Appendix A
Stage 1 Meaningful Use Objectives for Eligible Professionals

Objective	Measure
Core set	
Record patient demographics (sex, race/ethnicity, date of birth, preferred language)	More than 50% of patients' demographic data recorded as structured data
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
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
Maintain active medication list	More than 80% of patients have at least one entry recorded as structured data
Maintain active medication allergy list	More than 80% of patients have at least one entry recorded as structured data
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
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
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
Generate and transmit permissible prescriptions electronically	More than 40% are transmitted electronically using certified EHR technology
Computer provider order entry for medication orders	More than 30% of patients with at least one medication in their medication list have at least one medication ordered through computer provider order entry
Implement drug-drug and drug-allergy interaction checks	Functionality is enabled for these checks for the entire reporting period
Implement capability to electronically exchange key clinical information among providers and patient-authorized entities	Perform at least one test of EHRs' capacity to electronically exchange information
Implement one clinical decision support rule and ability to track compliance with the rule	One clinical decision support rule implemented
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
Report clinical quality measures to CMS or States	Provide aggregate numerator and denominator through attestation

(continued)

Objective	Measure
Menu Set	
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
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
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
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
Perform medication reconciliation between care settings	Medication reconciliation is performed for more than 50%of transitions of care
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
Submit electronic immunization data to immunization registries or immunization information systems	Perform at least one test of data submission and followup submission (where registries can accept electronic submissions)
Submit electronic syndromic surveillance data to public health agencies	Perform at least one test of data submission and followup submission (where public health agencies can accept electronic data)
Send reminders to patients (per patient preference) for preventive and followup care	More than 20% of patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders
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

EHR = electronic health record.

Source: Blumenthal D, Tavenner M. The 'Meaningful Use' regulation for electronic health records. N Engl J Med 2010 363:501-504. Available at: http://www.nejm.org/doi/full/10.1056/NEJMp1006114.