Helping Patients *Quit*

Implementing The Joint Commission Tobacco Measure Set in Your Hospital

Partnership for Prevention
Shaping Policies • Improving Health

Action TO QUIT
Advancing Tobacco Control Policy

Contents

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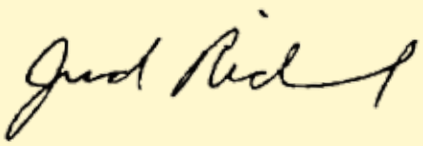
Partnership for Prevention's ActionToQuit initiative is pleased to offer this "Helping Patients Quit" guide to hospital leaders and care providers as a useful tool in implementing a comprehensive tobacco cessation program. It is Partnership's belief that hospitals have a critical role to play in decreasing the lives lost to tobacco in the United States. Screening all patients for tobacco use and offering treatment and follow-up to those who use tobacco is both good policy and practice.

The Joint Commission has provided national leadership by developing new tobacco cessation performance measures and, as a result, many hospitals will make this a priority. Since the hospitalized tobacco user, at least temporarily, is in a tobacco-free environment, this is an ideal time and place to intervene. Additionally, patients may be more motivated to quit during their hospital stay than at any other time because the reason for their hospitalization may have been caused or made worse by tobacco use.

Partnership for Prevention seeks to create a "prevention culture" in America, where the prevention of disease and the promotion of health, based on the best scientific evidence, are the first priorities for policy makers, decision-makers, and practitioners. ActionToQuit is a tobacco control policy initiative that urges all sectors — health care systems, employers, quitlines, insurers, and policymakers — to work together to ensure that all tobacco users have access to comprehensive cessation treatments.



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Section 1

Introduction

Foreword

According to the U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, "tobacco use presents a rare confluence of circumstances: 1) a highly significant health threat; 2) a disinclination among clinicians to intervene consistently; and 3) the presence of effective interventions… Indeed, it is difficult to identify any other condition that presents such a mix of lethality, prevalence, and neglect, despite effective and readily available interventions."[1] Tobacco use is a prevalent and critical public health issue that is highly treatable through utilization of existing resource networks and coordinated action by health care providers.

Tobacco users, including, but not limited to smokers, have higher hospitalization rates than those who do not use tobacco.[2] However, most hospitals have not placed a priority on systematically identifying tobacco users, recording their current tobacco use status, offering evidence-based assistance in quitting, and following up with patients after discharge.

Hospitalization provides an opportunity to assist tobacco users with quitting, as well as to instruct inpatients that exposure to secondhand smoke in the home setting poses health consequences for families. As the U.S. Surgeon General wrote in her 2010 report, there is no risk-free level of exposure to tobacco smoke. If a hospital is to be accredited by The Joint Commission* it must now be smoke-free, and hospitals are increasingly implementing 100% tobacco-free campus policies.[3] As a result, almost every hospitalized tobacco user is temporarily in a tobacco-free environment. If they are not offered medications to quit or ease withdrawal symptoms, some patients will leave the hospital property to use tobacco, potentially putting their safety at risk. However, the policy prohibiting tobacco use in the hospital can be an important start on the road to successfully quitting. Patients may be more motivated to quit during their hospital stay than at any other time because the reason for their hospitalization may have been caused or made worse by tobacco use. Hospitals have the expertise and resources to support patients interested in quitting tobacco use. In addition, if hospitalized tobacco users have a positive experience using cessation medications to try to quit or manage withdrawal, they may be more likely to continue the use of such treatments after discharge to stay quit for good. For all of these reasons, hospitals have an important opportunity to serve their communities, providing quality care by encouraging and supporting their patients to quit the use of tobacco.

In the past year, tobacco cessation has been elevated as a priority in the delivery of quality medical care with the passage of the Affordable Care Act, enhanced coverage by the Centers for Medicare & Medicaid Services (CMS), and a new measure set by The Joint Commission.

While The Joint Commission has had measures addressing tobacco cessation for some time, the newly released measure set goes far beyond past initiatives. This, together with changes mandated by health care reform and incentives offered by Medicare and Medicaid, make now an ideal time for hospitals to implement a comprehensive tobacco cessation program for patients.

