

# Stage 2 Eligible Professional Meaningful Use Core Measures Measure 5 of 17

Date issued: October, 2012

| Record Smoking Status |   |
|-----------------------|---|
| Objective             | Record smoking status for patients 13 years old or older.   |
| Measure               | More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data. |
| Exclusion             | Any EP that neither sees nor admits any patients 13 years old or older.   |

## Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Certification and Standards Criteria

## Definition of Terms

**Unique Patient** – If a patient is seen by an EP 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

### DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

- DENOMINATOR: Number of unique patients age 13 or older seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator with smoking status recorded as structured data.
- THRESHOLD: The resulting percentage must be more than 80 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP that neither sees nor admits any patients 13 years old or older.

## 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.
- This is a check of the medical record for patients 13 years old or older. 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.

- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(a)(11).

## 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).

*\*Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

### Standards Criteria

#### § 170.207(h) Smoking Status

Smoking status must be coded in 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