Combined Matrix Showing Proposed Stage 1 Meaningful Use Objectives, Measures, and Certification Criteria

Stage 1 Objectives for Eligible Professionals	Stage 1 Objectives for Hospitals	Stage 1 Measures	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospitals
Health outcomes policy priority: Improving quality, safety, efficiency, and reducing health disparities.				
Care Goals: (1) provide access to comprehensive patient health data for patient's health care team; (2) use evidence-based order sets and CPOE; (3) apply clinical decision support at the point of care; (4) generate lists of patients who need care and use them to reach out to patients; and (5) report information for quality improvement and public reporting.				
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.	Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types: 1. Medications; 2. Laboratory; 3. Radiology/imaging; and 4. Provider referrals.	Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types: 1. Medications; 2. Laboratory; 3. Radiology/imaging; 4. Blood bank; 5. Physical therapy; 6. Occupational therapy; 7. Respiratory therapy; 8. Rehabilitation therapy; 9. Dialysis; 10. Provider consults; and 11. Discharge and transfer.
Implement drug-drug, drug-allergy, drug-formulary checks.	Implement drug-drug, drug-allergy, drug-formulary checks.	The EP/eligible hospital has enabled this functionality.	1. Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, age, and CPOE. 2. Enable a user to electronically check if drugs are in a formulary or preferred drug list in accordance with the standard specified in Table 2A row 2. 3. Provide certain users with administrator rights to deactivate, modify, and add rules for drug-drug and drug-allergy checking. 4. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.	Same as for EPs.
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.	Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care (i.e., over multiple office visits) in accordance with the applicable standards specified in Table 2A row 1.	Same as for EPs.

Stage 1 Objectives for Eligible Professionals	**Stage 1 Objectives for Hospitals**	**Stage 1 Measures**	**Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals**	**Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospitals**
Generate and transmit permissible prescriptions electronically (eRx).	NA	At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	Enable a user to electronically transmit medication orders (prescriptions) for patients in accordance with the standards specified in Table 2A row 3.	No Associated Proposed Meaningful Use Stage 1 Objective.
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.	Enable a user to electronically record, modify, and retrieve a patient’s active medication list as well as medication history for longitudinal care (i.e., over multiple office visits) in accordance with the applicable standard specified in Table 2A row 1.	Same as for EPs.
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. At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data.	Enable a user to electronically record, modify, and retrieve a patient’s active medication allergy list as well as medication allergy history for longitudinal care (i.e., over multiple office visits).	Same as for EPs.

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Record demographics: ○ preferred language ○ insurance type ○ gender ○ race ○ ethnicity ○ date of birth	Record demographics: ○ preferred language ○ insurance type ○ gender ○ race ○ ethnicity ○ date of birth ○ date and cause of death in the event of mortality	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.	Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, insurance type, gender, race, ethnicity, and date of birth.	Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, insurance type, gender, race, ethnicity, date of birth, and date and cause of death in the event of mortality.
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.	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 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.	1. Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, the height, weight, blood pressure, temperature, and pulse. 2. Automatically calculate and display body mass index (BMI) based on a patient's height and weight. 3. Plot and electronically display, upon request, growth charts (height, weight, and BMI) for patients 2–20 years old.	Same as for EPs.
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.	Enable a user to electronically record, modify, and retrieve the smoking status of a patient to: current smoker, former smoker, or never smoked.	Same as for EPs.

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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.	1. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. 2. Electronically display in human readable format any clinical laboratory tests that have been received with LOINC® codes. 3. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). 4. Enable a user to electronically update a patient's record based upon received laboratory test results.	Same as for EPs.
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.	Enable a user to electronically select, sort, retrieve, and output a list of patients and patients' clinical information, based on user-defined demographic data, medication list, and specific conditions.	Same as for EPs.
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.	1. Calculate and electronically display quality measure results as specified by CMS or states. 2. Enable a user to electronically submit calculated quality measures in accordance with the standard specified in Table 2A row 5.	Same as for EPs.
Send reminders to patients per patient preference for preventive/follow up care.	NA	Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over.	Electronically generate, upon request, a patient reminder list for preventive or follow-up care according to patient preferences based on demographic data, specific conditions, and/or medication list.	No Associated Proposed Meaningful Use Stage 1 Objective.

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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).	1. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) according to specialty or clinical priorities that use demographic data, specific patient diagnoses, conditions, diagnostic test results and/or patient medication list. 2. Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts and care suggestions based upon clinical decision support rules and evidence grade. 3. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.	1. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) according to a high priority hospital condition that use demographic data, specific patient diagnoses, conditions, diagnostic test results and/or patient medication list. 2. Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts and care suggestions based upon clinical decision support rules and evidence grade. 3. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.
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.	Enable a user to electronically record and display patients' insurance eligibility, and submit insurance eligibility queries to public or private payers and receive an eligibility response in accordance with the applicable standards specified in Table 2A row 4.	Same as for EPs.
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.	Enable a user to electronically submit claims to public or private payers in accordance with the applicable standards specified in Table 2A row 4.	Same as for EPs.
Health outcomes policy priority: Engage patients and families in their health care.				
Care goals: 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.	Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in: (1) Human readable format; and (2) accordance with the standards specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.	Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, discharge summary, and procedures in: (1) Human readable format; and (2) accordance with the standards specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.

