

Assessing Tobacco Use The National Landscape August 2013

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Executive Summary

- Virtually every healthcare system asks about and documents tobacco use status in the EHR and many regulatory guides mandate the documentation of tobacco use.
- There is tremendous variability in terms of *when* tobacco use is asked about in the patient visit workflow, *how* it is asked, *where* it is documented in the electronic health record (EHR), *how frequently* it is asked about, and whether tobacco use status is a *required field* in the EHR.
- The Meaningful Use (MU) of EHR Incentive Program, part of the Health Information Technology for Economic and Clinical Health (HITECH) Act, has been the chief driver of the near-universal recent requirements for documentation of tobacco use in the EHR. In response to these MU requirements, EHR vendors have worked to meet healthcare customer demand to effectively and efficiently document and report the required core performance objective to record smoking status on patients 13 years and older.
- The most widely used tobacco use status measure in the country today is the **“Record Smoking Status”** item in Meaningful Use. It only requires identification and documentation of smoking status, and does not include documentation of smokeless, e-cigarettes, or other tobacco products. While it does not prescribe how clinicians ask about smoking, it does require use of the following required discrete, structured smoking status Systematized Nomenclature of Medicine (SNOMED) CMS 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

“Current every day smoker” or “Current some day smoker” has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes every day or periodically, yet consistently “Former smoker” has smoked at least 100 cigarettes during his/her lifetime but does not currently smoke

“Never smoker” has not smoked 100 or more cigarettes during his/her lifetime

“Smoker, current status unknown” was known to have smoked at least 100 cigarettes in the past, but whether they currently still smoke is unknown

“Unknown if ever smoked” is self-explanatory

“Heavy smoker” is greater than 10 cigarettes per day or an equivalent (but less concretely defined) quantity of cigar or pipe smoke

“Light smoker” is fewer than 10 cigarettes per day, or an equivalent (but less concretely defined) quantity of cigar or pipe smoke

Definitions from the 2014 Edition EHR Certification Criterion § 170.314(a)(11) (Smoking status). Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology Federal Register/ Vol. 77, No. 171 / Tuesday, September 4, 2012 / Rules and Regulations, Pages 54204-54205. (<http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-20982.pdf>).

Background - Healthcare Landscape

Many aspects of the current healthcare regulatory policy environment (Table 1) mandate that clinicians and healthcare systems identify, document, and treat patients who use tobacco. Chief among these initiatives is the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act that calls for the provision of incentives to clinicians and hospitals that adopt and demonstrate meaningful use of EHR systems focused on quality performance measures, *including documentation of smoking status*. In addition, the 2010 Affordable Care Act mandates coverage of evidence-based tobacco use treatment. In 2012, The Joint Commission (TJC) strengthened inpatient quality performance measures to identify and treat hospitalized patients who use tobacco. Finally, payment reform is another driver of change in the healthcare landscape, one example being Accountable Care Organizations (ACO).

Specifically, policy and regulatory forces that are driving documentation of tobacco use include:

- Meaningful Use of Electronic Health Records Incentive Program (MU)
- The Patient Protection and Affordable Care Act (ACA)
- The Joint Commission (TJC)
- National Quality Forum (NQF)
- The United States Preventive Services Task Force (USPSTF)
- National Committee for Quality Assurance (NCQA)

While there is substantial emphasis on assessing tobacco use among patients visiting healthcare settings, the means by which tobacco use status is assessed is highly variable on a number of dimensions, including:

- Language/text/wording;
- Frequency;
- Whether it is required or not required;
- When it is asked about in the patient visit workflow;
- Who asks the patient about and documents tobacco use status; and,
- How and where it is documented in the electronic health record (EHR).

In the appendices of this document, we provide examples of ways in which tobacco use status is assessed and documented. The most commonly used method, and possibly most important exemplar is the Meaningful Use “Record Smoking Status” (see Appendix 1).

Table 1. Current Healthcare Landscape

Affordable Care Act • Centers for Medicaid and Medicare Services (CMS) • Preventive Services	Standards & Quality Measures • Joint Commission • Registries • NQCA/Patient Centered Medical Home Certification	New Payment Systems • Global Payments • Alternative Quality Contracts
HHS Initiatives • Office of Personnel Management • 130 US health plans	Health Information Technology (HIT) • Meaningful Use (CMS) • Health Information Exchange (HIE)	New Care Delivery Models • Patient-Centered Care Coordination • Patient Center Medical Home • Accountable Care Organizations

Table 1 Source: Thomas Land, Massachusetts Department of Public Health

National/Federal/Private Sector Regulations and Policies That Include Assessment of Tobacco Use

Meaningful Use (MU) of Electronic Health Records (EHR) Incentive Program (See Appendix 1)

The federally-funded MU EHR Incentive Program is currently one of the most important drivers of healthcare system change in the United States. Meaningful Use is an incentive plan that eligible health care professionals and hospitals qualify for through Medicare and/or Medicaid when they adopt certified Electronic Health Record (EHR) technology and use it to achieve specified performance and technology objectives.

For each stage of MU, there are specific performance measures and goals which must be met to achieve MU. Table 2 summarizes the required, core “Record Smoking Status” MU measure for stages 1 and 2.

Table 2. Meaningful Use Stage 1 and Stage 2: Record Smoking Status – Eligible Professionals (EPs)/Hospitals*

Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data	Record smoking status for patients 13 years old or older	More than 80% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data

*EHR must enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; and unknown if ever smoked.

MU goes further than just tobacco use status identification by including a tobacco cessation Clinical Quality Measure (CQM) (Table 3). The MU CQM for tobacco cessation was required in Stage 1, and becomes “recommended” for Stage 2. Eligible Providers (EPs) must report 9 out of 64 total CQMs and Hospitals must report 9 of the 16 total CQMs. The CQM age is 18 (rather than 13 and older in Record Smoking Status) because the evidence for tobacco cessation is strongest for tobacco users 18 and older.

Table 3. Meaningful Use Tobacco Cessation Clinical Quality Measure (CQM)

Stage 1 Measure (Required)	Stage 1 Measure	Stage 2 Measure (Recommended - “EPs should report on these recommended CQMs if representative of their clinical practice and patient population.”)	Stage 2 Measure
National Quality Forum (NQF) 0028	The percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user	National Quality Forum (NQF) 0028	The percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

The Patient Protection and Affordable Care Act (ACA) (Appendix 2)

The landmark Affordable Care Act (ACA) was signed into law by President Barack Obama in 2010. With various components implemented from 2010 to 2016, the law mandates universal healthcare coverage for all Americans, and requires massive shifts in the way healthcare is practiced in the US. Among those changes, doctors will be reimbursed based on the quality of care that they provide, as opposed to receiving a set fee for services provided. Importantly, the ACA mandates large shifts in the Information Technology (IT) infrastructure of healthcare. Finally, ACA mandates coverage of evidence-based tobacco use treatment.

The Joint Commission (TJC) (Appendix 3)

On January 1, 2012, The Joint Commission (TJC) released updated tobacco cessation performance measures for hospitals. They are the most powerful inpatient tobacco cessation clinical mandates to date, requiring identification and documentation of tobacco use status on all patients age 18 and older, provision of evidence-based cessation counseling and medication during hospitalization for all identified tobacco users, a referral at discharge for evidence-based cessation, and documentation of tobacco use status approximately one month post-discharge. Unfortunately, the adoption of the tobacco cessation performance measure set by hospitals is voluntary. Hospitals must select and report 4 of 14 available Joint Commission performance measures, of which the tobacco cessation measure is one.

National Quality Forum (NQF) (Appendix 4)

The National Quality Forum (NQF) is a nonprofit, nonpartisan, public service organization which reviews, endorses, and recommends use of standardized healthcare performance measures. Performance measures, also called quality measures, are essential tools used to evaluate how well healthcare services are being delivered. NQF endorsement of national consensus standards for measuring and publicly reporting on healthcare performance is an important element of healthcare reform.

The NQF-endorsed “Tobacco Use Screening and Cessation Intervention” (NQF Number 0028) performance measure is widely used throughout healthcare including in Meaningful Use, the Medicare Shared Savings Program, which includes CMS’ Accountable Care Organization (ACO) Program; and the Physician Quality Reporting System (PQRS)

The United States Preventive Services Task Force (USPSTF) (Appendix 5)

Created in 1984, the U.S. Preventive Services Task Force is an independent, volunteer panel of non-Federal national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by conducting scientific evidence reviews and making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. Tobacco use identification received the USPSTF highest recommendation, an A. The ACA required that all new private insurance plans cover preventive services given an ‘A’ or ‘B’ rating by the U.S. Preventive Service Task Force (USPSTF) as of September 23, 2010.

