



Eligible Professional Meaningful Use Core Measures Measure 9 of 13

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 seen by the EP have smoking status recorded as structured data.
Exclusion	Any EP who sees no patients 13 years 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

NUMERATOR / DENOMINATOR/EXCLUSION

- **DENOMINATOR:** Number of unique patients age 13 or older seen by the EP during the EHR reporting period.
- **NUMERATOR:** Number of patients in the denominator with smoking status recorded as structured data.
- **EXCLUSION:** An EP who sees no patients 13 years or older would be excluded from this requirement. EPs must enter ‘0’ in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP 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.
- 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.

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