Stage 1 vs. Stage 2 Comparison Table for Eligible Hospitals

Core Objectives (Source: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage1vsStage2CompTablesforHospitals.pdf)				
	Stage 1 Objective	**Stage 1 Measure**	**Stage 2 Objective**	**Stage 2 Measure**
CPOE	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 admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) 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 authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE
Drug	Implement drug-drug and drug-allergy interaction checks	The eligible hospital/CAH has enabled this functionality for the entire EHR reporting period	***No longer a separate objective for Stage 2***	***This measure is incorporated into the Stage 2 Clinical Decision Support measure***
Demographics	Record demographics: preferred language, gender, race, ethnicity, date of birth, date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 50% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data	Record the following demographics: preferred language, gender, race, ethnicity, date of birth, date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
Problem List	Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient 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***
Medication List	Maintain active medication list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) 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***
Medication Allergy	Maintain active medication allergy list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) 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***
Vital Signs	Record and chart changes in vital signs: height and weight; blood pressure; calculate and display BMI; and plot and display growth charts for children 2-20 years, including BMI	More than 50% of all unique patients age 2 and over admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have blood pressure height and weight recorded as structured data	Record and chart changes in vital signs: height and weight; blood pressure (age 3 and over); calculate and display BMI; and plot and display growth charts for patients 0-20 years, including BMI	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data
Smoking	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	Record smoking status for patients 13 years old or older	More than 80% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data
Decision Support	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	1. 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. 2. The eligible hospital or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period
CQMs	Report clinical quality measures (CQMs) to CMS or the States	For 2011, provide aggregate numerator, denominator, and exclusions through attestation or electronically through the Hospital Reporting Pilot	***No longer a separate objective for Stage 2, but providers must still submit CQMs to CMS or the States in order to achieve meaningful use***	***Starting in 2014, all CQMs will be submitted electronically to CMS***
Patient Access to health Information	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request	More than 50% of all patients of the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days	Provide patients the ability to view online, download and transmit their health information within 36 hours after discharge from the hospital	1. More than 50% of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the EHR reporting period are provided timely (available to the patient within 36 hours after discharge from the hospital.) online access to their health information 2. More than 5% of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information
Clinical Summaries	Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it	***This objective is eliminated from Stage 1 in 2014 and is no longer a separate objective for Stage 2***	***This measure has been incorporated into the View, Download, and Transmit objective***
Exchange Clinical Data	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 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	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
Drug Formulary Checks	Implement drug-formulary checks [1]	The eligible hospital/CAH 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***
Lab Test results	Incorporate clinical lab-test results into certified EHR technology as structured data [1]	More than 40% of all clinical lab tests results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) 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	Incorporate clinical lab-test results into Certified EHR Technology as structured data	More than 55% of all clinical lab tests results ordered by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 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

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Core Objectives (continued)

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	Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Patient Lists	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach [1]	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition	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 eligible hospital or CAH with a specific condition
Patient-Specific Education Materials	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate [1]	More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources	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 admitted to the eligible hospital's or CAH's inpatient and emergency departments (POS 21 and 23) are provided patient- specific education resources identified by Certified EHR Technology
Transfer Medication Reconciliation	The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation [1]	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)	The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)
Transition Summary of Care	The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral [1]	The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals	The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	1. The eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals 2. The eligible hospital or CAH that transitions 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 ONC–established governance mechanism to facilitate exchange for 10% of transitions and referrals 3. The eligible hospital or CAH that 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 successful tests with the CMS-designed test EHR during the EHR reporting period
Immunization Registry	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice [1]	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 eligible hospital or CAH submits such information have the capacity to receive the information electronically)	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice	Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period
Electronic Lab Results to Public Agencies	Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice [1]	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically)	Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized, and in accordance with applicable State law and practice
Electronic Syndromic Surveillance Data	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 [1]	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 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
Medication Tracking	**NEW**	**NEW**	Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)	More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked are tracked using eMAR

[1] A Stage 1 Menu Measure prior to 2014

Menu Objectives

	Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Advance Directives	Record advance directives for patients 65 years old or older	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded	Record whether a patient 65 years old or older has an advance directive	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data
Electronic Notes	**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 admitted to the eligible hospital or CAH's inpatient or emergency department during the EHR reporting period
Imaging Results	**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 an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are incorporated into or accessible through Certified EHR Technology
Family Health History	**NEW**	**NEW**	Record patient family health history as structured data	More than 20% of all unique patients admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) 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
eRX	**NEW**	**NEW**	Generate and transmit permissible discharge prescriptions electronically (eRx)	More than 10% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology
Lab Results to Ambulatory Providers	**NEW**	**NEW**	Provide structured electronic lab results to ambulatory providers	Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20% of electronic lab orders received