



Eligible Hospital and Critical Access Hospital Meaningful Use Core Measures

Measure 7 of 11

Stage 1 (2014 Definition)

Last updated: May 2014

Record Vital Signs

Objective	Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 0-20 years, including BMI
Measure	For more than 50 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.
Exclusion	No exclusion.

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Definition of Terms

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 (age 3 or over for blood pressure) 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 at least one entry of their height, weight and blood pressure (ages 3 and over) recorded as structured data.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an eligible hospital or CAH to meet this measure.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- The only information required to be inputted by the provider or staff is the height, weight, and blood pressure of the patient. The certified EHR technology will calculate BMI and the growth chart if applicable to patient based on age.
- Height, weight, and blood pressure do not have to be updated by the provider at every patient encounter. The provider can make the determination based on the patient's individual circumstances as to whether height, weight, and blood pressure need to be updated.
- Height, weight, and blood pressure can get into the patient's medical record as structured data in a number of ways. Some examples include entry by a physician, entry by hospital staff, transfer of the information electronically or otherwise from another provider, or entered directly by the patient through a portal or other means.

- This specification sheet has been updated to reflect the applicable Stage 1 provisions in the [Stage 2 Meaningful Use Final Rule](#), published on September 4, 2012.

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)(4) Record and chart vital signs	<p>(i) Vital signs. Enable a user to electronically record, change, and access, at a minimum, a patient's height/length, weight, and blood pressure. Height/length, weight, and blood pressure must be recorded in numerical values only.</p> <p>(ii) Calculate body mass index. Automatically calculate and electronically display body mass index based on a patient's height and weight.</p> <p>Optional – Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients.</p>
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*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