National Committee for Quality Assurance (NCQA) (Appendix 6)

The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. NCQA develops quality standards and performance measures for a broad range of health care entities. These measures and standards are the tools that organizations and individuals can use to identify opportunities for improvement. One of NCQA’s tools is the Healthcare Effectiveness Data and Information Set (HEDIS); a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. One of the measures is Tobacco Use.

More detail regarding Healthcare Reform and Health Information Technology terms and definitions/descriptions is provided in Appendix 7.

Electronic Health Records (EHR) (Appendix 8)

Electronic Health Records are the one innovation that perhaps is resulting in the most dramatic changes to healthcare delivery, quality reporting, and systems in the last decade. In part, EHR innovations have contributed to improvement in the number of patients screened for tobacco use, having their tobacco use documented in the medical record, and receiving treatment for their tobacco dependence. Table 5 provides considerations for identifying and documenting tobacco use status in the EHR.

Table 5. Considerations for identifying and documenting tobacco use status in the EHR

Some considerations healthcare providers and systems should take into account when designing their EHR and clinical workflow to identify and document tobacco use status.

- Data must be discrete, retrievable, and reportable.
- Collection and documentation of tobacco use should be part of the vital signs.
- If tobacco use is part of social or substance use history, ensure that it is not overwritten each visit or the historical tobacco use data for patients will be lost.
- Workflow and staff roles are as important, if not more so, than the actual EHR fields. If staff do not have a clear understanding of whose role it is to ask about and document tobacco use, as well as how and where it fits into the workflow, tobacco use will rarely or never be identified and documented.

Table 6 provides a summary of how each of the key policy and regulatory forces described above address and document tobacco use.

Table 6. Smoking/Tobacco Use Assessment Summary Table

	Required or Voluntary	Periodicity	How Asked	Where Asked in Patient Visit Workflow	Where in the EHR it is Documented
Federal Meaningful Use of EHR Incentive Program	Core, required performance measure in Stages 1 and 2. Stage 3 TBD. More than 50% (Stage 1) / 80% (Stage 2) of all unique patients 13 years old or older have smoking status recorded as structured data	If smoking status is already documented in the EHR, an inquiry does not need to be made every time the patient is seen. The frequency of updating smoking status is left to the provider.	Not defined, but EHR must enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; and unknown if ever smoked.	Not defined	Must be recorded as structured, discrete data to enable a user to electronically record, modify, and retrieve the smoking status of a patient.

Affordable Care Act	Mandates coverage of evidence-based tobacco cessation services	Not applicable	Not applicable	Not applicable	Not applicable
The Joint Commission	Voluntary (One of 14 performance measures; hospitals must complete 4 for accreditation)	Every patient 18 years and older who is admitted to the hospital.	Not defined, but EHR must enable the user to electronically document tobacco use status in a way that is retrievable/reportable	Upon admission	Must be recorded as structured, discrete data to enable a user to electronically record, modify, and retrieve the smoking status of a patient.
National Quality Forum	Required for MU; Medicare Shared Savings Program; Physician Quality Reporting System	All patients aged 18 years and older who were seen or who had at least one preventive care visit during the measurement reporting period	Not defined	Not defined	Must be recorded as structured, discrete data to enable a user to electronically record, modify, and retrieve the smoking status of a patient
U. S. Preventive Services Task Force	ACA mandates coverage for prevention services, including tobacco cessation. Ask about tobacco use is Grade 'A' recommendation for all patients 18 years and older	Not defined	Not defined	Not defined	Must be recorded as structured, discrete data to enable a user to electronically record, modify, and retrieve the smoking status of a patient
EHR Vendor with Largest U.S. Market Share (Epic)	Some, but not all, healthcare systems who use Epic, make it a mandatory field in the vital signs which needs to be verified or edited at each visit.	Every visit	Tobacco use status includes: current every day smoker; current some day smoker; former smoker; never smoker; smokeless tobacco user; and unknown.	Typically, the person rooming the patient collects tobacco use status as part of vital signs or health history.	Typically in vital signs, but varies by healthcare system.

Recommended/Leading Tobacco Use Status Assessment

The tobacco assessment most widely used in the country is the MU "record smoking status" (See Appendix 1 for details). As of March 2013, 73% of eligible professionals and 85% of hospitals are registered and participating in the MU of EHR incentive program. Record smoking status is a required, core performance measure of MU.

Appendix 1: Meaningful Use

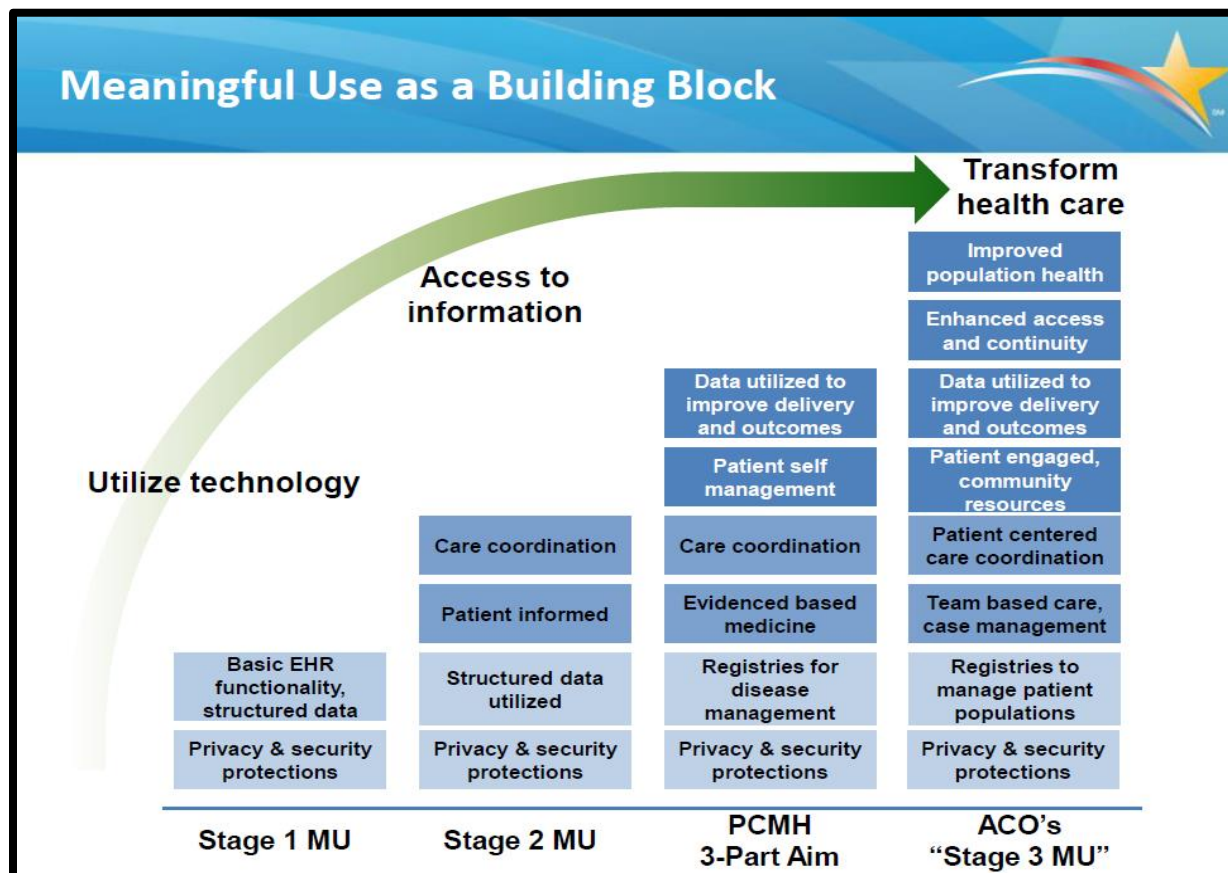
Meaningful Use is a federally-funded incentive plan that eligible health care professionals and hospitals can qualify for through Medicare and/or Medicaid when they adopt certified Electronic Health Record (EHR) technology and use it to achieve specified objectives. Meaningful Use came out of regulations from the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Meaningful use is using certified electronic health record (EHR) technology to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

Ultimately, it is hoped that meaningful use compliance will result in:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems



Meaningful Use (MU) of Electronic Health Records: Record Smoking Status

For each stage of MU, there are performance measures and goals which must be met. The table below shows the required, core “Record Smoking Status” outpatient measure for stages 1 and 2.

Meaningful Use Stage 1 and Stage 2: Record Smoking Status – Eligible Professionals (EPs)/Hospitals*

Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data	Record smoking status for patients 13 years old or older	More than 80% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data

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MU goes beyond tobacco use identification by including a tobacco cessation Clinical Quality Measure (CQM) (See table below). The MU CQM for tobacco cessation was required in Stage 1, and becomes “recommended” for Stage 2. Eligible Providers (EPs) must report on 9 out of 64 total CQMs and Hospitals must report on 9 of the 16 total CQMs.