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NA	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.	No Associated Proposed Meaningful Use Stage 1 Objective.	Enable a user to create an electronic copy of the discharge instructions and procedures for a patient, in human readable format, at the time of discharge to provide to a patient on electronic media, or through some other electronic means.
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.	NA	At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information.	Enable a user to provide patients with online access to their clinical information, including, at a minimum, lab test results, problem list, medication list, medication allergy list, immunizations, and procedures.	No Associated Proposed Meaningful Use Stage 1 Objective.
Provide clinical summaries for patients for each office visit.	NA	Clinical summaries are provided for at least 80% of all office visits.	1. Enable a user to provide clinical summaries to patients (in paper or electronic form) for each office visit that include, at a minimum, diagnostic test results, medication list, medication allergy list, procedures, problem list, and immunizations. 2. If the clinical summary is provided electronically (i.e., not printed), it must be provided in: (1) Human readable format; and (2) accordance with the standards specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.	No Associated Proposed Meaningful Use Stage 1 Objective.
Health outcomes policy priority: Improve care coordination.				
Care goal: Exchange meaningful clinical information among professional health care team.				

Stage 1 Objectives for Eligible Professionals	Stage 1 Objectives for Hospitals	Stage 1 Measures	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospitals
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.	1. Electronically receive a patient summary record, from other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures and upon receipt of a patient summary record formatted in an alternative standard specified in Table 2A row 1, displaying it in human readable format. 2. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with the standards specified in Table 2A row 1.	1. Electronically receive a patient summary record, from other providers and organizations including, at a minimum, discharge summary, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures and upon receipt of a patient summary record formatted in an alternative standard specified in Table 2A row 1, displaying it in human readable format. 2. Enable a user to electronically transmit a patient summary record, to other providers and organizations including, at a minimum, discharge summary, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with the standards specified in Table 2A row 1.
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.	Electronically complete medication reconciliation of two or more medication lists (compare and merge) into a single medication list that can be electronically displayed in real-time.	Same as for EPs.
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.	1. Electronically receive a patient summary record, from other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures and upon receipt of a patient summary record formatted in an alternative standard specified in Table 2A row 1, displaying it in human readable format. 2. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with the standards specified in Table 2A row 1.	1. Electronically receive a patient summary record, from other providers and organizations including, at a minimum, discharge summary, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures and upon receipt of a patient summary record formatted in an alternative standard specified in Table 2A row 1, displaying it in human readable format. 2. Enable a user to electronically transmit a patient summary record, to other providers and organizations including, at a minimum, discharge summary, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with the standards specified in Table 2A row 1.
Health outcomes policy priority: Improve population and public health.				
Care goal: Communicate with public health agencies.				

Stage 1 Objectives for Eligible Professionals	Stage 1 Objectives for Hospitals	Stage 1 Measures	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospitals
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.	Electronically record, retrieve, and transmit immunization information to immunization registries in accordance with the standards specified in Table 2A row 8 or in accordance with the applicable state-designated standard format.	Same as for EPs.
NA	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).	No Associated Proposed Meaningful Use Stage 1 Objective.	Electronically record, retrieve, and transmit reportable clinical lab results to public health agencies in accordance with the standards specified in Table 2A row 6.

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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).	Electronically record, retrieve, and transmit syndrome-based (e.g., influenza like illness) public health surveillance information to public health agencies in accordance with the standards specified in Table 2A row 7.	Same as for EPs.
Health outcomes policy priority: Ensure adequate privacy and security protections for personal health information.				
Care goals: (1) ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law and (2) provide transparency of data sharing to patient.				

Stage 1 Objectives for Eligible Professionals	Stage 1 Objectives for Hospitals	Stage 1 Measures	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospitals
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.	1. Assign a unique name and/or number for identifying and tracking user identity and establish controls that permit only authorized users to access electronic health information. 2. Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency. 3. Terminate an electronic session after a predetermined time of inactivity. 4. Encrypt and decrypt electronic health information according to user-defined preferences (e.g., backups, removable media, at log-on/off) in accordance with the standard specified in Table 2B row 1. 5. Encrypt and decrypt electronic health information when exchanged in accordance with the standard specified in Table 2B row 2. 6. Record actions (e.g., deletion) related to electronic health information in accordance with the standard specified in Table 2B row 3 (i.e., audit log), provide alerts based on user-defined events, and electronically display and print all or a specified set of recorded information upon request or at a set period of time. 7. Verify that electronic health information has not been altered in transit and detect the alteration and deletion of electronic health information and audit logs in accordance with the standard specified in Table 2B row 4. 8. Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information. 9. Verify that a person or entity seeking access to electronic health information across a network is the one claimed and is authorized to access such information in accordance with the standard specified in Table 2B row 5. 10. Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in Table 2B row 6.	Same as EPs.