AMA AMERICAN MEDICAL ASSOCIATION

STAGES 1 AND 2 REQUIREMENTS FOR MEETING MEANINGFUL USE OF EHRs[1]

Requirement	Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
CORE				
CPOE	Use CPOE for medication orders directly entered by any licensed health care professional who can enter orders into the medical record per state, local, and professional guidelines	More than **30**% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE **Exclusion:** Any EP who writes fewer than 100 prescriptions during the EHR reporting period qualifies for an exclusion from this objective/measure ***Change:*** *[Optional - –2013 Onward]* *More than **30%** of medication orders created by the EP during the EHR reporting period are recorded using CPOE*	Use 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 to create the first record of the order	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 **Exclusion:** Any EP who writes fewer than 100 medication orders during the EHR reporting period. Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. Any EP who writes fewer than 100 radiology orders during the EHR reporting period. An EP through a combination of meeting the thresholds and/or exclusions must satisfy all three measures for this objective.
e-Prescribing	Generate and transmit permissible prescriptions electronically (Note: only non-controlled substances are permissible)	More than **40**% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology (Note: only non-controlled substances are permissible)	Generate and transmit permissible prescriptions electronically (eRx) (Note: only non-controlled substances are permissible)	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. **Exclusions:** Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period or

[1] The information contained herein is general in nature and is based on authorities that are subject to change. It is not intended as legal advice provided by the American Medical Association and should not be relied upon as a substitute for legal advice or opinion. This material may not be applicable to, or suitable for, the specific circumstances or needs of the reader, and may require additional consideration of other factors not described herein.

Requirement	Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
		Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period qualifies for an exclusion from this objective/measure ***Change/Exclusion:*** *[Required – 2013 Onward]* ***Additional Exclusion Added****: Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period*		any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.
Record demo-graphics	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 demographics • Preferred language • Gender • Race • Ethnicity • Date of Birth .	More than **80**% of all unique patients seen by the EP during the EHR reporting period have demographics recorded as structured data
Record vital signs	Record and chart changes in vital signs: • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for	For more than **50**% of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data **Exclusion:** Any EP who either sees no patients 2 years or older, or who believes that all	Record and chart changes in the following vital signs: o height/length and weight (no age limit); o blood pressure (ages 3 and over); o calculate and display body mass index (BMI); and o plot and display growth	More than **80**% of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data **Exclusions:** 1. EP who does not see any patients 3 years old or older is excluded from recording blood

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	children 2-20 years, including BMI	three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice during the EHR reporting period qualifies for an exclusion from this objective/measure ***Change:*** *[Required - 2014 Onward]* *More than **50%** of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data* ***Exclusion Change:*** *[Optional - 2013 Only]* *Addition of alternative exclusions:* *Any EP who:* *1. Sees no patients 3 years or older is excluded from recording blood pressure;* *2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;* *3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or* *4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is*	charts for patients 0-20 years, including BMI.	pressure. 2. EP who believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them. 3. EP who believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure. 4. EP who believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.

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		excluded from recording height and weight. ***Change / Exclusion:*** *[Required – 2014 Onward]* *Any EP who:* *1. Sees no patients 3 years or older is excluded from recording blood pressure;* *2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;* *3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or* *4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.*		
Record smoking status for patients	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" recorded as structured data **Exclusion:** Any EP who sees no patients 13 years or older during the EHR reporting period qualifies for an exclusion from this objective/measure	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 during the EHR reporting period have smoking status recorded as structured data **Exclusion:** Any EP who sees no patients 13 years old or older.

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Implement clinical decision support	Implement one clinical decision support rule relevant to specialty or high clinical priority with the ability to track compliance to that rule.	Implement one clinical decision support rule	Use clinical decision support to improve performance on high priority health conditions	EPs must satisfy **both** measures in order to meet the objective: 1. Implement **5** clinical decision support interventions related to **4** or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent 4 clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency. 2. The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. **Exclusion for this second measure:** Any EP who writes fewer than 100 medication orders during the EHR reporting period.
Incorporate clinical lab-test results into EHR as structured data	Incorporate clinical lab-test results into Certified EHR Technology as structured data.	More than **40**% of all clinical lab tests 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 (MENU) **Exclusion:** An EP who orders no lab tests whose results are either in a positive /negative or numeric format during the EHR reporting period qualifies for an exclusion from this objective/measure	Incorporate clinical lab-test results into Certified EHR Technology as structured data	More than **55**% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data **Exclusion:** Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

