

**NPRM EP/Eligible Hospital Objective:
Record smoking status for patients 13
years old or older**

In the proposed rule, we explained that we believe it is necessary to add an age restriction to this objective as we do not believe this objective is applicable to patients of all ages and there is no consensus in the health care community as to what the appropriate cut off age may be. We encouraged comments on whether this age limit should be lowered or raised. We received many comments on the age limit and address them below.

Comment: Several commenters requested a different age limitation. Commenters suggested ages anywhere between 5 years old up to 18 years old.

Response: For the purposes of this objective and for meaningful use, our interest is focused on when a record of smoking status should be in every patient's medical record. Recording smoking status for younger patients is certainly not precluded. We do believe there would be situations where an EP/eligible hospital/CAH's knowledge about other risk factors would indicate that they should inquire about smoking status if it is unknown for patients under 13 years old. However, in order to accurately measure and thereby assure meaningful use, for this objective we believe that the age limit needs to be high enough so that the inquiry is appropriate for all patients. Therefore, we are maintaining the age limitation at 13 years old or older.

Comment: Some commenters suggested expanding smoking status to any type of tobacco use.

Response: While we agree that an extended list covering other types of tobacco use may provide valuable insight for clinical care for certified EHR technology, the CDC's NHIS standard recodes for smoking status. This will provide a standard set of questions across providers and standardize the data. The extended list does not make the collection of multiple survey questions clear. For example, a patient may be a current tobacco user as well as a smoker. For these reasons in Stage 1 we will use the standards adopted by the CDC for certified EHR technology at 45 CFR 170.302(g). For future stages, we will review this measure for possible inclusion of other questions. This is a minimum set. We do not intend to limit developers of EHR technology from creating more specific fields or to limit EPs/eligible hospitals/CAHs from recording more specific information.

Comment: We also received comments requesting that second-hand

smoking be included in the objective for children and adolescents.

Response: Including second-hand smoking introduces much more variability into the objective as to what constitutes a level of exposure and difficulty in measuring it successfully with different age limits to different aspects. For instance, how much exposure is acceptable for a given age and how is such exposure determined? How would these differing requirements be accounted for by certified EHR technology? As with the change from smoking status to tobacco use, we believe this introduces an unacceptable level of complexity for Stage 1 of meaningful use. For Stage 1 of meaningful use we are not adding second hand smoke exposure to this objective. However, we remind EPs, eligible hospitals and CAHs that nothing about the criteria for meaningful use prevents them from working with their EHR developer to ensure that their EHR system meets their needs and the needs of their patient population. We encourage all EPs, eligible hospitals and CAHs to critically review their implementation in light of their current and future needs both to maximize their own value and to prepare for future stages of meaningful use.

Comment: We received comments asking at what frequency the information must be recorded and whether the information can be collected by support staff.

Response: We clarify that this is a check of the medical record for patients 13 years old or older. If this information is already in the medical record available through certified EHR technology, we do not intend that an inquiry be made every time a provider sees a patient 13 years old or older. The frequency of updating this information is left to the provider and guidance is provided already from several sources in the medical community. The information could be collected by any member of the medical staff.

Comment: We received a number of comments recommending either removing this objective to record smoking status from the HIT functionality objectives or removing the smoking measure from the core clinical quality measures as these measures serve the same purpose and to require both is to require duplicative reporting.

Response: We disagree that these two measures serve the same purpose and therefore only one should be included. The objective included here seeks to ensure that information on smoking status is included in the patient's record. Furthermore, that the information is stored in a structured

format so that it can automatically be identified by certified EHR technology as smoking status for possible reporting or exchanging. We also note that the clinical quality measure only focuses on patients 18 years or older, while the objective focuses on patients 13 years or older. In addition, many quality measures related to smoking are coupled with follow-up actions by the provider such as counseling. We consider those follow-up actions to be beyond the scope of what we hope to achieve for this objective for Stage 1 of meaningful use.

After consideration of the public comments received, we are finalizing the meaningful use objective for EPs at § 495.6(d)(9)(i) and for eligible hospitals at § 495.6(f)(8)(i) of our regulations as proposed.

We include this objective in the core set as it is integral to the initial or ongoing management of a patient's current or future healthcare and would give providers the necessary information to make informed clinical decisions for improved delivery of patient care.

NPRM EP/Eligible Hospital Measure: At least 80 percent of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital have "smoking status" recorded.

In the proposed rule, discussion of this measure referenced other sections exclusively.

Comment: We received comments recommending alternative thresholds for this measure. Commenters provided thresholds ranging from anything greater than zero to 60 percent in stage 1.

Response: In the proposed rule, we established a consistent threshold for measures not requiring the exchange of information. For the final rule, (other than up-to-date problem list, active medication list and active medication-allergy list), we have lowered the threshold associated with these measures to 50 percent. In our discussion of the objective, we noted many concerns by commenters over the appropriate age at which to inquire about smoking status. There were also considerable differences among commenters as to what the appropriate inquiry is and what it should include. Due to these concerns, we do not believe this objective and measure fit into the threshold category described under up-to-date problem lists and therefore we adopt a 50 percent (rather than an 80 percent) threshold for this measure. After consideration of the public comments received, we are modifying the meaningful use measure for EPs at § 495.6(d)(9)(ii) and for eligible hospitals at § 495.6(f)(8)(ii) of

our regulations to “More than 50 percent 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 departments (POS 21 or 23) have smoking status recorded as structured data”.

