MU Criteria	%	Denominator	Numerator	Meeting Measure in PCC EHR	Exclusions
CPOE (Computerized Provider Order Entry) For Medication Orders CMS measure I	>30	Number of unique patients with at least one medication in their medication history seen by the EP (eligible professional) during the EHR reporting period.	The number of patients that have at least one medication ordered using CPOE	The provider must use Dr. First to prescribe medications. If a patient's medication history includes only medications entered as historical medications, that patient will not count in the numerator.	None
Transmit Permissible Prescription Electronically CMS measure IV	>40	Number of prescriptions written for drugs that require a prescription in order to be dispensed during the measurement period.	The number of prescriptions generated and transmitted electronically.	The provider must use Dr. First to prescribe medications. The report will reference a list of medications that cannot be prescribed electronically when calculating this measure.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
Record Demographics (Preferred language, gender, race, ethnicity and date of birth) CMS measure VII	>50	Number of unique patients seen by the EP during the EHR reporting period.	Number of patients who have all five elements of demographic information recorded.	The patient must have all five pieces of information entered in order to qualify for this measure. The demographic information can be entered in the EHR or in Partner (checkin, notjane, addpatient).	None
Maintain Up-to-Date Problem List CMS measure III	>80	Number of unique patients seen by the EP during the EHR reporting period.	Number of patients who have at least one entry or an indication that no problems are known for this patient.	If a patient has a blank problem list, they will not meet this measure. If the patient doesn't have any active problems, the provider must choose the “No known problems” option from the drop-down list.	None
Active Medication List CMS measure V	>80	Number of unique patients seen by the EP during the EHR reporting period.	Number of patients who have a medication or an indication that the patient is currently not prescribed any medications.	If a patient has a blank medication history list, they will not meet this measure. In Dr. First there is a section for Medication history which contains two selectable options: Unknown or Incomplete or Patient Takes No Medications. If a patient doesn't take any medications, the second option should be set.	None
Active Medication Allergy List CMS measure VI	>80	Number of unique patients seen by the EP during the EHR reporting period.	Number of patients who have at least one entry or an indication that no known drug allergies (NKDA) recorded.	The medication allergy information is set in Dr. First. If a patient doesn't have any medication allergies, the provider must select the NKDA status for the patient.	None

MU Criteria	%	Denominator	Numerator	Meeting Measure in PCC EHR	Exclusions
Record and Chart Changes in Vital Signs CMS measure VIII	>50	Number of unique patients age 2 and older seen by the EP during the EHR reporting period.	Number of patients who have at least one entry of their height, weight, blood pressure and BMI recorded.	The patient must have all four pieces of information entered to meet the measure. All four entries do not have to be entered in the same visit. The measure will look back to previous visits to gather vital information.	None
Record Smoking Status CMS measure IX	>50	Number of unique patients age 13 and older seen by the EP during the EHR reporting period	Number of patients with smoking status recorded.	There is a new component: Smoking Status (ARRA) that should be added to your protocols. The list cannot be edited, the options are mandated by CMS.	Any EP who does not see patients age 13 and older.
Electronic Access CMS additional measure V	>10	Number of unique patients seen by the EP during the EHR reporting period.	Number of patients who have timely (available within four business days) electronic access to their health information online.	This measure currently cannot be calculated in the EHR because it is dependent on the patient portal.	Any EP who doesn't orders lab tests or information that would be contained in the problem, medication, or medication allergy list during the EHR reporting period.
Provide Clinical Summaries to Patients for Each Visit CMS measure XIII	>50	Number of office visits by the EP during the EHR reporting period.	Number of office visits for which patients received a clinical summary within three business days.	The patient visit summary needs to be printed or saved as a PDF for at least 50% of visits. The visit doesn't need to be signed before the visit summary is generated, but the visit does need to be signed before the patient will count for the measure.	Any EP who has no office visits during the EHR reporting period.
Incorporate Lab Test Results as Structured Data CMS additional measure II	>40	Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed as structured data.	Number of lab results whose results are expressed in a positive or negative affirmation or as a number.	This measure tracks individual lab tests, not labs. You can use the lab configuration tool to assign tests to your labs.	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.
Sent Reminders to Patients CMS additional measure IV	>20	Number of patients 65 years old and older or 5 years old and younger seen by the EP during the EHR measurement period.	Number of patients who were sent the appropriate reminder.	The reminders can be for appointment reminders or for preventive care. The reminders must be generated in the EHR to qualify for the measure.	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.

MU Criteria	%	Denominator	Numerator	Meeting Measure in PCC EHR	Exclusions
Provide Electronic Copy of Health Information CMS measure XII	>50	Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.	Number of patients who receive an electronic copy of their electronic health information within three business days of the date they requested the information.	The patient has to have a visit signed by the EP, but the signed visit doesn't have to be during the measurement period. The report must be saved as a PDF in order to qualify.	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.
Provided Patient Education Resources CMS additional measure VI	>10	Number of unique patients seen by the EP during the EHR reporting period.	Number of patients who are provided patient-specific education resources.	The patient education must be generated using the EHR. The provider will click Patient Education under the reports menu. The three drop-down menus on the screen will populate the patient's: Problems, Medications and Lab Tests. You must select an item from a drop-down menu and then print in order for the patient to meet the measure.	None.
Performed Medication Reconciliation for Transitions of Care CMS additional measure VII	>50	Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.	Number of transitions of care where a medication reconciliation was performed	There is a new component called Transition of Care (ARRA). It contains two check boxes. Checking the first box puts the patient in the denominator, checking the second box puts them in the numerator.	An EP who was not the recipient of any transitions of care during the EHR reporting period.
Provide Summary of Care for Transitions of Care CMS additional measure VIII	>50	Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.	Number of transitions of care and referrals where a summary of care record was provided.	Any referral ordered using the Referral component in the EHR will automatically populate the denominator of the measure. There is a new drop-down field when generating the health information summary that will allow you to select the referral or other transition of care for the measure.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.