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Generate lists of patients by specific conditions	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 (MENU)	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	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. (MENU) **Exclusion:** An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology qualifies for an exclusion from this objective/measure	Use clinically relevant information to identify patients who should receive reminders for preventive / follow-up care and send these patients the reminders, per patient preference	More than **10**% of all unique patients who have had two or more office visits with the EP within 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available Use Certified EHR Technology to identify and provider reminders for preventive/follow up care. **Exclusion:** Any EP who has had no office visits in the 24 months before the EHR reporting period.
Provide patients with electronic access to their 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 EP who request an electronic copy of their health information are provided it within 3 business days **Exclusion:** Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) (e.g., lab test results, problem list, medication list, medication allergy list, immunizations, and procedures) during the EHR	Provide patients the ability to view online, download, and transmit their health information within **4 business days** of the information being available to the EP In order to meet this objective, the following information must be made available to patients electronically within 4	2 measures, **both** of which must be satisfied in order to meet the objective: 1. More than **50**% of all unique patients seen by the EP during the EHR reporting period are provided timely (within **4 business days** after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. 2. More than **5**% of all unique patients seen by the EP during the EHR reporting period (or

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		reporting period qualifies for an exclusion from this objective/measure ***Change:*** *[Required - 2014 Onward]* *1. Provider patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.* *2. More than **50**% of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information.*	business days of the information being made available to the EP: ● Patient name. ● Provider's name and office contact information. ● Current and past problem list. ● Procedures. ● Laboratory test results. ● Current medication list and medication history. ● Current medication allergy list and medication allergy history. ● Vital signs (height, weight, blood pressure, BMI, growth charts). ● Smoking status. ● Demographic information (preferred language, sex, race, ethnicity, date of birth). ● Care plan field(s), including goals and instructions, and ● Any known care team members including the primary care provider (PCP) of record. An EP can make available additional information and still align with the objective. In circumstances where there is no information	their authorized representatives) view, download or transmit to a third party their health information. **Exclusions:** Any EP who neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient name" and "Provider's name and office contact information," is excluded from both measures. Any EP who conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may be excluded only from the second measure.

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			available to populate one or more of the fields listed above, either because the EP can be excluded from recording such information (for example, vital signs) or because there is no information to record (for example, no medication allergies or laboratory tests), the EP may have an indication that the information is not available and still meet the objective and its associated measure.	
Provide clinical summaries for patients	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**. An office visit is defined as any billable visit that includes: 1) Concurrent care or transfer of care visits, 2) Consultant visits and 3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider **Exclusion:** Any EP who has no office visits during the EHR reporting period.	Provide clinical summaries for patients for each office visit The following information (or an indication that there is no information available) is required to be part of the clinical summary for Stage 2: ● Patient name. ● Provider's name and office contact information. ● Date and location of the visit. ● Reason for the office visit. ● Current problem list. ● Current medication list. ● Current medication allergy list. ● Procedures performed	Clinical summaries provided to patients or patient-authorized representatives within **1 business day** for more than **50**% of office visits. **Exclusion:** Any EP who has no office visits during the EHR reporting period.

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			during the visit. ● Immunizations or medications administered during the visit. ● Vital signs taken during the visit (or other recent vital signs). ● Laboratory test results. ● List of diagnostic tests pending. ● Clinical instructions. ● Future appointments. ● Referrals to other providers. ● Future scheduled tests. ● Demographic information maintained within CEHRT (sex, race, ethnicity, date of birth, preferred language). ● Smoking status ● Care plan field(s), including goals and instructions. ● Recommended patient decision aids (if applicable to the visit).	
Provide 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 seen by the EP are provided patient specific education resources (MENU) **Exclusion:** None	Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient if appropriate	Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than **10**% of all unique patients with office visits seen by the EP during the EHR reporting period **Exclusion:** Any EP who has no office visits during the EHR reporting period.

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Use secure messaging **NEW**	N/A	N/A	Use secure electronic messaging to communicate with patients on relevant health information	A secure message was sent using the electronic messaging function of Certified EHR Technology by more than **5**% of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period. **Exclusion:** Any EP who meets **1 or more** of the following criteria is excluded from this objective: 1. Any EP who has no office visits during the EHR reporting period; and/or 2. Any EP who conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of their EHR reporting period.
Medication reconcil-iation	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. (MENU) **Exclusion:** An EP who was not the recipient of any transitions of care during the EHR reporting period qualifies for an exclusion from this objective/measure	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. **Exclusion:** Any EP who was not the recipient of any transitions of care during the EHR reporting period.