The goal of this resource is to provide guidance to hospital leaders and practitioners in their implementation of the new tobacco cessation performance measures developed by The Joint Commission. Hospitals that select this measure set will be required to screen all inpatients, 18 years of age and older, for tobacco use; provide cessation treatment during the hospital stay and at discharge; and follow-up with inpatients up to 30 days after discharge.

*An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 18,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx

Overview of Tobacco Cessation in U.S. Hospitals

Over the past twenty years, several studies have demonstrated the efficacy and cost-effectiveness of initiating tobacco treatment during a hospital stay for myocardial infarction.[4,5] Despite the evidence, tobacco treatment interventions have not been widely adopted by health care providers. A likely reason for the failure to adopt a tobacco intervention program, as recently described by Dr. Nancy Rigotti in the *Archives of Internal Medicine*, was that it did not fit readily into the prevailing structure of U.S. health care provision, documentation requirements, or reimbursement.[6]

As Rigotti states, the health care environment has changed substantially in recent years. Building systems of care to improve the outcomes of patients with chronic diseases is now a priority. Reimbursement is beginning to shift from rewarding visit and procedure volumes to rewarding the value that treatments offer to patients and society.

Incentives for hospitals to address tobacco use were first introduced in 1992 by The Joint Commission, which accredits about 18,000 healthcare organizations in the U.S. Accreditation is contingent on the prohibition of smoking within the hospital. In 2004, The Joint Commission implemented performance measures for the delivery of evidence-based tobacco dependence interventions to patients with a history of tobacco use and diagnoses of acute myocardial infarction, congestive heart failure, or community-acquired pneumonia. The measures used to determine hospital compliance with this requirement included assessment of whether tobacco users discharged with these diagnoses received advice or assistance to quit during their hospital stay. Over time, hospitals' performance on this measure improved. However, because these measures only applied to a narrow patient group and did not require hospitals to connect patients to post-discharge care, the intervention was not sufficient to produce the desired change. These measures have now been retired by The Joint Commission.

In 2011 The Joint Commission developed a new set of performance measures to address the assessment and treatment of tobacco dependence for all hospitalized patients. This new measure set, which will be available for hospital selection in January 2012, is more comprehensive and will be of much greater benefit to patients than the original 2004 measures.[7]

Section 2

The Joint Commission's New Tobacco Measure Set

Overview of the Measure Set

The Joint Commission received funding from Partnership for Prevention to develop a set of performance measures to address the assessment and treatment of tobacco dependence for inpatients. This new measure set broadens the scope of the existing measures and will replace the current National Hospital Quality Measures for Adult Smoking Cessation Advice/Counseling in the acute myocardial infarction (AMI-4), heart failure (HF-4), and pneumonia (PN-4) measure sets. It is based on scientific evidence from the U.S. Public Health Service Clinical Practice Guideline on Treating Tobacco Use and Dependence.

The new Joint Commission measures (see Tobacco Measure Set Specifications table below) require acute care hospitals to screen all inpatients for tobacco use and to offer counseling and medications to patients 18 years of age or older who use tobacco. These services should be offered both during the hospital stay and at discharge to maximize patient health and reduce the likelihood of re-hospitalizations. Thereafter, patients must receive follow-up contact within 30 days of discharge to ascertain tobacco use status.

Unlike the earlier measures, the new measures do not target a specific diagnosis. Rather, they are broadly applicable to all hospitalized patients 18 years of age and older.

The Joint Commission encourages hospitals that provide tobacco cessation interventions to patients younger than 18 to continue this practice, though these data will not be a part of the new measure set. Meaningful Use, however, does require all patients 13 years of age and older be screened for tobacco use and for this information to be documented in their electronic health record (EHR).

