Eligible Hospital and Critical Access Hospital Meaningful Use Core Measures
Measure 8 of 11

Stage 1 (2014 Definition)
Last updated: May 2014

Record Smoking Status	
Objective	Record smoking status for patients 13 years old or older.
Measure	More than 50 percent of all unique patients 13 years old or older or admitted to the eligible hospital's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.
Exclusion	Any eligible hospital or CAH that admits no patients 13 years or older to their inpatient or emergency department (POS 21 or 23).

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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 13 or older admitted to the eligible hospital's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

- NUMERATOR: Number of patients in the denominator with smoking status recorded as structured data.

- EXCLUSION: An eligible hospital or CAH that sees no patients 13 years or older would be excluded from this requirement. Eligible hospitals or CAHs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

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.
- If this information is already in the medical record available through certified EHR technology, an inquiry does not need to be made every time a provider sees a patient 13 years old or older. The frequency of updating this information is left to the provider and guidance is provided already from several sources in the medical community.

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)(11) Smoking status	Enable a user to electronically record, change, and access the smoking status of a patient in accordance with the standard specified at §170.207(h)

*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	
§170.207(h)	Coded to one of the following SNOMED CT® codes: (1) Current every day smoker. 449868002 (2) Current some day smoker. 428041000124106 (3) Former smoker. 8517006 (4) Never smoker. 266919005 (5) Smoker, current status unknown. 77176002 (6) Unknown if ever smoked. 266927001 (7) Heavy tobacco smoker. 428071000124103 (8) Light tobacco smoker. 428061000124105