Stage 1 Meaningful Use Objectives and Associated Measures

Sorted by Core and Menu Set

15 CORE MEASURES

Health Outcomes Policy Priorities	#	Objective	Measure
Improving Quality, Safety, Efficiency & Reducing Disparities	1	Use Computer Physician Order Entry (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.
	2	Implement drug-drug and drug-allergy interaction checks.	The EP has enabled this functionality.
	3	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 patient recorded as structured data.
	4	Generate and transmit permissible prescriptions electronically (eRx).	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
	5	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.
	6	Record and chart changes in vital signs: - Height - Weight - Blood Pressure - Calculate and display BMI, - Plot and display growth charts for children ages 2-20 years, including BMI	More than 50% of all unique patients age 2 and over seen by the EP, height, weight and BP are recorded as structured data.
	7	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.
	8	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.
	9	Record smoking status for patients 13 and older.	More than 50% of all unique patients 13 years or older seen by the EP have smoking status recorded as structured data.
	10	Implement one clinical decision support rulesrelevant to specialty or high clinical priority along with the ability to track compliance with that rules.	Implement one clinical decision support rule.
	11	Report ambulatory clinical measures to CMS or the States.	For 2011, an EP would provide the aggregate numerator and denominator through *attestation* as discussed in section II(A)(3) of the final rule. For 2012, electronically submit the clinical quality measures as discussed in section II(A)(3) of the final rule.
Engage Patients & Families in Their Health Care	12	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and medication allergies) upon request.	More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days.
	13	Provide clinical summaries to 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	14	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and 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 & Security	15	Protect electronic health information created or maintained using certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per the 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its rish management process.

Stage 1 Meaningful Use Objectives and Associated Measures

Sorted by Core and Menu Set

MENU SET (Choose 5)			
Health Outcomes Policy Priorities	**#**	**Objective**	**Measure**
Improving Quality, Safety, Efficiency, and Reducing Health Disparities	**1**	Implement drug-formulary checks.	The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary.
	2	Incorporate clinical lab-test results into 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.
	3	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.
	4	Send reminders to patients per patient preference for preventative/ 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 Health Care	**5**	Provide patients with timely electronic access to their health information (including lab results, problem list, 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 within 4 business days of being updated in the certified EHR) electronic access to their health information subject to the EP's discretion to withhold certain information.
Improve Care Coordination	**6**	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 during the reporting period are provided patient-specific education resources.
	7	The EP who received a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	Perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.
	8	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 of care record for each transition of care or 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 of care record for each transition of care or referral.
Improve Population and Public Health	**9**	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 information electronically).
	10	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 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).