Requirement	Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Provide summary care record for each transition of care and referral	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care and referral	The EP who transitions or refers their patient to another setting of care or provider of care should provide summary of care record for more than **50**% of transitions of care and referrals. (MENU) **Exclusion:** An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period qualifies for an exclusion from this objective/measure	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral All summary of care documents used to meet this objective must include the following information if the EP knows it: ● Patient name. ● Referring or transitioning provider's name and office contact information (EP only). ● Procedures. ● Encounter diagnosis ● Immunizations. ● Laboratory test results. ● Vital signs (height, weight, blood pressure, BMI). ● Smoking status. ● Functional status, including activities of daily living, cognitive and disability status ● Demographic information (preferred language, sex, race, ethnicity, date of birth). ● Care plan field, including goals and instructions.	EPs must satisfy **all 3** measures in order to meet the objective: 1. The EP who 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 EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than **10**% of such transitions and referrals either (a) electronically transmitted using Certified EHR Technology to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. 3. 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 successful tests with the CMS-designated test EHR during the EHR reporting period. **Exclusion:** Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is

Requirement	Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
			● Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider. ● Reason for referral In circumstances where there is no information available to populate one or more of the fields listed above, either because the EP can be excluded from recording such information (for example, vital signs) or because there is no information to record (for example, laboratory tests), the EP may leave the field(s) blank and still meet the objective and its associated measure. In addition, all summary of care documents used to meet this objective must include the following in order to be considered a summary of care document for this objective: ● Current problem list (Providers may also include historical problems at their discretion)	excluded from all three measures.

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			● Current medication list, and ● Current medication allergy list. An EP must verify these three fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP as of the time of generating the summary of care document.	
Submit electronic data to immuniz-ation registries	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to 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) (MENU) **Exclusion:** An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically qualifies for an exclusion from this objective/measure	Capability to submit electronic data to immunization registries or immunization information systems 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. **Exclusions:** Any EP who meets **1 or more** of the following criteria is excluded from this objective: 1. The EP does not administer any of the immunizations to any of the populations for which data is collected by the jurisdiction's immunization registry or immunization information system during the EHR reporting period; 2. The EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for Certified EHR Technology at the start of his or her EHR

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				reporting period; 3. The EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; 4. The EP operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by Certified EHR Technology at the start of his or her EHR reporting period can enroll additional EPs. The second exclusion will not apply if an entity designated by the immunization registry or immunization information system can receive electronic immunization data submissions. For example, if the immunization registry cannot accept the data directly or in the standards required by the Certified EHR Technology, but if it has designated a Health Information Exchange (HIE) to do so on their behalf and the HIE is capable of accepting the information in the standards required by the Certified EHR Technology, the provider could not claim the second exclusion.
Protect electronic health information created or maintained by the certified EHR Technology through the implementati	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 in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process

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on of Appropriate technical capabilities				
Report ambulatory quality measures to CMS or the States	Report ambulatory clinical quality measures (CQMs) to CMS or the States	For 2011 and 2012, provide aggregate numerator and denominator through attestation. ***Change:*** *[Required – 2013 Onward]* *CMS eliminates this objective from CORE requirements. Clinical quality measure reporting will be a standalone requirement under meaningful use.* *Through 2013, EPs must report on three core clinical quality measures. Insofar as the denominator for one or more of the core measures is zero, EPs must report results for up to three alternate core measures. If all six of the core/alternate core clinical quality measures have zeros for the denominators (this would imply that the physician's patient population is not addressed by these measures) then the EP is still required to report on three additional clinical measures. And if three additional measures are not applicable (as evidenced by a zero on the summary report), the EP*	No longer a separate objective for Stage 2, but EPs must submit CQMs to CMS or the States in order to achieve meaningful use.	Starting in 2014, EPs must report on a total of nine clinical quality measures from at least three of the National Quality Strategy domains out of a potential list of sixty-four CQMs across six domains. Unlike Stage 1 meaningful use, CMS is not requiring the submission of a core set of CQMs, but rather identifies a core set of nine CQMs focusing on adult populations with a particular focus on controlling blood pressure and is also recommending a core set of nine CQMs for pediatric populations. EPs should report on these recommended CQMs if they are representative of their clinical practice and patient population. Alternatively, EPs can satisfy the CQM reporting component of meaningful use if they submit and satisfactorily report CQMs under the PQRS' EHR Reporting Option. CMS modified the reporting period for CQMs in 2014. Specifically, CMS will allow three-month quarters (e.g., January-March) as the reporting period in 2014 for EPs who are beyond their first year of demonstrating meaningful use. This is only applicable for year 2014. For 2015 and beyond, CMS will require one year of reporting CQMs. Note that EPs choosing to report CQMs through the PQRS EHR option for Stage 2 would be subject to the reporting periods established

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		will need to further demonstrate that no additional measures apply.		under the PQRS program, which is one calendar year (January 1 – December 31). For the Medicare EHR meaningful use incentive program, EPs in their first year of demonstrating meaningful use must submit their CQM data via attestation, and those beyond their first year must submit their CQM data electronically via a CMS-designated transmission method. Starting in 2014, all CQMs must be submitted electronically to CMS (if technically feasible).

