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Measure Name	Tobacco Status: Assessment
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0028-1: Prevention & Screening Measure]* ACO Quality Measure #17 *[GPRO: Preventive Measure]* MIPS Clinical Quality Measure *[CMS 138 (EHR)/Registry 226:Process Measure]*
Measure Definition	*The percentage of patients, aged 18 years and older, who were screened for tobaco use at least one or more times within 24 months (the Measurement Period plus the 12 months prior to the Measurement Period)*
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)

Denominator	The **Denominator** consists of patients who:
	
	I. Are > 18 years old at the beginning of the Measurement Period
	II. **AND**, Were seen for two or more or more of the following applicable encounter types during the Measurement Period
	
	    A. Psychiatric
	    B. Occupational Therapy
	    C. Office Visit
	    D. Ophthalmological Services
	    E. Health and Behavioral Assessment
	    F. Home Healthcare
	
	III. **OR**, Were seen for one or more applicable Preventive Care or Annual Wellness encounters during the Measurement Period

Numerator	The **Numerator** consists of patients, from the Denominator, who were screened for tobacco use during the Measurement Period or the 12 months prior to the Measurement Period *(continued)*

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Measure Name	Tobacco Status: Assessment *(continued)*
Exclusions and/or Exceptions	Patients can be **excepted** from this measure if an acceptable reason exists for not performing the tobacco screen (i.e., medical reason or limited life expectancy) Note: The exception only applies if the patient was never assessed for tobacco use during the Measurement Period or the 12 months prior to the Measurement Period

Measure Documentation	**To Qualify For This Measure**
	(Denominator Documentation)
	
	I. The patient is seen for at least two applicable visit encounters during the Measurement Period
	
	    A. The following E&M codes identify applicable encounters
	
	        1. 90791 - 90792, 90832, 90834, 90837 and 90845
	        2. 92002, 92004, 92012 and 92014
	        3. 96150 - 96152
	        4. 97003 - 97004, and 97165 - 97168
	        5. 99201 - 99205, 99212 - 99215, 99341 - 99345 and 99347 - 99350
	
	    B. Record the appropriate E&M code in the Billing section of the Progress Note for the encounter
	    (Progress Notes → Billing)
	
	II. <u>OR</u>, The patient is seen for at least one preventive visit during the Measurement Period
	
	    A. The following E&M codes identify preventive encounters
	
	        1. 92521 - 92524, 92540, 92557 and 92625
	        2. 96160 - 96161
	        3. 99385 - 99387, 99395 - 99397, 99401 -99404, 99411 - 99412, 99420 and 99429
	        4. G0438 - G0439
	
	(continued)

Measure Name	Tobacco Status: Assessment *(continued)*
Measure Documentation *(continued)*	5. Note: Telehealth modifiers (GQ or GT) are **NOT** acceptable B. **Record the appropriate E&M code in the Billing section of the Progress Note for the encounter** *(Progress Notes → Billing)* **To Satisfy This Measure** *(Numerator Documentation)* I. **Screen the patient for tobacco use at least once during the Measurement Period or the 12 months prior to the Measurement Period** A. **Tobacco use includes all types of tobacco, including:** 1. Cigarettes 2. Cigars 3. Pipes 4. Chewing Tobacco 5. e-Cigarettes B. **Determine if the patient is:** 1. A Current Tobacco User (Current Smoker and/or other tobacco use) 2. A Former Tobacco User (Former Smoker and/or other tobacco use) 3. Never Used Tobacco II. **Document the patient's tobacco status in a structured data field in the Progress Note for the visit** A. **eCW recommends the following structured data pathway** *Progress Notes → Social History → Tobacco Use → Smoking → Are you a: (select option)* *(continued)*

Measure Name	**Tobacco Status: Assessment** *(continued)*

Measure Documentation *(continued)*	1. The required structured data field, to satisfy this measure, is outlined (boxed)
	2. The options available to select from are:
	
	    a. Current Smoker
	    b. Former Smoker
	    c. Non-Smoker
	    d. Current Everyday Smoker
	    e. Current Someday Smoker
	    f. Light Tobacco Smoker
	    g. Heavy Tobacco Smoker
	    h. Smoker, Current Status Unknown
	    i. Unknown if Ever Smoked
	    j. Uses Tobacco in Other Forms
	
	B. Record the patient's tobacco status, in the required structured data field, from one of the following locations:
	
	    1. From within the Progress Note for the visit, access the "Tobacco Control" Smart Form
	
	        a. Click the carat adjacent to the "SF" field (top, left-hand side of the Progress Note)
	        b. Select "Tobacco Control" from the drop-down list of options
	
