

Integrating Tobacco Cessation Into Electronic Health Records

The U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, calls for systems-level tobacco intervention efforts. Electronic health records (EHRs) allow for integration of this Guideline into the practice workflow, facilitating system-level changes to reduce tobacco use.

The American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) jointly advocate for EHRs that include a template that prompts clinicians and/or their practice teams to collect information about tobacco use, secondhand smoke exposure, cessation interest and past quit attempts. The electronic health record should also include automatic prompts that remind clinicians to:

- Encourage quitting
- Advise about smokefree environments
- Connect patients and families to appropriate cessation resources and materials

The tobacco treatment template should be automated to appear when patients present with complaints such as cough, upper respiratory problems, diabetes, ear infections, hypertension, depression, anxiety and asthma, as well as for well-patient exams.



Meaningful Use

The Health Information Technology for Economic and Clinical Health Act (HITECH), which was part of American Recovery and Reinvestment Act of 2009 (ARRA), provides incentives to eligible professionals (EP) and hospitals that adopt certified EHR technology and can demonstrate that they are meaningful users of the technology. To qualify as a meaningful user, EPs must use EHRs to capture health data, track key clinical conditions, and coordinate care of those conditions.

Smoking status objectives and measures included in the meaningful use criteria are:

- Objective: Record smoking status for patients 13 years old or older.
- Measure: More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded.
- EHR requirement: 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.

Patient education objectives and measures included in the meaningful use criteria are:

- Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient, if appropriate.
- Measure: More than 10% of all unique patients seen by the EP are provided patient-specific education resources.
- EHR requirement: Must enable a user to electronically identify and provide patient-specific education resources according to, at a minimum, the data elements included in the patient's: problem list; medication list; and laboratory test results; as well as provide such resources to the patient.

Template recommendations are on the back of this document.



AMERICAN ACADEMY OF
FAMILY PHYSICIANS

ASK AND ACT
A TOBACCO CESSATION PROGRAM

What should be included in a tobacco cessation EHR template?

Including tobacco use status as a vital sign provides an opportunity for office staff to begin the process. Status can be documented as:

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Unknown if ever smoked

A complementary field should document secondhand smoke exposure: current, former or never.

The template should include:

History:

Type of tobacco:

- Cigarettes Pipe Cigars Smokeless

How many years? _____ Packs per day: _____

Brand: _____

Approx date of last quit attempt: _____

Medication used in previous quit attempt:

- Patch
 Inhaler
 Gum
 Lozenge
 Bupropion
 Varenicline
 None
 Other: _____

Readiness to Quit:

- Not interested in quitting
 Thinking about quitting at some point
 Ready to quit

Assessment and Plan:

Quit Date: _____

Counseling:

Counseled for:

- Three minutes or less
 3 to 10 minutes
 10+ minutes

Payment for Counseling

As you incorporate tobacco cessation into your EHR templates, be sure to involve those who do your medical billing. Electronic claims systems may need to be modified to include tobacco dependence treatment codes. For a list of CPT & ICD-9 Codes related to tobacco cessation counseling, click on the Ask and Act Practice Toolkit link at www.askandact.org.

Counseled for secondhand smoke

Counseling notes: _____

Handouts provided:

- "Prescription:" Quit Smoking
 Quitline Card
 Quit Smoking Brochure
 Secondhand Smoke Brochure
 Stop Smoking Guide
 Familydoctor.org information
 Other: _____

Pharmacotherapy:

Recommended OTC:

- NRT Gum
 NRT Lozenge
 NRT Patch

Medical Treatment:

- NRT Nasal Spray
Dosing: 1–2 doses/hour (8–40 doses/day); one dose = one spray in each nostril; each spray delivers 0.5 mg of nicotine
- NRT Inhaler
Dosing: 6–16 cartridges/day; initially use 1 cartridge q 1–2 hours
- Bupropion SR
Dosing: Begin 1–2 weeks prior to quit date; 150 mg po q AM x 3 days, then increase to 150 mg po bid. Contraindications: head injury, seizures, eating disorders, MAO inhibitor therapy.
- Varenicline
Dosing: Begin 1 week prior to quit date; days 1–3: 0.5 mg po q AM; days 4–7: 0.5 mg po bid; weeks 2–12: 1 mg po bid
Black box warning for neuropsychiatric symptoms.

Follow Up Plan:

- Follow up visit in 2 weeks
 Staff to follow up in _____ weeks
 Address at next visit