

Proposed Rule: Stage 1 Meaningful Use Criteria

Objectives		Measures
Eligible Professionals	Eligible Hospitals	
Use CPOE	Use CPOE for orders directly entered by authorizing provider	Eligible Professionals: CPOE is used for at least 80% of all orders Eligible Hospitals: CPOE is used for at least 10% of all orders
Implement drug-drug, drug-allergy, drug-formulary checks		Functionality is enabled
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 eligible professional or admitted to the hospital have at least one entry (or an indication of none recorded) as structured data
Generate and transmit permissible prescriptions electronically		At least 75% of all permissible prescriptions written by the eligible professional are transmitted electronically using certified EHR technology
Maintain active medication list		At least 80% of all unique patients seen by the eligible professional or admitted to the 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		At least 80% of all unique patients seen by the eligible professional or admitted to the hospital have at least one entry (or an indication of "none" if the patient has no medication allergies) recorded as structured data
Record demographics: <ul style="list-style-type: none"> • Preferred language • Insurance type • Gender • Race • Ethnicity • Date of birth 	Record demographics: <ul style="list-style-type: none"> • Preferred language • Insurance type • Gender • Race • Ethnicity • Date of birth • Date and cause of death in the event of mortality 	At least 80% of all unique patients seen by the eligible professional or admitted to the hospital have demographics recorded as structured data
Record and chart changes in vital signs: <ul style="list-style-type: none"> • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI 		At least 80% of all unique patients 13 years or older seen by the eligible professional or admitted to the hospital have blood pressure and BMI recorded; additionally, plot growth chart for children age 2-20
Record smoking status for patients 13 years and older		At least 80% of all unique patients 13 years or older seen by the eligible professional or admitted to the hospital have smoking status recorded
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 the certified EHR technology as structured data

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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 eligible professional or eligible hospital with a specific condition
Report ambulatory quality measures to CMS or the State	Report hospital quality measures to CMS or the State	For 2011, provide aggregate numerator and denominator through attestation For 2012, electronically submit measures
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 eligible professional 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 eligible professional or eligible hospital is responsible for
Check insurance eligibility electronically from public and private payers		Insurance eligibility checked for at least 80% of all unique patients seen by the eligible professional or the eligible hospital
Submit claims electronically to public and private payers		At least 80% of all claims filed electronically by the eligible professional or admitted to the eligible hospital
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 summaries, procedures), upon request	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours
	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

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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 eligible professional		At least 10% of all unique patients seen by the eligible professional 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
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		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 for at least 80% of relevant encounters and transitions of care
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
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 hospitals 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		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 eligible professional or eligible hospital submits such information have the capacity to receive the information electronically)
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 and implement security updates as necessary