Appendix B
Proposed Stage 2 Meaningful Use Objectives for Eligible Professionals

Proposed Objective	Proposed Measure
Core set	
Computer provider order entry for medication, laboratory, and radiology orders directly entered by any licensed health care 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, laboratory, and radiology orders created by the EP during the EHR reporting period are recorded using computer provider order entry
Generate and transmit permissible prescriptions electronically	More than 65% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using certified EHR technology
Record the following demographics: preferred language, gender, race and ethnicity, and 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 and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0–20 years, including BMI	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
Record smoking status for patients 13 years of age 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
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 5 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period 2. The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients within 24 hours for more than 50% of office visits
Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities	None

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Proposed Objective	Proposed 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 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
Use clinically relevant information to identify patients who should receive reminders for preventive/followup care	More than 10% of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference
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	Both must be satisfied: 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 10% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information
Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient	Patient-specific education resources identified by the Certified EHR Technology are provided to patients for more than 10% of all office visits by the EP
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 65% of transitions of care in which the patient is transitioned into the care of the EP
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	EPs must satisfy both measures: 1. The EP who transitions or refers patients to another setting of care or provider of care provides a summary of care record for more than 65% of transitions of care and referrals 2. The EP who transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using Certified EHR Technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10% of transitions of care and referrals.

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Proposed Objective	Proposed 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
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 10% of unique patients seen by the EP during the EHR reporting period
Menu set	
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
Imaging results and information are accessible through Certified EHR Technology	More than 40% of all scans and tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through Certified EHR Technology
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
Capability to identify and report cancer cases to a State 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 cancer registry for the entire EHR reporting period
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

EHR = electronic health record; EP = eligible professional.