We further specify that in order to meet this objective and measure, an EP, eligible hospital, or CAH must use the capabilities Certified EHR Technology includes as specified and standards at 45 CFR 170.302(g). The ability to calculate the measure is included in certified EHR technology.

As noted previously in this section under our discussion of the burden created by the measures associated with the Stage 1 meaningful use objectives, the percentage is based on patient records that are maintained using certified EHR technology.

To calculate the percentage, CMS and ONC have worked together to define the following for this objective:

- **Denominator:** Number of unique patients age 13 or older seen by the EP or admitted to an eligible hospital’s or CAH’s inpatient or emergency departments (POS 21 or 23) during the EHR reporting period. A unique patient is discussed under the objective of maintaining an up-to-date problem list.

- **Numerator:** The number of patients in the denominator with smoking status recorded as structured data.

- **Threshold:** The resulting percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure. As addressed in other objectives, EPs, eligible hospitals or CAHs who see no patients 13 years or older would be excluded from this requirement as described previously in this section under our discussion of whether certain EP, eligible hospital or CAH can meet all Stage 1 meaningful use objectives given established scopes of practices. Most EPs and all eligible hospitals and CAHs would have access to this information through direct patient access. Some EPs without direct patient access would have this information communicated as part of the referral from the EP who identified the service as needed by the patient. Therefore, we did not include an exclusion based on applicability to scope of practice or access to the information for this objective and associated measure.

NPRM EP/Eligible Hospital Objective: Record advance directives.

In the proposed rule, we discussed this objective, but did not propose it as a requirement for demonstrating meaningful use, for a number of reasons, including: (1) It was unclear whether the objective would be met by

indicating that an advance directive exists or by including the contents of the advance directive; (2) the objective seems relevant only to a limited and undefined patient population when compared to the patient populations to which other objectives of Stage 1 of meaningful use apply; and (3) we believe that many EPs would not record this information under current standards of practice. Dentists, pediatricians, optometrists, chiropractors, dermatologists, and radiologists are just a few examples of EPs who would require information about a patient’s advance directive only in rare circumstances.

Comment: We received several comments including a comment from the HIT Policy Committee that we should include advance directives in the final rule. The HIT Policy Committee clarified that this would be an indication of whether a patient has an advanced directive. Furthermore, they recommend limiting this measure to patients 65 and older. We received other comments that said this should be a requirement for eligible hospitals. Other commenters reported that having this information available for the patient would allow eligible hospitals to make decisions that were better aligned with the patient’s expressed wishes.

Response: In the proposed rule, we said that confusion as to whether this objective would require an indication of the existence of an advanced directive or the contents of the advance directive itself would be included in certified EHR technology was one of the reasons for not including the objective in Stage 1 of meaningful use. We expressed concerns that the latter would not be permissible in some states under existing state law. As commenters have clarified that advance directives should be just an indication of existence of an advance directive and recommended a population to apply the measure to, we reinstate this objective for eligible hospitals and CAHs. We believe that the concern over potential conflicts with state law are alleviated by limiting this to just an indication. We also believe that a restriction to a more at risk population is appropriate for this measure. By restricting the population to those 65 years old and older, we believe we focus this objective appropriately on a population likely to most benefit from compliance with this objective and its measure. This objective is in the menu set so if an eligible hospital or CAH finds they are unable to meet it then can defer it. However, we believe many EPs would not record this information under current standards of practice. Dentists, pediatricians,

optometrists, chiropractors, dermatologists, and radiologists are just a few examples of EPs who would only require information about a patient’s advance directive in rare circumstances. For other meaningful use objectives, we have focused our exclusions on rare situations, which would not be the case for this objective. Therefore, we do not include this objective for EPs.

After consideration of the public comments received, we are including this meaningful use objective for eligible hospitals and CAHs at § 495.6(g)(2)(i) of our regulations as “Record whether a patient 65 years old or older has an advanced directive as structured data”.

NPRM EP/Eligible Hospital Measure: N/A.

While we did not receive specific percentage recommendations from commenters, this objective is the recording of a specific data element as structured data in the patient record. This is identical to other objectives with established measures such as, recording vital signs, recording demographics and recording smoking status. Therefore, we adopt the measure format and the lower threshold (50 percent) from those objectives. We also believe that this information is a level of detail that is not practical to collect on every patient admitted to the eligible hospital’s or CAH’s emergency department, and therefore, have limited this measure only to the inpatient department of the hospital.

In the final rule, this meaningful use measure for eligible hospitals at § 495.6(g)(2)(ii) of our regulations: “More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital’s or CAH’s inpatient department (POS 21) have an indication of an advance directive status recorded as structured data”.

We further specify that in order to meet this objective and measure, an EP, eligible hospital, or CAH must use the capabilities Certified EHR Technology includes as specified and standards at 45 CFR 170.306(h). The ability to calculate the measure is included in certified EHR technology.

As noted previously in this section under our discussion of the burden created by the measures associated with the Stage 1 meaningful use objectives, the percentage is based on patient records that are maintained using certified EHR technology.

To calculate the percentage, CMS and ONC have worked together to define the following for this objective:

- **Denominator:** Number of unique patients age 65 or older admitted to an eligible hospital’s or CAH’s inpatient department (POS 21) during the EHR