Additional details about this measure set are available in The Joint Commission's "Specifications Manual for National Hospital Inpatient Quality Measures" which is available free on The Joint Commission website: http://www.jointcommission.org/specifications_manual_for_joint_commission_national_quality_core_measures

Set Measure ID#	Tobacco Measure Set Specifications
TOB-1 Tobacco Use Screening	**Numerator:** The number of patients who were screened for tobacco use status. **Denominator:** The number of hospitalized inpatients 18 years of age and older.
TOB-2 Tobacco Use Treatment Provided or Offered	**Numerator:** The number of patients who received or refused practical counseling to quit **and** received or refused U.S. Food and Drug Administration (FDA) approved cessation medications. **Denominator:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.
TOB-2a Tobacco Use Treatment	**Numerator:** The number of patients who received practical counseling to quit **and** received FDA-approved cessation medications. **Denominator:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.
TOB-3 Tobacco Use Treatment Provided or Offered at Discharge	**Numerator:** The number of patients who were referred to or refused evidence-based outpatient counseling **and** received or refused a prescription for FDA-approved cessation medication at discharge. **Denominator:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.
TOB-3a Tobacco Use Treatment at Discharge	**Numerator:** The number of patients who were referred to evidence-based outpatient counseling **and** received a prescription for FDA-approved cessation medication at discharge. **Denominator:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.
TOB-4 Tobacco Use: Assessing Status after Discharge	**Numerator:** The number of discharged patients who are contacted within 30 days after hospital discharge and follow-up information regarding tobacco use status is collected. **Denominator:** The number of discharged patients 18 years of age and older identified as current tobacco users.

Section 3

Message to Hospital Leaders

While the new tobacco measure set, like all other Joint Commission measure sets, is optional, there are many important reasons to select it for implementation in your hospital:

Public Health Impact of Tobacco Use

Tobacco use imposes enormous public health and financial costs on this nation — costs that are completely avoidable. Tobacco is responsible for over 440,000 deaths (or approximately one in every five deaths) each year in the United States. The chronic diseases caused by tobacco use lead the list of overall causes of death and disability in the United States and unnecessarily strain the health care system. The economic burden of tobacco use includes more than $193 billion annually in health care costs and lost productivity.[8] Hospitals and health care providers can play a critical role in the prevention of the health, financial and emotional tolls that tobacco use takes on individuals, families, and communities.

Health of Patients

Continued tobacco use may interfere with patients' recovery and overall health. Among cardiac patients, second heart attacks are more common in those who continue to smoke.[9,10] Lung, head, and neck cancer patients who are successfully treated for their cancer but who continue to smoke are at elevated risk for a second cancer.[11,12,13,14,15] Additionally, smoking negatively affects chronic obstructive pulmonary disease as well as bone and wound healing.[16,17,18,19,20,21,22]

Electronic Health Records/Meaningful Use

The federal Health Information Technology for Economic and Clinical Health Act (HITECH), part of American Recovery and Reinvestment Act (ARRA) of 2009, provides incentives to eligible health care professionals and hospitals that adopt certified electronic health record (EHR) technology and demonstrate that they are meaningful users of the technology. To qualify as a meaningful user, eligible professionals and hospitals must use EHRs to capture health data, track key clinical conditions, and coordinate care of those conditions.[23] Clinicians are required to report data on three core quality measures in 2011 and 2012: patient blood-pressure level, tobacco use status, and adult weight screening and follow-up provided by the health care provider. All eligible hospitals and physicians are required to screen all patients 13 years of age and older for tobacco use.

HITECH authorized incentive payments totaling up to $27 billion over ten years through CMS to clinicians and hospitals when they use EHRs privately and securely to achieve specified improvements in care delivery. The legislation ties payments specifically to the achievement of advances in health care processes and care delivery outcomes. Participating hospitals can expect between two and twelve million dollars in incentives annually for adopting EHRs and demonstrating meaningful use of these systems.

