Stage 1 Meaningful EHR Use via RevolutionEHR
Core 8 – Record Vital Signs

Overview

EHR technology is expected to have a standardized set of patient vital signs recorded. Users are expected to document these vital signs, assuming that they are relevant to the provider's scope of practice: height, weight, and blood pressure.

Certified EHR technology must allow the provider to receive an automatically calculated Body Mass Index (BMI) and plot and display growth charts for children 2-20 years old. These elements do not need to be addressed or utilized to meet this objective.

MU Objective and Calculation

The objective is to have more than 50 percent of patients seen in the reporting period have height and weight (patients all ages) and blood pressure (patients age 3 and over) recorded as structured data. Depending on scope of practice, a provider can comply with capturing all three vital signs, only height/weight, or only blood pressure.

Denominator for calculation: Number of unique patients age 2 and over (at the time of the patient encounter) seen by provider in reporting period
Numerator for calculation: Number of patients in denominator who have the necessary elements documented for vital signs relevant to the provider's scope of care (all three, only height/weight, only blood pressure.)
EXCLUSION: A provider who sees no patients over age 3 would be excluded from blood pressure. Also, a provider who believes that the height/weight, or blood pressure, vital signs have no relevance to their scope of practice would select exclusion from those at the time of attestation.

Meaningful Use Discussion

The documentation of scope-appropriate measurements of height, weight, and blood pressure is required to be input by the provider in the Vital Signs test. BMI and growth charts are automatically calculated by RevolutionEHR.

The Final Rule states that height can be self-reported by the patient, but weight must be measured. Other documentation says that these items can be recorded in a number of ways, including transfer of information electronically from another provider, or entered directly by the patient through a portal or other means. Clearly, the most challenging consideration for ECPs is the documentation of patient weight that creates a number of challenges for doctor, staff, and patients.

ECPs should give careful consideration to their role as primary health care providers before deciding to take an exclusion. The vital signs do not have to be updated at every visit.

Conclusion

Meeting this objective is not expected to be difficult if users establish standards for documenting all three of the vital sign measures.