	            1) The "Tobacco control" Smart Form will open
	            2) Select the option describing the patient's current tobacco status
	            3) Click "Save"
	            4) Click "Close" to exit
	
	                a) The information recorded in the Smart Form is automatically inserted into the Progress Note
	                b) The information recorded in the Smart Form is automatically saved as structured data
	
	(continued)

Measure Name	**Tobacco Status: Assessment** *(continued)*

Measure Documentation *(continued)*	**2. OR, Configure and map the required structured data field in the Social History section of the Progress Note**
	
	   a. From within a Progress Note or Virtual Visit, click the "Social History" link
	   b. If "Tobacco Use" is not included in the list of "Social Info" options that display:
	
	      1) Click the carat adjacent to the "Custom" button (at the bottom of the window)
	      2) Select "New Item" from the drop-down list of options
	      3) A "New Item/Category" window will open
	
	         a) Type "Tobacco Use" into the "Name" field
	         b) Check the "Structured Data" box
	         c) Click "OK" to save and close
	
	   c. Map the "Tobacco Use" field to its corresponding Community element
	
	      1) Click the "Community" tab (in the top menu bar)
	      2) Select "Mappings"
	      3) Select "Structured Data"
	
	         a) A "Mapper" window will open
	         b) Complete the following fields on the "Community" side:
	
	            (1) Section = Social History
	            (2) Category = Tobacco Use
	            (3) Item = Smoking
	
	         c) Complete the following fields on the "Local" side:
	
	            (1) Section = Social History
	            (2) Category = Social History (this field will auto-fill)
	            (3) Item = Tobacco Use
	
	(continued)

Measure Name	Tobacco Status: Assessment *(continued)*

Measure Documentation *(continued)*	d) Select the "Are you a:" option on the Community side
	           e) Click "Add" to add it to the Local side
	           f) Click "Map"
	           g) A new window with the available selection options will open
	
	                (1) Select the "Current Smoker" option on the "Community" side
	                (2) Click "Add" to add it to the Local side and map it to the Community counterpart
	                (3) Repeat for each of the remaining options on the "Community" side
	                (4) Mapped items display in blue font
	
	C. The patient's tobacco status should be assessed and recorded at every applicable visit encounter during the Measurement Period or the year prior to the Measurement Period
	
	D. Note: The "Social History Verified" box **MUST** be checked in order to satisfy the Numerator for this measure
	
	E. These structured data fields can be located in another customizable section of the Progress Note as long as they are mapped to the Community elements identified in the paths above

Exclusion and/or Exception Documentation	**To Except Patients From This Measure** *(Exclusion/Exception Documentation)* The patient can be excepted from this measure for one of the following reasons: **A.** The patient has limited life expectancy **B.** A valid medical reason exists for not performing the tobacco use assessment **C.** Document the reason for exception in a structured field, as follows: **1.** eCW recommends the following structured data path: *(continued)*

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Measure Name	Tobacco Status: Assessment *(continued)*
Exclusion and/or Exception Documentation	*Progress Notes* → *Social History* → *Tobacco Use* → Screening Not Performed → Reason ↙ ↘ Limited Life Expectancy Medical Reason ↓ ↓ *Details* *Type of Medical Reason* ↓ ↓ *Select option* *Select Option* 2. The required structured data fields are outline (boxed) in the path above 3. **Options for each reason include the following:** a. **For "Limited Life Expectancy"** Patient Status Determination, Pre-Terminal Prognosis Bad Terminal Illness Terminal Illness - Early Stage Terminal Illness - Late Stage b. **For "Medical Reason"** Absent Respnse to Treatment Adverse Reaction to Drug Complication of Medical Care Contraindicated Drug Allergy Drug Interaction Drug Intolerance Drug Resistance Drug Therapy Discontinued Drug Treatment Not Indicated Failure in Dosage History of Drug Allergy Late Effect of Medical and Surgical Care Complication Medical Contraindication Not Indicated Procedure Contraindicated Procedure Discontinued Procedure Not Indicated Treatment Changed Treatment Modification Treatment Not Indicated Treatment Not Tolerated c. **Prior to use, the required structured data fields may need to be configured and mapped** 1) From within a Progress Note or Virtual Visit, click the Social History link 2) Select "Tobacco Use" from the list of displayed items *(continued)*

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Measure Name	Tobacco Status: Assessment *(continued)*