Meaningful Use Tobacco Cessation Clinical Quality Measure (CQM)

Stage 1 Measure (Required)	Stage 1 Measure	Stage 2 Measure (Recommended - “EPs should report on these recommended CQMs if representative of their clinical practice and patient population.”)	Stage 2 Measure
National Quality Forum (NQF) 0028	The percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user	National Quality Forum (NQF) 0028	The percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

Attainment of a stage’s requirements equate to Meaningful Use of an EHR thereby qualifying for a bonus to Medicare or Medicaid reimbursements. Failure to meet or continue to meet the required stage of Meaningful Use for a given year will result in a monetary penalty or possibly losing full Medicare or Medicaid reimbursement.

Hospital MU Participation: More than 85 percent of eligible hospitals are participating in the Medicare and Medicaid EHR Incentive Programs, and more than 75 percent have received incentive payments for meaningfully using EHR technology as of March 2013.

Physicians and other Health Care Provider MU Participation: More than 388,000 of the nation's eligible professionals have registered to participate in the Medicare and Medicaid EHR Incentive Programs, representing 73 percent of all providers eligible to participate. More than 230,000, or 44 percent of all eligible professionals, have received an EHR incentive payment for meaningfully using EHR technology as of March 2013.

Appendix 2: Affordable Care Act Tobacco-Related Provisions



Tobacco-Related Provisions of the Affordable Care Act

Employer-Sponsored Insurance

	Section & Page Number	Implementation Date	More Details
Preventive Services Coverage	Sec. 1001 (new section 2713 of the Public Health Services Act); pgs. 13-14 of H.R. 3590	September 23, 2010	- Requires health insurance plans to cover preventive services at no cost to the patient - Applies to all new plans created since March 2010 - Required preventive services include all services given an 'A' or 'B' rating by the U.S. Preventive Services Task Force Tobacco cessation services are included, but HHS has not defined which medications and/or counseling are included in the requirement. Therefore insurance plans currently have a lot of flexibility in meeting this requirement

State Health Insurance Exchanges

	Section & Page Number	Implementation Date	More Details
Essential Health Benefit	Sec. 1302; pgs. 45-50 of H.R. 3590	January 1, 2014	- Requires all individual and small group plans (inside and outside state health insurance exchanges) to cover an Essential Health Benefit, which is to be defined by the Secretary of Health and Human Services (HHS) - Includes a list of ten categories of coverage required in the Essential Health Benefit – including prevention and wellness services and chronic disease management, which should include tobacco cessation treatments - HHS has instructed each state to choose a benchmark plan to serve as its Essential Health Benefit. The benchmark plan must include coverage of 'A' and 'B' rated preventive services, which includes tobacco cessation – however, this requirement is undefined.

Insurance Premiums	Sec. 1201 (new section 2701 of the Public Health Service Act); pgs. 37-38 of H.R. 3590	January 1, 2014	• Lists four factors health insurance companies are allowed to vary premium costs based on. One of these factors is tobacco use • Health insurance companies will be able to charge a tobacco user up to 50 percent more in premiums than non-tobacco users. This could mean thousands of dollars in additional costs for tobacco users • In a proposed rule released November 26, 2012, HHS proposed that insurance companies varying premiums based on tobacco use must offer tobacco users the non-user rate if they participate in a wellness program and try to quit.
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Medicaid

	Section & Page Number	Implementation Date	More Details
Essential Health Benefit	Sec. 2001; pgs. 153-161 of H.R. 3590	January 1, 2014	• All Medicaid recipients newly eligible to enroll under the Affordable Care Act must have coverage for an Essential Health Benefit • This Essential Health Benefit is to be defined by the Secretary of Health and Human Services (HHS) • In a letter to state Medicaid Directors released November 26, 2012, HHS indicated that states will choose their Medicaid benchmark plan, which will then become the Essential Health Benefit for new Medicaid enrollees.
Tobacco Cessation Medications Coverage	Sec. 2502; pg. 192 of H.R. 3590	January 1, 2014	• Medicaid programs will no longer be able to exclude tobacco cessation medications from their prescription drug coverage • Unclear as to whether this provision requires coverage of all seven tobacco cessation medications, or just some.
Tobacco Cessation Coverage for Pregnant Women	Sec. 4107; pgs. 442-443 of H.R. 3590	October 1, 2010	• Requires all state Medicaid programs cover a comprehensive tobacco cessation benefit for pregnant women at no cost to the patient

			The Centers for Medicare and Medicaid Services (CMS) provided guidance on implementing this provision in a June 2011 letter.
Incentive for Covering Preventive Services	Sec. 4106; pgs. 441-442 of H.R. 3590	January 1, 2013	- States that cover all preventive services rated an 'A' or 'B' by the U.S. Preventive Services Task Force will receive a one percentage increase in its federal Medicaid matching funds Tobacco cessation services are included in the list of 'A' rated services
Pilot Projects on Preventing Chronic Disease	Sec. 4108; pgs. 443-446 of H.R. 3590	January 1, 2011	- Establishes a grant program to explore ways to encourage Medicaid enrollees to participate in programs that prevent chronic disease. - Such programs can include tobacco cessation programs. Grant recipients in California, Connecticut and Wisconsin are working on incentivizing the use of tobacco cessation treatments. Learn more here.

Medicare

	Section & Page Number	Implementation Date	More Details
Annual Wellness Exam	Sec. 4103; pgs. 435-439 of H.R. 3590	January 1, 2011	Adds a free, annual wellness visit and personalized prevention plan to Medicare coverage. If applicable, this visit can include tobacco cessation counseling and prescription for a tobacco cessation medication

Miscellaneous

	Section & Page Number	Implementation Date	More Details
Prevention and Public Health Fund	Sec. 4002; pg. 423 of H.R. 3590	Fiscal Year 2010	- Establishes a fund to provide for expanded and sustained national investment in prevention and public health programs - Started at \$500 million in 2010, and gradually grows to \$2 billion in 2015 - This fund has already funded several tobacco-related initiatives, including the Tips from Former Smokers

			campaign and grants to quitlines, as well as items below
Community Transformation Grants	Sec. 4201; pgs. 446-448 of H.R. 3590	2011	- Establishes a grants program, to be administered by the Centers for Disease Control and Prevention (CDC) to design and implement community-level programs that prevent chronic disease - Reducing tobacco use is one of the main project areas of these grants. Find more information here - Funded by the Prevention and Public Health Fund
National Prevention, Health Promotion and Public Health Council	Sec. 4001; pgs. 420-423 of H.R. 3590	2010	- Establishes a National Prevention, Health Promotion and Public Health Council, consisting of leaders in several federal government agencies, to provide coordination among all Federal departments and agencies for prevention, wellness and health promotion practices in the U.S. - The Council published its National Prevention Strategy in June 2011, which includes tobacco-free living as one of seven priorities

Source: <http://www.lung.org/stop-smoking/tobacco-control-advocacy/reports-resources/2012/factsheet-tobacco-related-provisions-of-the-aca.pdf>

Appendix 3: The Joint Commission (Inpatient/Hospital)

On January 1, 2012, The Joint Commission (TJC) released updated tobacco cessation performance measures for hospitals. They are the most powerful inpatient tobacco cessation mandates to date, requiring identification and documentation of tobacco use status on all patients age 18 and older, provision of evidence-based cessation counseling and medication during hospitalization for all identified tobacco users, a referral at discharge for evidence-based cessation, and documentation of tobacco use status approximately one month post-discharge. Unfortunately, the adoption of the tobacco cessation performance measure set by hospitals is voluntary. Hospitals must select and report on 4 of 14 available Joint Commission performance measures.