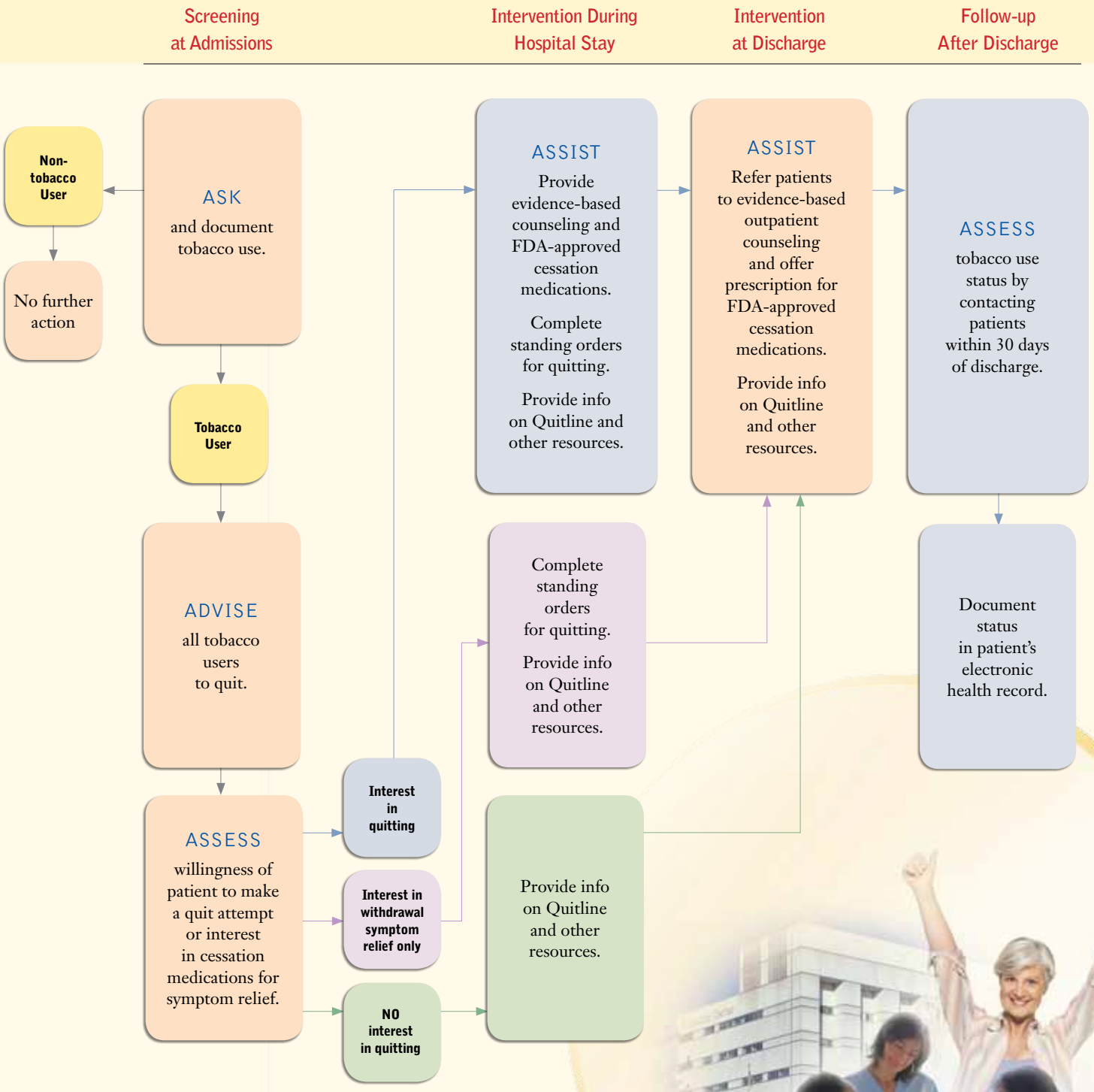
Commitment to Community Wellness/ Hospital Mission

Most hospital mission statements include language about improving the health of the communities they serve. Approximately one of five citizens in communities surrounding America's hospitals will die from a tobacco-related cause.[24] Investing in tobacco cessation is one of the most important ways a hospital can contribute to the overall health of its community. Many hospitals have made this commitment already and are helping patients quit.

CMS Endorsement

The Centers for Medicare and Medicaid Services (CMS) has included the tobacco measure set in their aligned manual with The Joint Commission.[25] CMS is also considering the inclusion of this measure set in their Inpatient Prospective Payment System (IPPS) rule, at present designating the measure set "For Future Use". The IPPS rule determines Medicare payment to hospitals for the implementation of designated quality measures.

The Patient's Path:
Hospital Tobacco Dependence Screening and Treatment



Adapted from: Treating Tobacco Use and Dependence in Hospitalized Smokers.
Center for Tobacco Research and Intervention, University of Wisconsin Medical School.

