Stage 2
Eligible Hospital and Critical Access Hospital
Meaningful Use Core Measures
Measure 4 of 16
Date issued: October, 2012

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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 2 of Meaningful Use objectives. Find out more in this FAQ.

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.

Attestation Requirements
DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

- DENOMINATOR: Number of unique patients age 13 or older seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) 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, eligible hospital, or CAH to meet this measure.
- EXCLUSION: Any eligible hospital or CAH 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 (CEHRT), an inquiry does not need to be made every time a hospital admits 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.

<table>
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<th>Certification Criteria*</th>
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<td>§ 170.314(a)(11) Smoking Status</td>
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*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.

<table>
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<tr>
<th>Standards Criteria</th>
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| § 170.207(h) Smoking Status | Smoking status must be coded in one of the following SNOMED 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 |