Tobacco Use Screening Inpatient Performance Measure

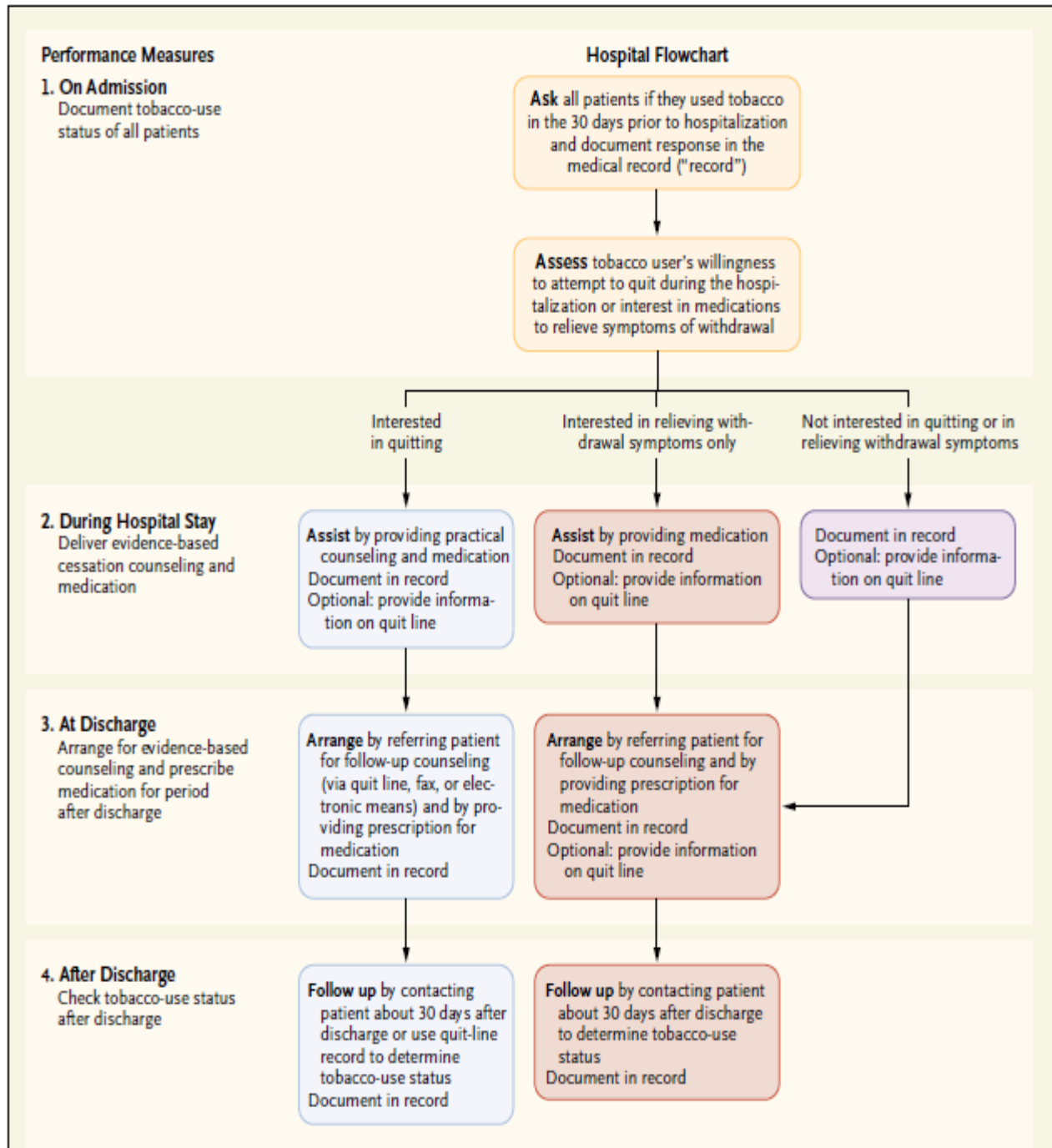
Purpose: To ensure that tobacco use status is queried and documented for every patient admitted to a hospital for every hospitalization.

Description: To fulfill this measure, hospitals must document that all admitted patients (18 years of age or older) were screened during the hospital stay for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the 30 days prior to their hospitalization.

Tobacco use screening is the essential first step in the intervention process. Although it is important to determine tobacco use status for all patients, the Joint Commission measures require documentation only for patients 18 years of age or older that are admitted to the hospital. The reason this measure is limited to those 18 and older is that the evidence for tobacco cessation treatments is strongest for this age group. The tobacco use screen should identify the type of tobacco used, the volume used, and the timeframe of use.

To meet this Joint Commission measure, hospitals must implement a hospital-wide system that ensures that, for EVERY patient who is admitted, tobacco use status is queried and documented. This often takes place during the admission process at the same time that vital signs are recorded, either in the admitting office or by the admitting clinician during the history and physical.

The Joint Commission Voluntary Inpatient Tobacco Cessation Performance Measure Set



The New Joint Commission Tobacco Cessation Performance Measure-Set.

Graphic source: Fiore, MC, Goplerud, E, Schroeder, SA. The Joint Commission's New Tobacco-Cessation Measures — Will Hospitals Do the Right Thing? N Engl J Med 2012; 366:1172-1174 March 29, 2012 DOI: 10.1056/NEJMp1115176

Appendix 4: National Quality Forum

National Quality Forum Tobacco Use Assessment Measure Used in Multiple National/Federal Programs August 2013

Measure Title	NQF#	Measure Description	Numerator Statement	Denominator Statement	Exclusions	Risk Adjustment	National Quality Strategy Priorities	Use in Federal Program	Actual/Planned Use	Care Setting
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	0028	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user	Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user *Includes use of any type of tobacco ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two year measurement period	Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)	No	Prevention and Treatment of Cardiovascular Disease	Meaningful Use Stage 2 (EHR Incentive Program) - Eligible Professionals, Medicare Shared Savings Program, Physician Quality Reporting System (PQRS)	Professional Certification or Recognition Program, Public Reporting, Quality Improvement (Internal to the specific organization)	Ambulatory Care: Clinician Office/Clinic, Behavioral Health/Psychiatric: Inpatient, Behavioral Health/Psychiatric: Outpatient, Other

Source: National Quality Forum. http://www.qualityforum.org/Measures_Reports_Tools.aspx; <http://www.qualityforum.org/QPS/QPSTool.aspx>

Appendix 5: United States Preventive Services Task Force (USPSTF)

Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women

Clinical Summary of U.S. Preventive Services Task Force Recommendation

This document is a summary of the 2009 recommendation of the U.S. Preventive Services Task Force (USPSTF) on counseling and interventions to prevent tobacco use and tobacco-caused disease in adults and pregnant women. This summary is intended for use by primary care clinicians.

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Population	Adults Age ≥18 Years	Pregnant Women of Any Age
Recommendation	Ask about tobacco use. Provide tobacco cessation interventions to those who use tobacco products. Grade: A	Ask about tobacco use. Provide augmented pregnancy-tailored counseling for women who smoke. Grade: A
Counseling	The "5-A" framework provides a useful counseling strategy: 1. Ask about tobacco use. 2. Advise to quit through clear personalized messages. 3. Assess willingness to quit. 4. Assist to quit. 5. Arrange follow-up and support. Intensity of counseling matters: brief one-time counseling works; however, longer sessions or multiple sessions are more effective. Telephone counseling "quit lines" also improve cessation rates.	
Pharmacotherapy	Combination therapy with counseling and medications is more effective than either component alone. FDA-approved pharmacotherapy includes nicotine replacement therapy, sustained-release bupropion, and varenicline.	The USPSTF found inadequate evidence to evaluate the safety or efficacy of pharmacotherapy during pregnancy.
Implementation	Successful implementation strategies for primary care practice include: • Instituting a tobacco user identification system. • Promoting clinician intervention through education, resources, and feedback. • Dedicating staff to provide treatment, and assessing the delivery of treatment in staff performance evaluations.	
Relevant Recommendations from the USPSTF	Recommendations on other behavioral counseling topics are available at http://www.uspreventiveservicestaskforce.org .	

Note: FDA = U.S. Food and Drug Administration; USPSTF = U.S. Preventive Services Task Force.

Source: <http://www.uspreventiveservicestaskforce.org/uspstf09/tobacco/tobaccosum2.htm>

Appendix 6: National Committee for Quality Assurance (NCQA)

HEDIS MEASURES of CARE

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by most HMOs and PPO plans to measure performance on important dimensions of care and service. By providing objective, clinical performance data measures against a detailed set of measurement criteria, HEDIS helps purchasers and consumers compare health plans' performance. HEDIS measures address a broad range of important health issues, including **smoking**. HEDIS includes the CAHPS 4.0 Survey that measures members' experiences with their health care.

HEDIS Tobacco Use Measure Definition

This measure assesses provision of medical assistance with tobacco use cessation:

Advising Tobacco Users to Quit. The percentage of people 18 years of age and older who were current tobacco users, were seen by a health plan practitioner during the measurement year and received advice to quit smoking or using tobacco

Discussing Cessation Medications. The percentage of people 18 years of age and older who were current tobacco users, were seen by a practitioner during the measurement year and discussed or were recommended cessation medications

Discussing Cessation Strategies. The percentage of people 18 years of age and older who were current tobacco users, were seen by a practitioner during the measurement year and discussed or were recommended cessation methods or strategies.