Section 4

Implementation

Hospitals that have successfully implemented a comprehensive tobacco use cessation program typically followed some variation of the following steps in implementation:

- Obtain commitment from leadership
- Conduct an assessment of existing tobacco use treatment services
- Plan and build consensus with key stakeholders
- Train hospital staff
- Provide tobacco cessation interventions to patients
- Monitor performance and solicit feedback from staff and patients

The support and commitment of hospital administration, clinical leaders, and other stakeholders is crucial to the success of the implementation plan. Each step in this process is described further below.

Obtain Commitment

Hospital leadership can begin this implementation process by convening a group of staff leaders from a variety of disciplines (both inpatient and outpatient) that will help promote and champion the initiative. They can represent emergency medicine, cardiology, hospitalists, respiratory therapy, physical therapy, pharmacy, nursing, professional education, and quality improvement, among other areas. Consider having a physician and nurse serve as leaders for the effort in order to obtain buy-in from other physicians and nurses and the hospital leadership. It will be important to develop a clinical workflow to ensure all providers know their roles and responsibilities.

The change in the Joint Commission measure set is also an opportunity for hospitals to review their own smoking cessation employee benefit to ensure it is comprehensive in nature and includes access to all of the seven FDA-approved treatments. Partnership for Prevention and the American Lung Association recommend that health care plans provide smoking cessation coverage that is free of barriers. This includes eliminating co-pays, duration limits, prior authorization requirements, stepped care therapy, and other requirements for cessation medications and counseling. Eliminating these barriers to coverage is especially important for low-income populations, like Medicaid recipients, since barriers are more likely to discourage these smokers from getting help.[26]

Conduct an Assessment of Existing Tobacco Use Treatment Services

Conduct a preliminary assessment to understand what tobacco use interventions are already in place and whether current practice and documentation will meet one or more of The Joint Commission's measures.

- To ensure that you have a comprehensive understanding of the evidence regarding effective tobacco-use treatment strategies, visit: http://www.surgeongeneral.gov/tobacco to review the U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*.
- Determine the tobacco use treatment services and activities in each area of the hospital, and obstacles that may prevent effective implementation of The Joint Commission tobacco measure set. An integrated approach to tobacco cessation is recommended. This may include tobacco treatment specialists who cross multiple departments so that patients will receive the same comprehensive care regardless of the department in which they are served.
- Identify units or departments that have successfully implemented tobacco use screening and intervention policies or processes.
- Determine what tobacco use treatment coverage is being provided within your health system (counseling and medication) by examining health plans that cover the highest numbers of enrollees to help you understand variations in reimbursement for services.

Plan and Build Consensus

Define your objectives and establish quality improvement measures. Think about the delivery systems and providers you will engage and the policies, processes and practices you will champion

to ensure that a comprehensive tobacco intervention program is implemented effectively. The environment must be supportive of best clinical practice. Therefore, to ensure that all tobacco users admitted to the hospital are provided tobacco dependence treatment routinely, it will be crucial to implement a systematic approach. This should include establishing new workflows, developing staff performance objectives, assigning tasks, revising job descriptions, and providing easy access to referrals. Expanding hospital formularies to include all FDA-approved tobacco dependence medications and including tobacco screening questions in electronic medical records are good steps to consider up front.

Train Staff

Set objectives for health care provider education, offer staff training, and determine ongoing training needs. To the extent possible, follow the recommendations from the Clinical Practice Guideline which advocates use of the "5A's" framework for comprehensive tobacco cessation counseling: 1) Ask about tobacco use; 2) Advise patients to quit; 3) Assess readiness to quit; 4) Assist with quitting; and 5) Arrange follow-up care.[27] Educate hospital staff about the seven FDA-approved medications that may be used to reduce nicotine withdrawal symptoms, even if the patient is not intending to quit at this time. On a regular basis, offer staff continuing education (e.g., lectures, workshops, in-services) on tobacco dependence treatments. It may be helpful to designate one person in each department as the tobacco cessation champion responsible for ensuring that staff are trained and patients are screened and treated. Give feedback to clinicians about their performance, drawing on data from chart audits and electronic health records.

In the hospital setting, the healthcare team should provide all of the five elements of cessation treatment. Physicians, nurses, therapists, social workers, and allied health professionals should all understand the importance of repeated, consistent messages — even brief messages if time does not allow for more. It is important to identify one or more clinicians to deliver inpatient tobacco dependence consultation services and to determine how these services will be delivered at the bedside. Some hospitals provide extended counseling services.

