PCC Pediatric EHR Solutions

2014 Meaningful Use Stage 1 Core Objectives

MU Criteria	%	Denominator	Numerator	Meeting Measure in PCC EHR	Exclusions
CPOE (Computerized Provider Order Entry) For Medication Orders Objective 1 of 13	>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. Optional Alternative: The number of medication orders created by the EP during the EHR reporting period.	The number of patients in the denominator that have at least one medication ordered using CPOE. Optional Alternative: The number of medication orders in the denominator that are recorded using CPOE.	The provider must use PCC eRx 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
Implement drug-drug and drug-allergy interaction checks Objective 2 of 13	N/A	N/A (Attestation)	N/A (Attestation)	Eligible professionals (EPs) must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure. This is a built-in default for PCC eRx.	None
Maintain Up-to-Date Problem List Objective 3 of 13	>80	Number of unique patients seen by the EP during the EHR reporting period.	Number of patients who have at least one active problem or an indication that are "No Known Problems" 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. The problem list entries can be recorded before, during or after the reporting period.	None

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Transmit Permissible Prescriptions Electronically Objective 4 of 13	>40	Number of prescriptions written for drugs that require a prescription in order to be dispensed during the measurement period. Prescriptions for controlled substances are not included.	The number of prescriptions in the denominator generated and transmitted electronically.	The provider must use PCC eRx to prescribe medications. Provider entries in the Partner table need to be appropriately mapped to EHR users for this measure to report accurately.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period. If there is not a pharmacy within your organization and there are no pharmacies that accept electronic Rx within 10 miles of your practice location at the start of your EHR reporting period.
Maintain Active Medication List Objective 5 of 13	>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.	In PCC eRx press the "Medications Reviewed" link to ensure medications flow over to PCC EHR. If a patient has a blank medication history list, they will not meet this measure. In PCC eRx 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. The active medications (or indication of no known meds) can be recorded before, during or after the reporting period.	None
Maintain Active Medication Allergy List Objective 6 of 13	>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.	In PCC eRx press "Allergies Reviewed" link to ensure allergies flow over to PCC EHR. If a patient doesn't have any medication allergies, the provider must select the NKDA status for the patient. The medication allergies (or indication of NKDA) can be recorded before, during or after the reporting period.	None

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Record Demographics (Preferred language, gender, race, ethnicity and date of birth) Objective 7 of 13	>50	Number of unique patients seen by the EP during the EHR reporting period.	The number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.	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). The demographic data can be recorded before, during or after the reporting period.	None
Record and Chart Changes in Vital Signs Objective 8 of 13	>50	Number of unique patients seen by the EP during the EHR reporting period.	Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.	Historic growth chart points as well as visit-based height/length and weight will count toward this measure. The patient must have all three pieces of information entered to meet the measure. All three entries do not have to be entered in the same visit. You do not need to record blood pressure for patients under 3 years old. The measure will look back to previous visits to gather vital information.	1. Sees no patients 3 years or older is excluded from recording blood pressure; 2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; 3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or 4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight

MU Criteria	%	Denominator	Numerator	Meeting Measure in PCC EHR	Exclusions
Record Smoking Status for patients 13 years and older Objective 9 of 13	>50	Number of unique patients age 13 and older seen by the EP during the EHR reporting period	Number of patients age 13 and older at time of visit with smoking status recorded as structured data.	The "Smoking Status (ARRA)" component should be added to your protocols used for patients 13 and older. The list cannot be edited, the options are mandated by CMS. The smoking status can be recorded before, during or after the reporting period.	Any EP who does not see patients age 13 and older.
Implement one clinical decision support rule Objective 10 of 13	N/A	N/A (Attestation)	N/A (Attestation)	Eligible professionals (EPs) must attest that they have implemented clinical decision support that can trigger alerts or clinical information when they encounter patients with certain diagnoses or treatments. This can be accomplished using PCC EHR Clinical Alerts	None
Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP. Objective 11 of 13	>50	Number of unique patients seen by the EP during the EHR reporting period.	The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information to view, download, and transmit to a third party.	More than 50% of your patients seen in the reporting period need to have a MyKidsChart user with access to their records.	None