Exclusion and/or Exception Documentation *(continued)*	3) The "Social History Notes" window will open
	
	    a) **If "Screening Not Performed" is not listed as an option, click the "Custom" button at the bottom of the window**
	    b) A "Structured Data" window will open
	
	        (1) Click the "Add" button at the top pf the window
	        (2) Type "Screening Not Performed" in the "Name" field
	        (3) Select "Structured Text" as the data "Type"
	        (4) Click "OK" to save and close
	
	    c) Select "Screening Not Performed" and click the "Customize Structured Text" button at the bottom of the window
	
	        (1) Click "Add" and type "Limited Life Expectancy"
	        (2) Click "Add" and type "Medical Reason"
	        (3) Click "OK" to save and close
	
	    d) Select "Screening Not Performed" again and click the "Add Child" button at the top of the window
	
	        (1) Enter "Type of Medical Reason" in the "Name" field
	        (2) Select "Structured Text" as the data "Type"
	        (3) Select "Medical Reason" as the "Trigger"
	        (4) Click "OK" to save and close
	
	    e) Select "Screening Not Performed" again and click the "Add Child" button at the top of the window
	
	        (1) Enter "Details" in the "Name" field
	        (2) Select "Structured Text" as the data "Type"
	        (continued)

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Measure Name	Tobacco Status: Assessment *(continued)*
Exclusion and /or Exception Documentation *(continued)*	(3) Select "Limited Life Expectancy" as the "Trigger" (4) Click "OK" to save and close **4) To map the fields, click the "Community" tab in the top menu bar** a) Select "Mappings" b) Select "Structured Data" c) A "Mapper" window will open (1) Enter the following for the "Community" side: (a) Section = Social History (b) Category = Tobacco Use (c) Item = Screening Not Performed (2) Enter the following for the Local side: (a) Section = Social History (b) Category = Social History (field should auto-fill) (c) Item = Tobacco Use d) Select "Reason" on the Community side and "Screening Not Performed" on the Local side and click "Map" (1) A new window with associated Community options will open (2) Select each idividual option on the Community side and click "Add" to add and map it to the Local side e) Repeat the mapping process for both "Details" and "Type of Medical Reason" *(continued)*

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Measure Name	Tobacco Status: Assessment *(continued)*
Exlusion and/or Exception Documentation *(continued)*	4. If applicable, document a reason for excepting the patient from this measure in the appropriate structured data fields

Trouble-Shooting *(continued)*	**Having Problems? Check Out These Trouble Shooting Tips**
	
	I. **Verify that tobacco assessment data is recorded in appropriate structured data fields within a Progress Note for an applicable visit**
	
	II. **Verify that all structured data fields are mapped to the correct Community counterparts in your EMR**
	
	    A. **This includes the structured fields included in the "Tobbaco Control" Smart Form**
	
	        1. **To determine if the "Tobacco Control" Smart Form fields are mapped, do the following:**
	
	            a. From within eCW, click the "Community" tab in the top menu bar
	            b. Click "Mappings"
	            c. Click "Smart Forms"
	
	                1) A "Smart Form Mapper" window will open
	                2) Select the "Tobacco Control" Smart Form on the "Master" side
	
	                    a) The "Tobacco Control" Smart Form questions will be displayed
	                    b) Mapped questions will display in blue font
	                    c) Unmapped questions will display in black font
	
	        2. **If mapping of the Smart Form fields is required**
	
	            a. From above, on the "Local" side of the Smart Form Mapper window, enter the following:
	
	                1) Section = Social History
	                2) Category = Social History (field should auto-fill)
	(continued)

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Measure Name	Tobacco Status: Assessment *(continued)*

Trouble-Shooting
(continued)
	3) Item = Tobacco Use
	
	    b. The "Tobacco Control" Smart Form questions should also display on the "Local" side
	    c. Select each matching pair of questions (from both the "Master" and "Local" side) and click "Map"
	
	B. Mapping of non-Smart Form "Tobacco Use" structured data fields is detailed in the "Measure Documentation" section, above
	
	C. For additional assistance with structured fields or mapping, contact an eCW technical representative

	III. **Verify that the "Social History Verified" box has been checked in the Progress Note**
	IV. **For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)**
For Further Information	**For Further Information** I. NQF 0028: "**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**" II. eClinicalWorks "**MIPS - CMS 138 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**" III. eClinicalWorks "**MIPS - Registry 226 (NQF 0028) (MIPS - CMS 138) - Preventive Care and Screening: Tobacco Use - Screening and Cessation Intervention**"