ADVISING SMOKERS AND TOBACCO USERS TO QUIT					
YEAR	COMMERCIAL		MEDICAID	MEDICARE	
	HMO	PPO	HMO	HMO	PPO
2011	77.6	72.4	74.6	81.5	79.3
2010	76.7	71.7	73.6	77.9	78.3
2009	-	-	-	77.9	75.2
2008	76.7	71.6	69.3	76.9	76.5
2007	75.8	71.0	69.4	75.8	75.4
2006	73.8	70.1	68.2	76.1	77.3
2005	71.2	66.9	65.6	75.5	77.3
2004	69.6	-	66.7	64.7	-
2003	68.6	-	65.8	62.9	-
2002	67.7	-	63.6	61.6	-
2001	65.7	-	63.9	60.9	-
2000	66.3	-	-	-	-

Appendix 7: Healthcare Reform and Health Information Technology Terms and Definitions/Descriptions

Accountable Care Organization (ACO)

An accountable care organization (ACO) is a type of payment and delivery reform model that ties provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. An ACO is formed by a group of coordinated healthcare providers, and is accountable to patients and third-party payers for the quality, appropriateness and efficiency of the healthcare provided. Although the model is designed to be flexible, three core principles have been defined for all ACOs. They state that ACOs are provider-led organizations with a strong base of primary care, collectively accountable for quality and per capita costs across the full continuum of care; ACO payments are linked to quality improvements that also reduce overall costs; and ACOs have a reliable and progressively more sophisticated performance measurement to support improvement and provide confidence that savings are achieved through improvements in care.

American Recovery and Reinvestment Act (ARRA)

Congress passed the American Recovery and Reinvestment Act on February 17, 2009. A direct response to the economic crisis of 2008, the Recovery Act had three immediate goals: to create new jobs and save existing ones, to spur economic activity and invest in long-term growth and to foster more accountability and transparency in government spending. The law directed about \$150 billion in new funds to the healthcare industry. It included \$87 billion for Medicaid, \$24.7 billion to subsidize private health insurance for people who lose or have lost their jobs, \$19.2 billion for health information technology, and \$10 billion for the National Institutes of Health (NIH). The act also provided \$650 million to support prevention and wellness activities targeting obesity, smoking, and other risk factors for chronic diseases as well as \$500 million for health professions training programs, including \$300 million to revitalize the National Health Service Corps (NHSC).

Clinical Decision Support (CDS)

Clinical decision support is a process for enhancing health-related decisions and actions with pertinent clinical knowledge and patient information to improve health and healthcare delivery. The information delivered can include general clinical knowledge and guidance, processed patient data or both. Information delivery formats can be drawn from options that include data and order entry facilitators, filtered data displays, reference information, alerts and more. Clinical decision support systems (CDSS) form a significant part of the field of clinical knowledge management technologies through their capacity to support the clinical process and use of knowledge. These systems are typically designed to integrate a medical knowledge base, patient data, and an inference engine to generative case-specific advice.

Cloud computing

“Cloud computing” refers to delivering hosted services over the Internet. The services tend to be divided into three categories: infrastructure-as-a-service (IaaS), platform-as-a-service (PaaS), and software-as-a-service (SaaS). A cloud service has characteristics that differentiate it from traditional hosting. It is sold on-demand, is elastic – so the user can have as much or as little of the service they want – and is fully managed by the provider. Recent innovations in virtualization, as well as improved access to high-speed

Internet, have accelerated the growth of cloud computing.” A cloud can be either public or private. A public cloud sells services to anyone on the Internet; a private cloud is a data center or proprietary network that supplies hosted services to a restricted number of people. Whether public or private, the goal of cloud computing is to provide scalable and easy-to-access computing resources and IT services.

Computerized Physician Order Entry (CPOE)

Computerized physician order entry is a system that allows direct entry of medical orders and instructions for the treatment of patients by a medical practitioner. The orders are communicated through a computer network to medical staff or other various departments responsible for fulfilling an order, including pharmacy, radiology or laboratory. Used properly, CPOE decreases delay in order completion, reduces errors related to handwriting or transcriptions, allows order entry at point-of-care or offsite, provides error checking for duplicate or incorrect doses or tests, and simplifies inventory and positing of charges.

Direct Project

The Direct Project, managed by Health and Human Services Office of the National Coordinator for Health Information Technology’s Office of Standards and Interoperability develops specifications for a secure, scalable, standards-based way to establish universal health addressing and transport for participants to send encrypted health information directly to known, trusted recipients over the Internet. The project itself does not run health information exchange services. Several federal agencies and healthcare organizations are already using the Nationwide Health Information Network, which is a set of standards, services, and policies that enable secure health information exchange over the Internet, to exchange information amongst themselves. The Direct Project expands the standards and service descriptions available to address the key Stage requirements for Meaningful Use and provides an easy “on-ramp” for a wide set of providers and organizations looking to adopt. At the end of the project, there will be one nationwide exchange, consisting of the organizations that have come together in a common policy framework to implement the standards and services.

Electronic Health Record (EHR)

An electronic health record is a collection of patient health information generated by one or more meetings in any care delivery setting. An EHR typically includes patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. It’s said to streamline clinicians’ workflow, and it has the ability to generate a complete record of a clinical patient encounter. EHRs focus on the total health of the patient. They go beyond standard clinical data collected in the provider’s office and include a broader view of the patient’s care. EHRs are designed to reach beyond the health organization that originally collected the data and are built to share information with other providers. EHRs’ most notable benefits include a secure sharing of data, which, in turn, results in more open communication and more involvement on the patient’s part.

Electronic Medical Record (EMR)

An EMR is a digital version of a paper chart in a clinician’s office. It contains the medical and treatment history of the patients in one practice. An EMR allows a clinician to track data over time, easily identify which patients are due for preventative screenings, check how patients are doing on certain parameters such as blood pressure readings or vaccines and monitor and improve overall quality of care within the practice. An EMR is said to make the process of patient record-keeping easier, more accurate and comprehensive and more efficient. Doctors use specialized software, which allows them to enter information electronically and makes a patient’s complete history available immediately. Physicians can use a desktop, laptop or electronic clipboard to navigate through patients’ charts and record notes.

e-Prescribing

e-Prescribing is the ability to electronically send an accurate, error-free and understandable prescription directly from a clinic/healthcare setting to a pharmacy. Included in the Medicare Modernization Act of 2003, it represents an important means to improve the quality of patient care. The July 2006 Institute of Medicine report on the role of e-prescribing in reducing medication errors expanded its popularity and helped spread awareness of its benefits. The adoption of standards to facilitate e-prescribing is one of the key action items in the plan to expedite the adoption on EMRs. The benefits of e-prescribing are many and include reducing illegibility; providing warning and alert systems, which reduce medication errors; and offering access to patients' medical history. E-Prescribing also reduces or eliminates phone calls and call-backs to pharmacies, eliminates faxes to pharmacies, streamlines the refill's requests and authorization processes, and increases patient compliance.

Health Information Exchange (HIE)

Health information exchange is the transmission of healthcare-related data among facilities, health information organizations and government agencies, according to national standards for interoperability, security and confidentiality. It is an important part of the health information technology (HIT) infrastructure under development in the U.S., and the associated National Health Information Network (NHIN). Development of HIE initiatives continues to grow. The HIE implementation challenge will be to create a standardized interoperable model that is patient-centric, trusted, longitudinal, scalable, reliable and financially sustainable.

Health Information Technology for Economic and Clinical Health (HITECH) Act

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law in February 2009. It promotes the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, partly through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules. The act stipulates that, as of 2011, healthcare providers will be offered financial incentives for demonstrating meaningful use of electronic health records (EHRs). Incentives will be offered until 2015. After that point, penalties may be charged for failing to demonstrate such use. The act also established grants for training centers for the personnel required to support a health IT infrastructure.

Health IT Policy Committee

The Health IT Policy Committee is a federal board created as part of the American Recovery and Reinvestment Act of 2009. The committee advises the National Coordinator for Health IT on the creation of a nationwide health IT infrastructure. The committee comprises 20 experts in both the medical and technical professions. The experts were appointed by the Secretary of Health and Human Services, the acting comptroller general of the United States, the majority and minority leaders of the Senate, and the speaker and minority leader of the House of Representatives. A number of work groups have been formed as sub-committees and include those focusing on meaningful use, certification and adoption, information exchange and more.

Health IT Standards Committee

The Health IT Standards Committee makes recommendations to the National Coordinator for Health IT on standards, implementation specifications, and certain criteria for the electronic exchange and use of health information. Originally, the committee focused on the policies developed by the Health IT Policy Committee's initial eight areas. Four HIT Standards Committee workgroups have been formed as sub-

committees to the parent FACA. These workgroups meet periodically to discuss their topics, present their findings at HIT Standards Committee meetings, and make recommendations to the HIT Standards Committee. They include those focused on clinical operations, clinical quality, privacy and security, implementation, and a vocabulary task force.

Health Level 7 International (HL7)

Health Level 7 International (HL7) is a group dedicated to developing standards for the exchange of electronic health information. The organization's goal is to improve the interoperability of software applications used by the health care industry. The "7" in the organization's name refers to Layer 7 in the Open Systems Interconnection (OSI) reference model. It is the final layer in the communication model the International Organization for Standardization developed for OSI. The standards address message and data exchange, decision support, rules syntax, visual integration of applications, insurance claims, clinical documents such as discharge summaries, product labels for prescription medication, electronic health records and personal health records.