Some training resources include:

University of Wisconsin—Tobacco Use and Dependence: An Updated Review of Treatments CME/CE https://login.medscape.com/login/sso/getlogin?urlCache=aHR0cDovL3d3dy5tZWRzY2FwZS5vcmcvdmlld3Byb2dyYW0vMTc3MTA=&ac=401

US Department of Health and Human Services Guideline: Quick Reference Guide for Clinicians, Treating Tobacco Use and Dependence, http://www.ahrq.gov/clinic/tobacco/tobaqrg.htm

Provide the Screening, Treatment and Follow-Up

The program should consist of some variation of the 5 A's (Ask, Advise, Assess, Assist, Arrange) or the following components:

A. Tobacco Use Screening and Documentation (ASK)

All hospitalized inpatients will be screened for tobacco use and the status will be noted in the patient's record.

A system should be implemented that ensures that tobacco use status is asked and documented for every patient who is admitted. Asking patients about tobacco use—including length of time smoked, level of smoking and previous attempts to quit—should take place during the admission process when vital signs are recorded, either in the admitting office or by the admitting clinician.

B. Tobacco Use Treatment (ADVISE, ASSESS, ASSIST)

Evidence-based counseling to quit and strategies for withdrawal management are offered to all patients who use tobacco.

Once a tobacco user has been identified, he or she should be advised to quit in a manner that is clear, strong, and personalized. Even brief advice to quit results in increased quit rates.[28] After being advised to quit, tobacco users should be asked if they are willing to make a quit attempt. If the patient is willing to make a quit attempt and/or is interested in pharmacotherapy, a systematic method for providing counseling and pharmacotherapy is needed.

- Standing orders for tobacco cessation: Once it is documented that the patient is a tobacco user and interested in quitting or getting relief of withdrawal symptoms, a standing order form for tobacco cessation should be initiated. This should lead the physician or nurse to call for a tobacco cessation consult or bedside counseling session and initiate pharmacotherapy for tobacco cessation as recommended in the clinical practice guidelines. The attending or rounding physician then completes the standing order form, tailoring it to the individual needs of the patient.[29]

> "We have developed an evidence-based "system process" that is considered a best practice for tobacco cessation in the in-patient setting. It allows us to provide clinical staff with the tools for effective interventions and patients the tools they need to stay quit successfully."
>
> Kim Olson, Tobacco Cessation Program Coordinator, INTEGRIS Health

- Counseling consult: The counseling consult conducted at the bedside during the hospital stay should be completed by a designated staff member trained in tobacco cessation counseling best practices outlined in the U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, www.surgeongeneral.gov/tobacco. In general, the counseling should include discussing past quit attempts, obtaining support from family and friends, learning new skills and behaviors to avoid triggers, relapse, high-risk situations, pharmacotherapy, follow-up, and a review of the health consequences associated with exposing others (especially children) to secondhand smoke. A smoke free home policy is highly recommended.

C. Pharmacotherapy (ASSIST)

All FDA-approved tobacco cessation medications should be offered to all patients who use tobacco (unless contra-indicated or for certain populations) during the hospital stay. The PHS guideline states that counseling and pharmacotherapy used together are more effective than either alone.

> **Case Study Example** The Massachusetts General Hospital is taking this requirement a step further by offering free pharmacotherapy to discharged patients for up to 90 days, thereby removing barriers to use of medications such as cost and the need to go to a pharmacy after leaving the hospital.

D. Follow-up (ARRANGE)

At discharge, all current tobacco users (use within the past 30 days) 18 years of age and older should be referred to evidence-based outpatient counseling and provided a prescription for FDA-approved cessation medications. In addition, discharged patients 18 years of age and older identified as current tobacco users should receive at least one follow-up contact within 30 days of hospital discharge to ascertain their tobacco use status.

Patients should also be provided with resources such as access to tobacco Quitlines (e.g., 1-800-QUIT-NOW) and other community resources, self-help materials, and information about additional effective tobacco cessation medications.