Requirement	Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
MENU				

Requirement	Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Make imaging results available through EHR **NEW**	N/A	N/A	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through through Certified EHR Technology	More than **10**% of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through Certified EHR Technology. **Exclusion:** Any EP who meets **1 or more** of the following criteria is excluded from this objective: 1. Any EP who orders less than 100 tests whose result is an image during the EHR reporting period; and/or 2. Any EP who has no access to electronic imaging results at the start of the EHR reporting period.
Record patient and family information **NEW**	N/A	N/A	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. **Exclusion:** Any EP who has no office visits during the EHR reporting period.
Record electronic notes in patient records **NEW**	N/A	N/A	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 with at least one office visit during the EHR reporting period. Electronic progress notes must be text-searchable. Nonsearchable, notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with searchable notes under this measure.

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Provide electronic syndromic surveillance data to public health agencies	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 and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically) **Exclusion:** An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically qualifies for an exclusion from this objective/measure	Capability to submit electronic syndromic surveillance data to public health agencies 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. **Exclusions:** Any EP who meets **1 or more** of the following criteria is excluded from this objective: (1) the EP is not in a category of providers who collect ambulatory syndromic surveillance information on their patients during the EHR reporting period; (2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by Certified EHR Technology at the start of their EHR reporting period; (3) the EP operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data; or (4) the EP operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional EPs.

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				The third and fourth exclusions do not apply if the public health agency has designated an HIE to collect this information on its behalf and that HIE can do so in the specific Stage 2 standards and/or the same standard as the provider's Certified EHR Technology.
Cancer registry reporting **NEW**	N/A	N/A	Capability to identify and report cancer cases to a public health central 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 public health central cancer registry for the entire EHR reporting period **Exclusions:** Any EP who meets **1 or more** of the following criteria is excluded from this objective: 1. The EP does not diagnose or directly treat cancer; or 2. The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for Certified EHR Technology at the beginning of their EHR reporting period. 3. The EP operates in a jurisdiction where no public health agency provides information timely on capability to receive electronic cancer case information. 4. The EP operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required for Certified EHR Technology at the beginning of their EHR reporting period

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				can enroll additional EPs.
Non-cancer registry reporting **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 **Exclusions:** Any EP who meets **1 or more** of the following criteria is excluded from this objective: 1. The EP does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible, or the public health agencies in their jurisdiction; 2. The EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible is capable of receiving electronic specific case information in the specific standards required by Certified EHR Technology at the beginning of their EHR reporting period; 3. The EP operates in a jurisdiction where no public health agency or national specialty society for which the EP is eligible provides information timely on capability to receive information into their specialized registries; 4. The EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society

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				for which the EP is eligible that is capable of receiving electronic specific case information in the specific standards required by Certified EHR Technology at the beginning of his or her EHR reporting period can enroll additional EPs.

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OBJECTIVES / MEASURES THAT WERE DELETED OR MERGED INTO OTHER REQUIREMENTS AND MENU RULE CHANGE				
Drug-drug and drug-allergy checks	Implement drug-drug and drug-allergy interaction checks	The EP 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
Maintain an up-to-date problem list of current and active diagnoses	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	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
Maintain active medication list	Maintain active medication list	More than **80**% of all unique patients seen by the EP 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

Maintain active medication allergy list	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
Implement drug-formulary checks	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. (MENU)	No longer a separate objective for Stage 2	This measure is incorporated into the e-prescribing measure for Stage 2
Provide patients with electronic access to their health information	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request (electronic copy must be in an electronic form---patient portal, PHR, CD, USB, etc.)	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 ***Change:*** *[Required – 2014 Onward]* *Replaced and incorporated into Stage 2 measure / objective addressing patients ability to view online, download, or transmit their health information*	This objective is eliminated from Stage 1 in 2014 and is no longer an objective for Stage 2	This measure is eliminated from Stage 1 in 2014 and is no longer a measure for Stage 2 See Stage 2 objective/measure on addressing patients ability to view online, download, or transmit their health information.
Exchange key clinical information	Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information ***Change:*** *[Required – 2013 Onward]* *Objective is no longer required.*	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

	providers of care and patient authorized entities electronically.			
Meeting Exclusions	Meeting an exclusion for a menu set objective counts towards the number of menu set objectives that must be satisfied to meet meaningful use	***Change:*** *[Required – 2014 Onward]* *Beginning in 2014, EPs will no longer be permitted to count an exclusion toward the minimum of 5 menu objectives on which they must report if there are other menu objectives which they can select. In other words, a physician cannot select a menu objective and claim an exclusion for it if there are other menu objectives they can meet.*	Rules for meeting an exclusion for a menu set objective change in 2014	Beginning in 2014, EPs will no longer be permitted to count an exclusion toward the minimum of 5 menu objectives on which they must report if there are other menu objectives which they can select. In other words, a physician cannot select a menu objective and claim an exclusion for it if there are other menu objectives they can meet.