Healthcare Information and Management Systems Society (HIMSS)

HIMSS is a nonprofit, cause-based organization focused on providing global leadership for the optimal use of information technology and management systems for the betterment of healthcare. The organization was founded in 1961 and has related organizations headquartered in Chicago, with additional offices in the US, Europe, and Asia. HIMSS represents more than 38,000 individual members of which more than two thirds work in healthcare provider, governmental, and not-for-profit organizations. HIMSS also includes more than 540 corporate members and more than 120 nonprofit organizations that share the same mission. The organization frames and leads healthcare practices and public policy through its content expertise, professional development, research initiatives and media vehicles designed to promote information and management systems' contributions to improving the quality, safety, access, and cost-effectiveness of patient care.

Interoperability

Interoperability is a system or product's ability to work with other systems or products. The term is used often in either a technical system engineering sense, or in a broader sense – including social, political and organizational factors that impact system-to-system performance. Products achieve interoperability by either adhering to published interface standards or by making use of a "broker" of services that converts one's product interface into another product's interface instantaneously. With regard to healthcare, interoperability is looked upon as the ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities. A more expansive notion of interoperability includes the uniform movement of healthcare data, the uniform presentation of data, uniform user controls, uniform safeguarding data security and integrity, uniform protection of patient confidentiality and uniform assurance of a common degree of system service quality.

Meaningful Use

Meaningful use is a qualification to receive federal funding for health information technology, specifically, the use of electronic health records. According to the provisions of the Healthcare Information Technology for Economic and Clinical Health Act (HITECH), healthcare organizations that have achieved meaningful use by 2011 will be eligible for incentive payments, and those who have failed to achieve that standard by 2015 may be penalized. Stage 1 meaningful use criteria set the baseline for electronic data capture and information sharing. Stage 2 and Stage 3 (expected to be implemented in 2015) will continue to expand on that baseline.

Nationwide Health Information Network (NHIN)

The Nationwide Health Information Network is a set of standards, services and policies that enable secure health information exchange over the Internet. The network provides a foundation for the exchange of health information across diverse entities, within communities and across the country, helping to achieve the goals of the HITECH Act. It is comprised of a diverse set of federal agencies and non-federal organizations that have come together to securely exchange electronic health information. NHIN is considered a critical part of the national health IT agenda and enables health information to follow the consumer, be available for clinical decision making and support appropriate use of healthcare information beyond direct patient care to improve population health.

National eHealth Collaborative (NeHC)

National eHealth Collaborative is a public-private partnership that aims to enable secure and interoperable nationwide health information exchange through education and stakeholder engagement. NeHC was established through a grant from the Office of the National Coordinator for Health IT to build on the achievements of the American Health Information Community, a federal advisory committee to the U.S. Department of Health and Human Services until 2008. With a mission to promote the successful deployment of health IT and health information exchange nationwide, the collaborative offers a variety of programs for stakeholders and consumers such as the HIE Learning Network, its Consumer Consortium on eHealth stakeholder engagement program and NeHC University, a Web-based education program designed to provide stakeholders with timely and relevant information on health information technology and health information exchange in the United States.

National Quality Forum

Established in 1999, the National Quality Forum is a nonprofit organization based in Washington, D.C. NQF reviews and recommends use of standardized healthcare performance measures at the federal, state and private-sector levels, and promotes initiatives focused on enhancing the value of healthcare services. NQF members include purchasers, physicians, nurses, hospitals and fellow quality improvement organizations. Recently, NQF named Christine K. Cassel, MD, as president and CEO. To expand its health IT portfolio, NQF created the Health IT Advisory Committee in 2009. HITAC's mission is to promote input and collaboration among measure developers, electronic health record vendors and users on best practices to support performance measurement, reporting and improvement.

The Office of the National Coordinator for Health Information Technology (ONC)

The Office of the National Coordinator for Health Information Technology (ONC) is a staff division within the U.S. Department of Health and Human Services, primarily focused on implementing an interoperable, private and secure nationwide health information system and supporting the widespread, meaningful use of technology. ONC was created in 2004 through an executive order by President George W. Bush, and was legislatively mandated in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009. Farzad Mostashari, MD, a physician and public health expert, currently serves as the National Coordinator for Health Information Technology. He is preceded by physician and Harvard Medical School Professor David Blumenthal (2009- 2011), psychiatrist Robert Kolodner (interim 2006, permanent 2007-2009). The first national coordinator was physician and venture capitalist, David Brailer, MD, who served from 2004 until 2007.

SNOMED CT (Systematized Nomenclature of Medicine--Clinical Terms)

A comprehensive clinical terminology and one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information and also a required

standard in interoperability specifications of the U.S. Healthcare Information Technology Standards Panel. This use of a standard terminology enables the use of health information across borders, facilitates public health surveillance and supports evidence-based research.

Telehealth

Telehealth refers to any remote telecommunications healthcare providers use to interact with and manage patients. It can range from teleconferencing between patient and provider (or provider to provider) to advanced “high-quality online voice and video interactions” with a patient’s EHR, enabling healthcare providers and patients to interact with each other remotely. Properly implemented, telehealth can expand access and reduce costs of healthcare. For example, patients with mobile devices can monitor and report on their own vital signs and manage treatment, eliminating the need for a trip to the doctor’s office. This process can save time and money for both the patient and the healthcare provider. Another example, in Arizona, makes use of telemedicine to link patients living outside of an area with stroke experience with qualified healthcare providers.

Source: <http://www.healthcareitnews.com/directory>

The **Healthcare IT Index** is a directory of terms that includes key people, organizations, technology and concepts within the healthcare IT industry.

Identifying and Recording Tobacco Use Status in the EHR
Screen Capture Examples from Top EHR Vendors by Market Share
August 2013

Epic Systems Corporation (46% of U.S. EHR Market Share)

Outpatient

The screenshot displays the 'Vitals' section of an Epic EHR interface. The 'Taken on' field is set to 05/04/2012, and the time is 0959. The patient's tobacco use status is recorded as 'Current Everyday Smoker (Quit: 1/1/2005)'. The form also includes fields for BP, SpO2, Pulse, Weight, Resp, Height, Temp, Source, and PF (best). The 'Tobacco Use' section is expanded, showing 'Uses Cigarettes', 'Packs/Day: 1', 'Years: 10', 'Pack Years: 10', and 'Smokeless: Unknown'. The 'Last reviewed' date is 4/17/2012.

Vitals	
Taken on:	05/04/2012 0959
BP:	SpO2:
Pulse:	Weight:
Resp:	Height:
Temp:	
Source:	PF (best):
Tobacco Use — Review / Edit	
Current Everyday Smoker (Quit: 1/1/2005)	
Uses Cigarettes	
Packs/Day: 1 Years: 10	
Pack Years: 10	
Smokeless: Unknown	
Last reviewed: 4/17/2012	

Office Visit

RFV

Date of Inj/III

BestPractice

Vitals

Tobacco/Substanc...

Verify Rx Benefits

Reconcile Dispens...

Disclaimer

Allergies

Nursing Notes

Progress Notes

Diagnoses

Orders

Pt. Instructions

LOS & Follow-up

Learning/Action

Tobacco/Substance History

✓ Mark as Reviewed

Last Reviewed by TERRI PREHN on 08/28/2009

Tobacco History

Tobacco Use?

Yes

Never

Quit

Passive

Comment

Packs/day

.5

1

1.5

2

Years

.5

1

2

3

4

5

Quit Date

Type(s) of tobacco used

Cigarettes

Pipe

Cigars

Snuff

Chew

Tobacco History

Willing to set a quit date in the next 30 days?

Yes

No

Counseled to quit?

Yes

No

Tobacco History Verified?

Note: Epic Outpatient EHR examples from a Madison, Wisconsin health system. In this system, at every outpatient visit, the rooming staff must review/verify tobacco use status when collecting vital signs. If it needs to be changed and updated, the roomer does so by clicking "Review/Edit" as part of collecting vital signs.

August 2013

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Inpatient

Tobacco Treatment - Tobacco Use

Time Taken:
Date: 11/29/2010  ☒ Show Last Filed Value
Time: 1232  ☐ Show Row Info

"To flag data as significant, right click on the row name."

[-] Unable To Assess

Unable To Assess  

Last Filed Value:
"No data filed"

[-] Tobacco Treatment

Select "Yes" if Patient
 Has Used Tobacco
 In Last 12 Months;  Yes No  

Otherwise, Select
 "No"

Last Filed Value:
No taken at 09/29/10 0849 by Pat Bates

Tobacco Cessation
 Brochure Given?  

