

Cigarette Smoking Prevalence Metric – FAQ

May 12, 2016

This document provides frequently asked questions and answers regarding the new cigarette smoking prevalence metric, and is designed to accompany the measure specification sheet.

Please direct any additional questions to Metrics.Questions@state.or.us.

Are the measure specifications posted online final?

OHA updated the cigarette smoking prevalence measure specifications on May 12th – these are the most current specifications available. OHA does not intend to publish further “final” specifications, although reserves the right to update these specifications for CY 2016 if additional clarification is needed, or errors found.

Is the measure based on Meaningful Use Core Objective “Record Smoking Status” or Meaningful Use NQF 0028 “Tobacco Use Assessment & Cessation Intervention”?

The measure is based on the Meaningful Use Core Objective “Record Smoking Status.” Please note that the new measure does not directly align with the Core Objective, which looks for the percent of patients who have their status recorded. While this is one component (Rate 1) of the CCO measure, the CCO measure then looks at of those who have their status recorded, how many are cigarette smokers (Rate 2) and/or tobacco users (Rate 3).

However, some EHRs may already have functionality to be able to report on prevalence in line with the CCO measure specifications based on a custom query from NQF 0028, rather than the Core Objective.

Are there technical specifications available for the Meaningful Use Core Objective “Record Smoking Status”?

The Core Objective is *not* an eQIM and there are not equivalent specifications or logic flows available.

Documentation of the Objective is available online here: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2013DefinitionEP_9_Record_Smoking_Status.pdf

CEHRT criteria are available online here:

https://www.healthit.gov/sites/default/files/commonclinicaldataset_ml_11-4-15.pdf

According to CMS, the Core Objectives are going away. What does this mean for CCOs’ ability to leverage existing reporting?

OHA’s understanding of CMS’ guidance for Modified Stage 2 and Stage 3 Meaningful Use is that while smoking status goes away as a Core Objective, it was removed with the assumption that all EHRs will maintain the ability to record smoking status as a basic functionality.

The same guidance also notes that CMS is removing “record demographics” and “record vital signs” as core objectives, but again with the understanding that EHRs will continue to support these basic functions.

The measure specifications reference the Clinical Practice Guidelines: Treating Tobacco Use and Dependence (2008). What information from the Guidelines is needed for the measure?

The Clinical Practice Guidelines were used to create the minimum cessation benefit requirements for the pharmacotherapy products. The Guidelines are included in the specifications as a reference, and while they include helpful suggestions for clinic and health plan interventions, they are not needed to implement the measure specifications.

Appendix 2 of the measure specifications states that CCOs must use one of the following options (if Meaningful Use reports are available versus if unavailable). Does the CCO need to select a single option for use across all clinics that will be reporting?

No. OHA anticipates that each clinic will have their own approach and is not requiring CCOs to standardize across their entire data submission for this measure. This will be something that will be identified as part of the Year Four Data Proposal documentation for each clinic that will be submitting data.

What if tobacco use is recorded in the EHR in a structured way, but not according to the Meaningful Use Standard Criteria?

The measure can include any cigarette smoking and/or tobacco use status recorded as structured data (i.e., fields in the EHR that can be queried – not chart review, or open text chart notes). As long as the status is recorded as structured data and can be queried, it does not need to align with the Standard Criteria.

The specifications refer to “provider” – does this mean Meaningful Use Eligible Providers?

Yes. The preference is to limit this reporting to those Eligible Provider types.

Will OHA provide SNOMED codes to identify cigarette smoking and tobacco use?

There is considerable variance in how each EHR reports tobacco use – despite the Meaningful Use Core Objective and Standards Criteria, this is not very standardized. The measure is designed to allow as much flexibility across EHRs as possible; therefore OHA will not require specific SNOMED codes to be used for numerator compliance.

However, if using the Standards Criteria, there are SNOMED codes for each status. The SNOMED codes have been cross-walked to our measure specifications in the table below:

Status	SNOMED	SMOKING STATUS RECORDED	SMOKING PREVALENCE	TOBACCO PREVALENCE
Current every day smoker	449868002	Y	Y	Y
Current some day smoker	428041000124106	Y	Y	Y
Former smoker	8517006	Y		
Never smoker	266919005	Y		

Status	SNOMED	SMOKING STATUS RECORDED	SMOKING PREVALENCE	TOBACCO PREVALENCE
Smoker, current status unknown	77176002	Y	Y	Y
Unknown if ever smoked	266927001			
Heavy tobacco smoker	428071000124103	Y	Y	Y
Light tobacco smoker	428061000124105	Y	Y	Y

There are additional SNOMED CT codes that may be helpful in designing reports, but again, will be dependent on each individual EHR's functionality. OHA would be interested in hearing from any CCOs / clinics that have mapped their tobacco use recording to these SNOMED codes.

