

# Meaningful Use Stage 1 Measures

If you are an Eligible Professional (EP) seeking incentives for the meaningful use of EHRs, you must meet 20 out of 25 established objectives specified by CMS. 15 are core objectives that all

providers must meet to satisfy the measure or the exclusion. The 5 additional measures must come from the list of 10 menu objectives.

	Core Objectives	Menu Objectives
Meaningful Use Objectives	15 Required	5 out of 10 Selected

The CMS Medicare and Medicaid EHR incentive programs provide a financial reward for the meaningful use of certified EHRs to achieve health and efficiency goals. The criteria for meaningful use will be staged in three steps over the

course of the next five years. This worksheet addresses Stage 1 meaningful use as presented in the 2010 CMS Final Rule.

Core Measure Set (Must Pass All)		
Objective	Measure	Exclusion
Record patient demographics (sex, race, ethnicity, date of birth, preferred language)	More than 50% of patients' demographic data recorded as structured data	None
Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)	More than 50% of patients 2 years of age or older have height, weight, and blood pressure recorded as structured data	An EP who either sees no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice
Maintain up-to-date problem list of current and active diagnoses	More than 80% of patients have at least one entry recorded as structured data	None
Maintain active medication list	More than 80% of patients have at least one entry recorded as structured data	None
Maintain active medication allergy list	More than 80% of patients have at least one entry recorded as structured data	None

To learn more about Stage 1 Measures contact the New York eHealth Collaborative (NYeC). Visit [www.nyehealth.org](http://www.nyehealth.org) or email us at [recinfo@nyehealth.org](mailto:recinfo@nyehealth.org).

<b>Core Measure Set (Must Pass All)</b>		
<b>Objective</b>	<b>Measure</b>	<b>Exclusion</b>
Record smoking status for patients 13 years of age or older	More than 50% of patients 13 years of age or older have smoking status recorded as structured data	An EP who sees no patients 13 years or older
Provide patients with clinical summaries for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days	An EP who has no office visits during the EHR reporting period
On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies)	More than 50% of requesting patients receive electronic copy within 3 business days	An EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period
Generate and transmit permissible prescriptions electronically	More than 40% are transmitted electronically using certified EHR technology	An EP who writes fewer than 100 prescriptions during the EHR reporting period
Computer provider order entry (CPOE) for medication orders	More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE	An EP who writes fewer than 100 prescriptions during the EHR reporting period
Implement drug-drug and drug-allergy interaction checks	Functionality is enabled for these checks for the entire reporting period	None
Implement capability to electronically exchange key clinical information among providers and patient-authorized entities	Perform at least one test of EHR's capacity to electronically exchange information	None
Implement one clinical decision support rule and ability to track compliance with this rule	One clinical decision support rule implemented	None
Implement systems to protect privacy and security of patient data in the EHR	Conduct or review a security risk analysis, implement security updates as necessary, and correct identified security deficiencies	None
Report clinical quality measures to CMS or states	For 2011, provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures	None

Menu Measure Set (Select 5 out of 10) 1 of the 5 Must be a Public Health Objective (designated as *PH*)		
Objective	Measure	Exclusion
Implement drug formulary checks	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period	None
Incorporate clinical laboratory test results into EHRs as structured data	More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one listing of patients with a specific condition	None
Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate	More than 10% of patients are provided patient-specific education resources	None
Perform medication reconciliation between care settings	Medication reconciliation is performed for more than 50% of transitions of care	An EP who was not the recipient of any transitions of care during the EHR reporting period
Provide summary of care record for patients referred or transitioned to another provider or setting	Summary of care record is provided for more than 50% of patient transitions or referrals	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period
Send reminders to patients (per patient preference) for preventive and follow-up care	More than 20% of patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology
Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies)	More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR	An EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) during the EHR reporting period
<b>*PH*</b> Submit electronic immunization data to immunization registries or immunization information systems	Perform at least one test of data submission and follow-up submission (where registries can accept electronic submissions)	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically
<b>*PH*</b> Submit electronic syndromic surveillance data to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)	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