Last Filed Value:
Yes taken at 02/27/09 0700 by Margaret Turner

Nurse/Patient
 Requests A Tobacco
 Treatment Specialist
 Consult  

Last Filed Value:
Completed taken at 02/27/09 0700 by Margaret Turner

Nurse/Patient
 Requests Medication
 To Prevent
 Withdrawal 

Last Filed Value:
Not Applicable taken at 02/11/09 1104 by Ann Powell

How Many Years Did
 You Smoke?  

Source: [http://www.integration.samhsa.gov/pbhci-learning-community/07.11.13 Tobacco Webinar Series Part 4 - EHRs FINAL.pdf](http://www.integration.samhsa.gov/pbhci-learning-community/07.11.13_Tobacco_Webinar_Series_Part_4_-_EHRs_FINAL.pdf)

Allscripts (15% of U.S. EHR Market Share)

Add Clinical Item

Allscripts, David T 3 YO M DOB: 27Aug2007

History Builder Rx/Orders Problem-based Orders

Active PMH PSH Fam Hx Social Hx Allergies Med Hx Im

Social History Alpha

Problems

- ☐ Former Smoker V15.82
- ☐ Smoking Cigarettes For ____ Pack-y

Current Smoker (V15.82)

Former Smoker (V15.82)

Recently Stopping Smoking (V15.82)

Smoking Cigarettes (V15.82)

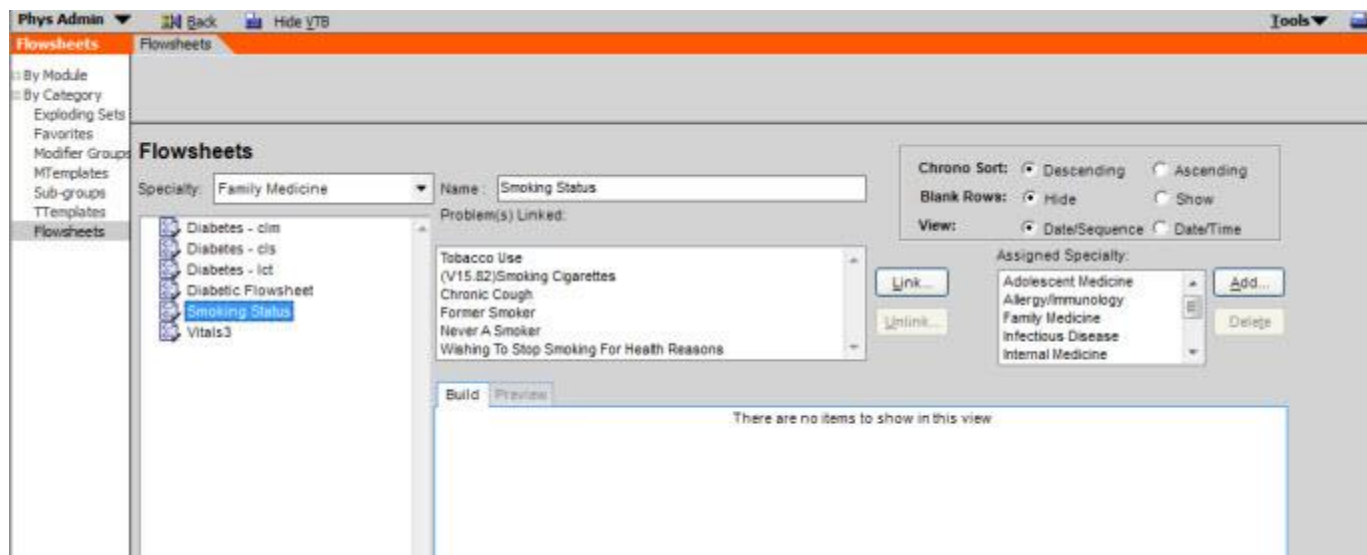
Smoking Cigarettes For ____ Pack-years (V15.82)

Wishing To Stop Smoking

CareGuide

- ☐ Smoker, Current Status Unknown (305.1)
- ☐ Smoking A Pipe
- ☐ Smoking Cigarettes (305.1)
- ☒ Smoking Cigarettes For ____ Pack-Years (305.1)
- ☐ Smoking Cigarettes Starting Only After First Meal Of Day

Source: <http://www.electronicmedicalresources.com/wp-content/uploads/2012/01/Quality-Measures.pdf>



Note: For Allscripts, smoking status is documented as part of the “active problems” or social history.”

The Allscripts EHR Tobacco Assessment provides the follow-up reminder information below for the clinician.



- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - None

Reporting & Setup Considerations

- Population Management Considerations
 - Create an Order Reminder for “Tobacco Assessment Follow Up” every 2 years for patients 18 years and older
 - Create Order “Smoking Assessment Follow Up” with CPT = 1000F
- Tobacco Use Cessation Counseling (Appropriate Orderable Item Dictionary Instruction Entries should be built or updated with below CPT Codes)
 - 99406 - Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
 - 99407 - Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes

GE Healthcare/Centricity (10% of U.S. EHR Market Share)

FM Core 09 Record Smoking Status

Meaningful Use Objective

Record smoking status for patients 13 years old or older

Meaningful Use Criterion

1. Smoking status must be recorded consistent with the certification criteria for this measure :
 - 1.1. In the EHR
 - 1.2. As structured data
 - 1.3. As ONC specified categories
 - 1.4. Present during the EHR reporting period
 - 1.5. For more than 50% unique patients 13 years old or older seen by the EP during the EHR reporting period

Original Logic

Record smoking status on or before the last day of the reporting period in the following Obs Terms using any value:

- SMOK STATUS
- TOBACCO USE

Current Logic (Revised Nov. 2011)

Record smoking status using any of the specified Obs terms below and specified values per ONC.

Specified Obs Terms			
HDID	OBS TERM	CRYSTAL	MQIC
130	Cigaret smkg	X	X
300015	SMOK STATUS	X	X
43476	Smokes	X	X
9407	smoking hx	X	X
16025	HX CIGARETTE	X	X
303701	SMKSTATOVR13	X	X

Specified ONC Categories		
	CRYSTAL	MQIC
current every day smoker	X	X
current some day smoker	X	X
former smoker	X	X
never smoker	X	X
smoker - current status unknown	X	X
unknown if ever smoked	X	X

Per the CMS Meaningful Use Final Rule, the following defines the specified categories

- "CURRENT EVERY DAY SMOKER" or "CURRENT SOME DAY SMOKER" is an individual who has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes every day or periodically, yet consistently;
- "FORMER SMOKER" would be an individual who has smoked at least 100 cigarettes during his/her lifetime but does not currently smoke;
- "NEVER SMOKER" would be an individual who has not smoked 100 or more cigarettes during his/her lifetime
- "SMOKER, CURRENT STATUS UNKNOWN" would apply to individuals who were known to have smoked at least 100 cigarettes in the past, but their whether they currently still smoke is unknown.
- "UNKNOWN IF EVER SMOKED" is self-explanatory.

Source: http://library.constantcontact.com/download/get/file/1103589636841-109/11+10+18_Updated+Data+CaptureStandards+and+Reporting+Logic.pdf

****Tobacco usage:** Prev Tobacco All Never

Last smoking result:

Cigarettes: ☒ current ☐ previous ☐ never
☐ everyday ☐ somedays *Amount: cigs/day pks/day
Year start: Pack yrs:

Oral tobacco: ☐ current ☐ previous ☐ never

Cigars: ☐ current ☐ previous ☐ never

Pipes: ☐ current ☐ previous ☐ never

Passive smoke exposure: ☐ current ☐ previous ☐ none

Comments: P

☐ Patient advised to quit using tobacco; assistance offered.

☐ Tobacco Education materials declined.

☐ Handout: 'Smoking-Ways to Quit' was given to the patient Print
Last printed:

☐ Handout: 'Environmental Smoke' was given to the patient. Print
Last printed:

☐ Quitline information printed and faxed. Print ND Print MN
Last printed:

Cerner (8% of U.S. EHR Market Share)

In Cerner, tobacco use is assessed and documented under adult assessment, which is the screen they use for rooming patients. The screen also has chief complaint, vitals, height, weight, etc. On the child assessment, they ask about exposure to second hand smoking.

