TABLE 2—STAGE I MEANINGFUL USE OBJECTIVES AND ASSOCIATED MEASURES

CORE SET	ELIGIBLE PROFESSIONALS	STAGE 1 MEASURES
Improving quality, safety, efficiency, and reducing health disparities	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
	Implement drug-drug and drug-allergy interaction checks	The EP has enabled this function for the entire EHR reporting period
	Generate and transmit permissible prescriptions electronically (e-Rx)	More than 40% of all permissible prescriptions written by the EP are 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
	Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data
	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 know medication allergies) recorded as structured data
	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 overseen by the EP height, weight, and Blood pressure are recorded as structured data
	Record smoking status for all patients 13	More than 50% of all unique patients 13

	years old or older	years old or older seen by the EP have smoking status recorded as structured data
	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Implement one clinical decision support rule
	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Implement one clinical decision support rule
	Report ambulatory clinical quality measures to CMS or the States	For 2011, provide aggregate numerator, denominator, and exclusions through attestation as discussed in Section H(A)(3) of this final rule
Engage patients and families in their health care	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication list, medication allergies) upon request	More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days
	Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days
Improve care coordination	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
Ensure adequate privacy and security protections for personal health information	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

MENU SET —HEALTH OUTCOMES POLICY PRIORITY	ELIGIBLE PROFESSIONALS	STAGE 1 MEASURES
Improving quality, safety, efficiency and reducing health disparities	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
	Incorporate clinical lab test results into certified EHR technology as structured data	More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either 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, research or outreach	Generate at least one report listing patients of the EP with a specific condition
	Send reminders to patients per patient preference for preventive/follow-up care	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period
Engage patients and families in their healthcare	Provide patients with timely electronic access to their health information (including lab results, problem lists, medication lists, medication allergies within four business days of the information being available to the EP	More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information
	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients seen by the EP are provided their patient-specific education resources
Improve care coordination	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP
	The EP who transitions his/her patient to another setting of care or provider of care or refers a patient to another provider of care should provide summary of care record for each transition of care or referral	The EP who transitions or refers his/her patient to another setting of care or provider of care provides a summary of care for more than 50% of transitions of care and referrals

*Improve population and public health**	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP 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 in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically

*Unless an EP has an exception for all of these objectives and measures, he/she must complete at least one part of his/her demonstration of his/her demonstration of the menu set in order to be a meaningful EHR user

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