Eligible Hospital and Critical Access Hospital Meaningful Use Core Measures
Measure 4 of 11

Stage 1 (2014 Definition)
Last updated: May 2014

Active Medication List	
Objective	Maintain active medication list.
Measure	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Exclusion	No exclusion.

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Definition of Terms

Active Medication List – A list of medications that a given patient is currently taking.

Admitted to the Emergency Department – There are two methods for calculating ED admissions for the denominators for measures associated with Stage 1 of Meaningful Use objectives. Eligible hospitals and CAHs must select one of the methods below for calculating ED admissions to be applied consistently to all denominators for the measures. That is, eligible hospitals and CAHs must choose either the "Observation Services method" or the "All ED Visits method" to be used with all measures. Providers cannot calculate the denominator of some measures using the "Observation Services method," while using the "All ED Visits method" for the denominator of other measures. Before attesting, eligible hospitals and CAHs will have to indicate which method they used in the calculation of denominators.

Observation Services method. The denominator should include the following visits to the ED:

- The patient is admitted to the inpatient setting (place of service (POS) 21) through the ED. In this situation, the orders entered in the ED using certified EHR technology would count for purposes of determining the computerized provider order entry (CPOE) Meaningful Use measure. Similarly, other actions taken within the ED would count for purposes of determining Meaningful Use.

- The patient initially presented to the ED and is treated in the ED's observation unit or otherwise receives observation services. Details on observation services can be found in the Medicare Benefit Policy Manual, Chapter 6, Section 20.6. Patients who receive observation services under both POS 22 and POS 23 should be included in the denominator.

All ED Visits method. An alternate method for computing admissions to the ED is to include all ED visits (POS 23 only) in the denominator for all measures requiring inclusion of ED admissions. All actions taken in the inpatient or emergency departments (POS 21 and 23) of the hospital would count for purposes of determining meaningful use.

Unique Patient – If a patient is admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term ''unique patient'' relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

- NUMERATOR: Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an eligible hospital or CAH to meet this measure.

Additional Information

- For patients with no active medications, an entry must still be made to the active medication list indicating that there are no active medications.
- A provider is not required to update this list at every contact with the patient. The provider can then use their clinical judgment to decide when additional updating is necessary.

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§170.314(a)(6) Medication list	Enable a user to electronically record, change, and access a patient's active medication list as well as medication history: (i) Ambulatory setting. Over multiple encounters; or (ii) Inpatient setting. For the duration of an entire hospitalization

*Additional certification criteria may apply. Review the ONC 2014 Edition EHR Certification Criteria Grid Mapped to Meaningful Use Stage 1 for more information.

Standards Criteria
N/A