More than 10% of all	This objective is	This measure is eliminated
timely electronic access	unique patients seen	eliminated from Stage 1	from Stage 1 in 2014 and is
to their health	by the EP are provided	in 2014 and is no longer	no longer a measure for
information (including	timely (available to the	an objective for Stage 2	Stage 2
lab results, problem list,	patient within four		
medication lists,	business days of being		
medication allergies)	updated in the		
within four business	certified EHR		
days of the information	technology) electronic		
being available to the EP	access to their health		
	information subject to		
	the EP's discretion to		
	the Er Suberetion to		
	withhold certain		





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





electronic data totest of certimmunization registriestechnologyor Immunizationto submit e		3.	ONC-established governance mechanism to facilitate exchange for 10% of transitions and referrals 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
electronic data totest of certimmunization registriestechnologyor Immunizationto submit e			was designed by a different EHR developer than the sender's, or b)
electronic data to test of cert immunization registries technology or Immunization to submit e	d at least one Capabil	ility to submit Suc	successful tests with the CMS-designated test EHR during the EHR reporting period ccessful ongoing
and actual submissionregistries a up submissionexcept whereup submissionprohibited and intest is successaccordance with(unless notestapplicable law andimmunizatepracticeregistries teEP submitseinformationcapacity toinformation	tified EHR electron y's capacity immuni electronic or Immuni and follow actual s sion if the where p cessful accorda one of the applicat tion practice to which the s such on have the o receive the on	onic data to sub nization registries imm nunization Cer ation Systems and an submission except imm prohibited and in syst ance with rep	omission of electronic munization data from rtified EHR Technology to immunization registry or munization information stem for the entire EHR porting period
NEW N		cure electronic A s	ecure message was sent ng the electronic





	communicate with	messaging function of	
	patients on relevant	Certified EHR Technology by	
	health information	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



