Stage 2
Eligible Professional
Meaningful Use Menu Set Measures
Measure 4 of 6

Date issued: October, 2012

Family Health History	
Objective	Record patient family health history as structured data.
Measure	More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.
Exclusion	Any EP who has no office visits during the EHR reporting period.

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Definition of Terms

First Degree Relative – A family member who shares about 50 percent of their genes with a particular individual in a family. First degree relatives include parents, offspring, and siblings.

Attestation Requirements

DENOMINATOR / NUMERATOR / THRESHOLD / EXCLUSION

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator with a structured data entry for one or more first-degree relatives.
- THRESHOLD: The resulting percentage must be more than 20 percent in order to meet this measure.
- EXCLUSION: Any EP who has no office visits during the EHR reporting period.

Additional Information

- This measure is a minimum and not a limitation on the health history that can be recorded.
- For patients who are asked about their family health history, but do not know their family history, it is acceptable for the provider to record the patient's family history as "unknown."
- Standards require CEHRT to be able to use SNOMEDCT or the HL7 Pedigree standard to record a patient's family health history.
- Either a structured data entry of "unknown" or any structured data entry identified as part of the patient's family history and conforming to the standards of CEHRT at 45 CFR 170.314(a)(13) must be in the provider's CEHRT for the patient to count in the numerator.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(a)(13).

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)(13) Family health history	Enable a user to electronically record, change, and access a patient's family health history according to: (i) At a minimum, the version of the standard specified in § 170.207(a)(3); or (ii) The standard specified in § 170.207(j).

**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(a)(3)	IHTSDO SNOMED CT® International Release July 2012 (incorporated by reference in § 170.299) and US Extension to SNOMED CT® March 2012 Release (incorporated by reference in § 170.299).
§ 170.207(j) Family health history	HL7 Version 3 Standard: Clinical Genomics; Pedigree, (incorporated by reference in § 170.299).