Outpatient

Tobacco Use			
☐ Never Smoker	☐ Cigarettes	Cigarettes/Day	
☐ Former Smoker >12 months ago	☐ Cigar	Cigars/Day	
☐ Former Smoker < or = to 12 months ago	☐ Chewing	Tins/Day	
☐ Current Smoker	☐ Pipes	Pipes (bowls)/Day	
☐ Unknown if Ever Smoked			
Smoking Cessation Education Materials:		Total years of use	
☐ Declined	☐ Provided and/or Reviewed	☐ Previously Given	
Clinic participating in the Smoking Treatment Program		Ready to Quit?	
☐ Yes		☐ Yes	
		☐ No	
		Previous Smoking Data	
		Smoking History	
		Last Recorded: 03/24/2008	
		Smoking History: Use: Never	

Inpatient

Admission History Adult - ProdTest1108, RefrangerNORMAL					
*Performed on: 10/03/2011 1602 By: Kersey RN, April D					
General Info	Substance Abuse + Add				
Subjective	Tobacco + Add				
Rapid Pain Asse					
Pain Associated					
Health History I					
Health History II					
Health History III					
Family History					
Medication Histo					
Allergy					
Meds/Immunizat					
Procedure Histor					
Anesthesia/Tran					
Nutrition					
Functional					
Functional Asses					
Living and Reso					
Social History					
Psychosocial/Sp					
Advanced Care I					
Safety					
Valuables/Belon					
Educ Needs					
DC Needs					
Patient use any type of tobacco product currently?		Patient utilize any tobacco product(s) Anytime During the Past 12 Months?		Type of Tobacco Product	
☐ Yes ☐ No		☐ Yes ☐ No		☐ Pipe ☐ Cigarette ☐ Cigar ☐ Smokeless Tobacco ☐ Other:	
If YES, an order will be placed for Resp. Therapy to perform Tobacco Cessation Education.		If there is documentation of any type of CURRENT tobacco use, or any type of tobacco use WITHIN ONE YEAR, select "Yes".		How many years used tobacco products? year(s)	
		If YES, an order will be placed for Resp. Therapy to perform Tobacco Cessation Education.		Tobacco usage per day	
Alcohol abuse in household		Substance abuse in household		Tobacco Household Concerns	
☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
				If YES, an order will be placed for Resp. Therapy to perform Tobacco Cessation Education.	
Injuries/Abuse/Neglect/Financial Neglect in household				Cigarette Smoking Status	
☐ Yes ☐ No				☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker ☐ Smoker current status unknown ☐ Unknown if ever smoked	
				100 Cigarettes = approximately 5 packs	
				Current every day smoker = someone who has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes everyday.	
				Current smoke day smoker = an individual who has smoked at least 100 cigarettes during his/her lifetime and still smokes periodically, yet consistently.	
				Former smoker = someone who has smoked at least 100 cigarettes during his/her lifetime but does not currently smoke.	
				Never smoker = someone who has not smoked 100 or more cigarettes during his/her lifetime.	
				Smoker current status unknown = individuals who were known to have smoked at least 100 cigarettes in the past, but whether they currently still smoke is unknown.	
If YES to any of the above questions, an order will be placed for a Case Management Consult.					

eClinicalWorks (1% of U.S. EHR Market Share)

DOH training
80 centre street
New York NY 10007
Ph: 201-545-4654 Fax:

Tobacco Control (TCNY 2)

Name: Date:

Are you a:

☒ Current smoker
☐ Former smoker
☐ Never smoker

If 'Current smoker' : How often do you smoke cigarettes?

☒ every day
☐ some days, but not every day

If 'Current smoker' : How many cigarettes a day do you smoke?

☒ 5 or less
☐ 6-10
☐ 11-20
☐ 21-30
☐ 31 or more

If 'Current smoker' : How soon after you wake up do you smoke your first cigarette?

☐ within 5 min
☒ 6-30 min
☐ 31-60 min
☐ after 60 min

If 'Current smoker' : Are you interested in quitting?

☐ Ready to quit
☒ Thinking about quitting
☐ Not ready to quit

Powered By eClinicalWorks LLC.

Document and save the smoking status of your patients in the smart form

The status and answers to subsequent questions are automatically populated in the Progress Note for each patient

Veterans Administration (1%+ of U.S. EHR Market Share)

Reminder Resolution: Tobacco Use Screen FY08

TOBACCO USE SCREENING
(REQUIRED) ASK patient about tobacco use. Then indicate the results of screening done at this encounter by checking one of the following:

☐ Lifetime non-user of tobacco
☐ Former tobacco user but now QUIT
☐ Current tobacco user

☐ <---CLICK HERE TO DOCUMENT COUNSELING (OPTIONAL IN THIS REMINDER)

1. ADVISE patient to quit tobacco.
2. ASSESS patient's willingness to quit. If patient is not willing now, preface discussion of the following strategies with "When you decide to quit, here is what will help you be successful..."
3. ASSIST patient to quit:
 - a. Discussed the following strategies with patient to help with quitting (ALL OF THE FOLLOWING ARE REQUIRED):
 1. Set a quit date, ideally within 2 weeks
 2. Remove all tobacco products from home and work
 3. Anticipate challenges to quitting and strategies to deal with them
 4. Offer referral to smoking cessation clinic
 5. Offer smoking cessation medication as appropriate
 - b. Provide strong message of encouragement and support

Clear Clinical Maint Visit Info < Back Next > Finish Cancel

<No encounter information entered>

The Veterans Health Information Systems and Technology Architecture (Vista) is an enterprise-wide information system built around an Electronic Health Record (EHR), used throughout the United States Department of Veterans Affairs (VA) medical system, known as the Veterans Health Administration (VHA). It consists of nearly 160 integrated software modules for clinical care, financial functions, and infrastructure.

The VHA manages the largest medical system in the United States, providing care to over 8 million veterans, employing 180,000 medical personnel and operating 163 hospitals, over 800 clinics, and 135 nursing homes throughout the continental U.S., Alaska, and Hawaii on a single electronic healthcare information network. Nearly 25% of the nation's population is potentially eligible for VA benefits and services because they are veterans, family members, or survivors of veterans.

Intergrity (Less Than 1% of U.S. EHR Market Share)

The screenshot displays the Intergrity EHR interface for a 'tob cessation' form. The interface includes a left sidebar with navigation icons for Forms, Marker, Draw, Text, Vitals, Cite, Search, and E & M. The main window has a title bar 'Form: tob cessation' and a tabbed interface with 'History', 'Advise/Assess', 'Assist', 'Arrange', 'Not Ready?', 'Browse', 'Outline', and 'Preview'. The 'Advise/Assess' tab is active, showing a 'Smoking Habits' section with various checkboxes and a text input field. Below this is a 'SSCHC Practice Menu' button. At the bottom, there are input fields for Prefix, Duration, Value, Modifier, Onset, Unit, Episode, Result, and Status, along with a 'Free Text' area. The 'Forms' section on the left includes 'Save' and 'Cancel' buttons.

Form: tob cessation

History | Advise/Assess | Assist | Arrange | Not Ready? | Browse | Outline | Preview

Smoking Habits

- ☐ Y tobacco use
- ☐ Y smoking cigarettes
- ☐ Y smoking cigars
- ☐ Y smoking a pipe
- smoking cigarettes for ____
- ☐ Y smoking cigarettes starting upon awakening
- ☐ Y smoking cigarettes starting with first beverage/food of day
- ☐ Y smoking cigarettes starting only after first meal of day
- ☐ Y smoking cigarettes starting only in afternoon / evening
- ☐ Y leaving a social or work setting for a cigarette
- ☒ Y exposure to smoke cigarette home
- ☐ Y exposure to smoke cigarette work

SSCHC Practice Menu

Forms

Save

Cancel

Free Text

Prefix Duration Value

Modifier Onset Unit Episode Result Status

Logician (Less Than 1% of U.S. EHR Market Share)

PHS Vitals: Mr. JOHN T. DOE

Vital Signs | Oximetry_Orthostatics | Reminders

VITAL SIGNS

Height (in): ? Weight (lb): BMI: Calc BMI

? BP: / mm Hg Cuff Size: Location: Pulse: Rhythm:

Temperature: degrees F Temp site: Respirations: Peak flow: CBG:

Vitals:

Comments:

Prev. Ask: **never** Advice: Assess: Assist:

Ask - Tobacco Use:

Over the last 2 weeks, how often have you been bothered by:

Little interest in things? ☐ yes ☐ no

Feeling down, depressed or hopeless? ☐ yes ☐ no

Advance Care Planning

Displays most recent entry until you change it. Focus on red entry.

Proxy ☐ reviewed

Adv Directive ☐ reviewed

POLST ☐ reviewed

Click "reviewed" to include in note

Update Adv Directive Section in Chart

Allergy Review

☐ Allergy list reviewed in this update

* PENICILLIN
PEN G SOD (PENICILLIN G SODIUM)

Update Allergies

☐ Interpreter used for visit

Is pain an issue needing to be addressed today? ☐ yes ☐ no

Reason for Visit:

Prev Form (Ctrl+PgUp) Next Form (Ctrl+PgDn) Close

*Note: All U.S. EHR Market Share information from 2012 EHR Market Share Report, 65,697 clinician survey responses, www.american ehr.com