Eligible Professional Meaningful Use Core Measures Measure 5 of 13

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 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.
Exclusion	No exclusion.

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Definition of Terms

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

Unique Patient – If a patient is seen by an EP more than once during the HER 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 HER reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients seen by the EP during the HER 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 EP 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.
- An EP is not required to update this list at every contact with the patient. The EP can then use his or her clinical judgment to decide when additional updating is required.

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