Four models of post-discharge follow-up are listed below:

i. In-person phone calls from hospital staff are standard practice after outpatient surgery or giving birth. A similar process can be put in place for follow-up regarding tobacco cessation, or additional questions and data gathering can be added to existing calls. In some hospitals, the follow-up call allows for a transfer to the state's Quitline as needed.

ii. Interactive Voice Response (IVR) is a telephone technology that allows a computer to place automated calls to patients inquiring about their tobacco use status after discharge. The IVR system recognizes patients' verbal responses, records the responses in a database, and responds with prerecorded audio. Staff can scan the results of all IVR calls and respond appropriately to particular patient needs or requests. An IVR system can eliminate substantial effort involved in making contact with and screening patients.[30]

iii. Referring patients to a tobacco cessation telephone support Quitline is a viable option for follow-up after discharge if the Quitline is able to expand its questions to include required Joint Commission data fields and transmit patient data back to the hospital. In order to meet the new Joint Commission requirements for follow-up, hospitals must maintain the follow-up data on their patients.

iv. Email and Web-based According to The Joint Commission, follow-up by e-mail is among the acceptable forms of post-discharge follow-up. As more evidence emerges regarding electronic health communication techniques, including web-based cessation strategies, these may be considered viable follow-up strategies.

The National Heart, Lung, and Blood Institute (NHLBI) recently funded a consortium of research projects studying the effectiveness of smoking cessation interventions for hospitalized patients. The University of Alabama Birmingham, *Web-based Smoking Cessation Intervention: Transition from Inpatient to Outpatient*, will create and evaluate a web-based system to support quitting smoking after an inpatient stay, with an e-referral system for providers and delegation function for caregivers and families.[31] The University of Michigan, *Dissemination of Tobacco Tactics Versus 1-800-QUIT-NOW for Hospitalized Smokers*, will examine the effectiveness of a web-based smoking cessation intervention compared to the state Quitline.[32]

Monitor Performance and Get Feedback

During the planning and consensus building phase of the implementation, each hospital's planning group should define objectives and establish quality improvement measures. These objectives serve as a starting place for reviewing progress and providing feedback on performance. Data can be used to show the benefits of active involvement in providing tobacco use screening and treatment.

Determine what tobacco use treatment data are already collected in the hospital and how they are

collected. Determine what tracking systems have to be created versus what systems are already in place to answer the types of evaluation questions discussed. Include the new Joint Commission measures to chart improvement over time. When referral resources are used, it will be necessary to devise a way to retrieve data from these resources and catalogue them in your hospital.

Provide feedback Drawing on data from chart audits, electronic medical records, and computerized patient databases, assess the degree to which clinicians and staff are identifying, documenting, and treating patients who use tobacco, and provide feedback about their performance.

Reimbursement

Reimbursement for tobacco cessation counseling varies, but it is improving. Medicare provides coverage for both counseling and prescription medications. Most state Medicaid programs provide some coverage for counseling or medications, with only a handful of states offering comprehensive coverage.[33] Commercial health plans vary from plan to plan.

In a hospital, tobacco use is typically listed as a secondary diagnosis. Tobacco use should be included in the discharge summary using the ICD-9 code 305.1 for tobacco use disorder or V15.82 for personal history of tobacco use.

Commercial health plans

The following Current Procedural Terminology (CPT) codes are for face-to-face counseling by a physician or other qualified health care professional, using "standardized, evidence-based screening instruments and tools with reliable documentation and appropriate sensitivity."

99406 For intermediate visit of between 3 and 10 minutes;

99407 For an intensive visit lasting longer than 10 minutes.

Medicare

The following codes are to be used for Medicare fee-for-service schedule patients.

G0436 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.

G0437 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes. http://www.cms.gov/MLNMattersArticles/downloads/MM7133.pdf

Medicaid

Coverage for tobacco treatment varies from state to state. However, the 2010 Affordable Care Act made some changes that affect Medicaid coverage of tobacco cessation treatments. Among these are the requirement that states cover a comprehensive cessation benefit for pregnant women, and the removal of tobacco cessation medications from the list of excludable medications.

For more details regarding billing and coding for tobacco dependence treatment, please refer to the U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, Appendix C: Coding Information Regarding the Diagnosis of and Billing for Tobacco Dependence Treatment at http://www.ncbi.nlm.nih.gov/books/NBK63955.

"It was a wakeup call for me at 61 years old, while I was in the hospital. If they had not talked to me in the hospital, it may have never come up to quit smoking. Thank you for being concerned."

