Recording Smoking Status in the EHR: Lessons from the Field

"*Our organization found it beneficial for a patient's smoking status to be recorded during the patient workup and flagged within the EHR for further review by the physician, who could discuss the issue with the patient as needed.*"

— Sarah Chouinard,MD, EHR Advisor and Chief Medical Officer, West Virginia Regional Health Information Technology Extension Center (WVRHITEC)

Implementers in the field identified an efficient process for recording smoking status while ensuring provider to patient discussions were pursued when necessary. During the patient workup, a nurse documents the patient's vitals and chief complaint as well as their tobacco status and body mass index (BMI). All tobacco and BMI data is then flagged in the EHR by applying blue font. The diagnosis of "Tobacco Use Disorder" or "Overweight" is also added to the problem list in blue font if that tobacco status is positive or if BMI is elevated. The blue font highlights these issues for the physician, alerting them to review the data and pursue tobacco or obesity counseling conversations during the patient appointment if necessary.

"*We found that practices that have been collecting the smoking status of patients for years may still fall short of meeting meaningful use simply because of the smoking status entries available within their EHR. We encourage practices take advantage of the option of adding more smoking status choices to their EHR if that is what the practice prefers, but to also ensure all of the smoking status options required by meaningful use are included and utilized within their EHR.*"

—Angela Strain, Organizational Advancement Director, The Center for the Advancement of Health IT

Ensuring that the smoking status data is entered appropriately into an EHR is a key component to successfully meeting this meaningful use measure. Each practice must work with their vendor to guarantee that all six (6) of the required smoking status options (as outlined in the ONC Final Rule Certification Criteria 170.302(g) [PDF - 10MB]) are available for physicians to select. However, they should also confirm that there are no duplicative options that might cause inconsistent data entry or limited use of the required status options. Properly utilizing these six (6) required options allows for physicians to compare their care to others across their community, their state, and the nation as these options are also utilized with the Center for Disease Control's Behavioral Risk Factor Surveillance System.

Meaningful use Stage 1 objective	Meaningful use Stage 1 measure	Certification criterion
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 or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.	Interim Final Rule Text: *Smoking status.* Enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current smoker, former smoker, or never smoked. Final Rule Text: §170.302(g). *Smoking status.* 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.

Source: http://www.healthit.gov/providers-professionals/achieve-meaningful-use/core-measures/record-smoking-status