Use of these SNOMED CT codes are not officially required as part of the measure specifications, but a crosswalk to our specifications is provided in the table below for reference:

Category	SNOMED	SMOKING STATUS RECORDED	SMOKING PREVALENCE	TOBACCO PREVALENCE
Tobacco use and exposure – finding	365980008	Y		Y
Ex-tobacco user	702975009	Y		
Finding relating to moist tobacco use	228499007	Y		Y
Finding related to tobacco chewing	228509002	Y		Y
Maternal tobacco abuse	16994006	Y		Y
Maternal tobacco use	427189007	Y		Y
Never used tobacco	702979003	Y		
No known exposure to tobacco smoke	711563001	Y		
Passive smoker	43381005	Y		
Snuff use – finding	365983005	Y		Y
Tobacco consumption unknown	160614008			
Tobacco smoking behavior – finding	365981007	Y	Y	Y
Tobacco user	110483000	Y		Y

How should “Unknown if ever smoked” from the Standards Criteria be reported / counted in the measure?

Unknown if ever smoked is likely designed for obtunded / demented / non-history given patients and is expected to be a low percentage of the overall denominator. “Unknown if ever smoked” should be counted as missing.

If any CCOs are interested in tracking any usage of “unknown if ever smoked” in their reporting, OHA is interested in the results, as this may be more appropriate as an exclusion in future versions of the measure.

If a member has their tobacco use status recorded multiple times, potentially from several providers, which status should be included in the measure?

If tobacco use status has been recorded multiple times from several providers *within the same practice*, use the most recent status on record from that practice, even if the individual saw multiple providers. If reporting at the practice level, then the individual will be in the denominator and the numerator once.

If tobacco use status has been recorded multiple times *across multiple practices*, reporting is dependent on the ability to de-duplicate individuals across multiple practices in the data submission. As OHA is not yet requiring all of the data to be submitted at the individual level, OHA will not be requiring de-duplication across all practices in the Year Four data submission. If reporting this at the practice level, the individual will be in the denominator and numerator once per practice, although they may be in multiple practices' data.

Can marijuana be included in the prevalence report if it is *not* recorded separately from cigarette smoking in the EHR?

No. This would not meet the measure specifications or the Core Measure. The EHR should work to separate out cigarette and marijuana smoking into discrete fields before developing a report and being included in a CCO's data submission.

Will OHA provide codes / value sets to exclude individuals on nicotine replacement therapy (NRT)?

No. If the measure is based on the Meaningful Use Core Measure "Record Smoking Status" – there should not be a problem in developing reports based on how / where smoking status is collected, without querying anything related to nicotine replacement therapy.

The exclusion related to nicotine replacement therapy is added to clarify that NRT should not be treated as equivalent to cigarette smoking or tobacco use *nor* should it be taken as a given that an individual with NRT is a non-smoker.

It is possible that a member is both on NRT and still documented as a tobacco user (in the fields where cigarette smoking / tobacco use status are recorded). In this case, the member would be counted as a tobacco user, despite the use of NRT. Individuals should only be counted as non-tobacco users when they have successfully quit, which would then be reflected in updated tobacco use status at subsequent visits.

If NRT is being excluded from the measure, should non-nicotine prescriptions for tobacco cessation also be excluded?

No. The measure is not about cessation services being provided, or percent of individuals who received medical assistance for smoking cessation. The measure is a measure of prevalence. Providers who write prescriptions for patients (NRT or non-nicotine) should not translate that prescription to mean the member is now a non-smoker.

How should a report determine if individuals are both on NRT and still smoking or using tobacco?

If an individual is still smoking, or using tobacco, despite NRT, they should be included in the numerator as this is a measure of prevalence.

The NRT exclusion was added to the specifications to clarify how / what status should be documented in the EHR, not to remove all NRT users from the measure entirely.

If an individual is a former cigarette smoker and on NRT, but took up chewing tobacco, how should they be counted in the measure?

The NRT would not be a factor in this individual's inclusion or exclusion in the measure. In this scenario, the individual is not included in Rate 2 (cigarette smoking prevalence), but would be included in Rate 3 (tobacco use prevalence).

Do existing Meaningful Use reports apply the "eligible as of the last date of the reporting period" or is this a new concept for clinics reporting Meaningful Use?

Meaningful Use is designed for clinics to measure their patients; eligibility is a health plan reporting construct. The specifications ask for this eligibility criteria "where possible" to reflect that some CCOs have integrated data warehouses and can look at eligibility and clinical data in conjunction. This is not expected of every practice in a CCO's data submission, especially as this is not part of standard Meaningful Use reporting.

Will clinics be able to submit data for a partial year if they implemented a change to their EHR or workflow?

Yes. Clinics will be able to submit data for a partial year. OHA has an exception process as part of the Data Proposal where CCOs will indicate which clinics would be reporting partial years and why.

Please note that pending determination of the population threshold for this measure for 2016 it may be preferable to not include some clinics if the reporting capacity is not built out, although each CCO will need to make this determination given their collective ability to report, as well as the potential 'cherry picking' that this may create for their baseline. That is, including fewer clinics may result in an artificially lower baseline, which would then make it harder to meet improvement targets / benchmarks in subsequent years when more clinics are included.