

# Stage 2

## Eligible Professional

### Meaningful Use Core Measures

#### Measure 4 of 17

Date issued: October, 2012

Record Vital Signs	
<b>Objective</b>	Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.
<b>Measure</b>	More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.
<b>Exclusion</b>	Any EP who: <ol style="list-style-type: none"> <li>(1) Sees no patients 3 years or older is excluded from recording blood pressure.</li> <li>(2) Believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them.</li> <li>(3) Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.</li> <li>(4) Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.</li> </ol>

### 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/EXCLUSIONS

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.
- THRESHOLD: The resulting percentage must be more than 80 percent in order for an EP to meet this measure.



- EXCLUSIONS:
  - (1) Any EP who sees no patients 3 years or older is excluded from recording blood pressure.
  - (2) Any EP who believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them.
  - (3) Any EP who believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.
  - (4) Any EP who believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.

### 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 the EP meets exclusion (3) or exclusion (4) they must both attest to the exclusion and report the numerator and denominator for the remaining elements of the measure.
- The only information required to be inputted by the provider is the height and weight, and/or blood pressure of the patient. The certified EHR technology will calculate BMI and the growth chart if applicable to patient based on age.
- Height, weight, and blood pressure do not have to be updated by the EP at every patient encounter. The EP can make the determination based on the patient’s individual circumstances as to whether height, weight, and blood pressure need to be updated.
- Vital sign information can be entered into the patient’s medical record in a number of ways including: direct entry by the EP; entry by a designated individual from the EP’s staff; data transfer from another provider electronically, through an HIE or through other methods; or data entered directly by the patient through a portal or other means. Some of these methods are more accurate than others, and it is up to the EP to determine the level of accuracy needed to care for their patient and how best to obtain this information.
- In order to meet this objective and measure, an EP must use the capabilities and standards of certified EHR technology (CEHRT) at 45 CFR 170.314(a)(4).

### 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)(4) <b>Record and chart vital signs</b>	(i) Vital signs. Enable a user to electronically record, change, and access, at a minimum, a patient’s height/length, weight, and blood pressure. Height/length, weight, and blood pressure must be recorded in numerical values only. (ii) Calculate body mass index. Automatically calculate and electronically display body mass index based on a patient’s height and weight. (iii) Optional—Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients.

*\*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**

N/A