MU Criteria	%	Denominator	Numerator	Meeting Measure in PCC EHR	Exclusions
Provide Clinical Summaries to Patients for Each Visit Objective 12 of 13	>50	Number of office visits conducted by the EP during the EHR reporting period.	Number of office visits in the denominator for which the patient is provided (or declines) a clinical summary within three business days.	The Clinical Summary is the "Patient Visit Summary" which can be printed from the Reports menu or from the "Appointment Details" section at the top of the visit ribbon. You are now given the opportunity to mark the visit summary as declined if the patient does not want one printed. This will count towards the numerator. Patients connected to an active MyKidsChart user at the time of the visit are automatically counted towards the numerator.	None
Protect Electronic Health Information Objective 13 of 13	N/A	N/A (Attestation)	N/A (Attestation)	Conduct or review a security risk analysis of certified EHR technology and implement updates as necessary at least once prior to the end of the EHR reporting period. The testing could occur prior to the beginning of the first EHR reporting period. However, a new review would have to occur for each subsequent reporting period.	None

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2014 Meaningful Use Stage 1 Menu Objectives (Choose 5 of 9)

1 of the chosen 5 must come from Public Health list consisting of the following:

MU Criteria	%	Denominator	Numerator	Meeting Measure in PCC EHR	Exclusions
Submit Electronic Data to Immunization Registries (At Least One Test) Menu Objective 1 of 9	N/A	N/A (Attestation)	N/A (Attestation)	PCC EHR currently submits immunization data to many state registries. Contact PCC support to determine if you are submitting to your state. If not, PCC can generate a test submission for you to pass this measure.	You could be excluded from meeting this objective for either of these reasons: • You don't administer immunizations • There's no immunization registry to which you can send information • It is prohibited
Submit electronic syndromic surveillance data to public health agencies Menu Objective 2 of 9	N/A	N/A (Attestation)	N/A (Attestation)	To attest for this measure, you must work with PCC to test the ability to electronically transmit syndromic surveillance information (e.g., influenza population data) to a public health agency.	You could be excluded from meeting this objective if you don't collect any reportable syndromic data during the EHR reporting period

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The remaining menu objectives must come from the following list:

MU Criteria	%	Denominator	Numerator	How to Meet the Measure in PCC EHR	Exclusions
Drug Formulary Checks Menu Objective 3 of 9	N/A	N/A (Attestation)	N/A (Attestation)	Eligible professionals (EPs) can attest YES to having enabled drug formulary checks for the length of the reporting period to meet this measure. This is a built-in default for PCC eRx.	You can be excluded from meeting this objective if you write fewer than 100 prescriptions during the reporting period.
Incorporate Lab Test Results as Structured Data Menu Objective 4 of 9	>40	Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.	Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data. The lab test results can be incorporated before, during or after the reporting period.	This measure tracks individual lab tests, not lab orders. Use the lab configuration tool to configure discrete lab tests for all lab orders. Any e-lab results received automatically count if positive, negative, or numeric.	You can be excluded from meeting this objective if you did not order any lab tests during the reporting period or if none of the results from the tests you ordered came back as a number or as a positive/negative response.
Generate Lists of Patients with Specific Conditions Menu Objective 5 of 9	N/A	N/A (Attestation)	N/A (Attestation)	Eligible professionals (EPs) can attest YES to this if they have used PCC EHR "Patient Lists" functionality to generate lists of patients based on problems/diagnoses	None
Sent Reminders to Patients Menu Objective 6 of 9	>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 in the denominator who were sent the appropriate reminder.	The reminders can be for appointment reminders or for preventive care. The reminders must be generated using the "Patient Reminders" tool in the EHR to qualify for the measure.	You can be excluded from meeting this objective if you have no patients 65 years or older or 5 years old or younger whose information is in your certified EHR.

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MU Criteria	%	Denominator	Numerator	How to Meet the Measure in PCC EHR	Exclusions
Provided Patient Education Resources Menu objective 7 of 9	>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-specific education resources can be provided before, during or after the reporting period.	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 Menu objective 8 of 9	>50	The number of transitions of care (defined as first encounters with a new patient and encounters with existing patients where a summary of care record of any type is provided to the receiving provider) during the EHR reporting period for which the EP was the receiving party of the transition.	Number of transitions of care in the denominator where medication reconciliation was performed.	Any referral ordered using the Referral component in the EHR will automatically populate the denominator of the measure. More details are coming soon on how to meet this measure.	You can be excluded from meeting this objective if you did not see any patients after they received care from another provider.
Provide Summary of Care for Transitions of Care Menu Objective 9 of 9	>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 in the denominator where a summary of care record was provided. The provision of a Summary of Care record can occur before, during or after the reporting period for transitions of care that occur during the reporting period.	TBD - Details coming soon	You can be excluded from meeting this objective if you don't refer any patients or transfer any patients to another setting for care during the reporting period.

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