Hospital Patient

INTEGRIS Health: Tobacco Freedom

Section 5

Case Studies

The Joint Commission's new Tobacco Measure Set requires interventions at hospitals that may seem like "the right thing to do," but the question remains — are they really achievable? The answer is definitely, "yes."

This case studies section offers an example of one hospital, Massachusetts General, which is already implementing a comprehensive tobacco cessation program for inpatients. Following the Massachusetts General case study are descriptions of hospital programs in other states and Canada — large and small, urban and rural — that are well on their way to meeting the requirements of The Joint Commission tobacco measures as well.

Massachusetts General Hospital in Boston, Massachusetts

Partners HealthCare, a large integrated health care system in eastern Massachusetts, has built tobacco cessation into the care of all inpatients in its five hospitals since 2005, when Partners leaders saw that performance on The Joint Commission's national hospital quality measures on tobacco needed improvement. Dr. Nancy Rigotti, Director of the Tobacco Research and Treatment Center at Massachusetts General Hospital (MGH), a hospital in the Partners system, was asked to chair a Tobacco Task Force to improve tobacco treatment across the system. Partners HealthCare provided internal funds to support the quality improvement effort. Dr. Rigotti, who had previously tested smoking cessation interventions for hospitalized patients at MGH, worked with colleagues across the Partners system to translate research evidence into a practical program that could be adopted by each of the five hospitals in the Partners system and meet Joint Commission standards. Each hospital adapted the MGH's pioneering program to its own unique situation, providing financial support from internal hospital funds. Over time, scores on the tobacco measure rose to high levels across the system.

MGH's model has three steps. The first step is to automatically identify every patient's smoking status during the hospital admission process. Physicians and nurses do so using a coded field in the hospital's computerized provider order entry system as part of the process of admitting a patient to the hospital. At the same time, with just one 'click,' physicians can order a treatment for patients. Nicotine patches, gum, lozenges and inhalers, as well as non-nicotine prescription treatments, can also be ordered from the hospital pharmacy. As a second step, certified Tobacco Treatment Specialists working for the hospital's Tobacco Treatment Service (TTS) download a list of identified smokers admitted the previous day, and visit them at the bedside to provide counseling. Their goal is to ensure adequate treatment of nicotine withdrawal symptoms, encourage smokers to quit, and offer assistance to smokers who want to do so. Notes from the counseling session are entered into the patient's electronic medical record and are accessible by outpatient physicians.

For smokers who are not ready to quit, visits from the Tobacco Treatment Specialists are brief, typically lasting fewer than five minutes. For smokers who want to consider quitting after hospital discharge, the counselor conducts a standard assessment and helps the smoker develop a quit plan to increase the odds of success. These visits usually last about 20 minutes.

The third step is to arrange for continuing tobacco treatment after hospital discharge. The goal is to link a smoker to smoking cessation counseling and medication resources after the return home. This is the responsibility of the TTS counselor, who makes recommendations for smoking

cessation medication and refers patients to community smoking cessation resources for post-discharge care. Recommendations about medication and program referrals are documented in the patient's medical record.

Counselors' efforts are reinforced by an internally developed, four-page pamphlet, "A Guide for Hospital Patients Who Smoke," which is part of the admission packet put at each new patient's bedside. It addresses reasons why a hospital admission is a good time to quit, offers information about managing nicotine withdrawal symptoms in the hospital, and provides contact information for community-based smoking cessation resources, including the state telephone Quitline, local programs, and websites.

Linking care from hospital to post-hospital is a challenge for the health care system in general, and tobacco treatment is not different. Ideally, a patient's primary care physician (PCP) would be kept in the loop not only about smoking status but also whatever cessation treatment was done in hospital and what is planned for post-discharge. Generally, this does not occur. Massachusetts General does this by having the tobacco treatment specialist put a summary note in the patient's electronic health record for the PCP to review.

TTS counselors initially used Massachusetts' QuitWorks fax-referral system to link smokers from the hospital to the state telephone Quitline after discharge, but this system produced a low rate of successful connection to the Quitline. Subsequently, MGH developed an innovative Extended Care management program to facilitate smoking cessation medication and counseling use after hospital discharge and ultimately increase cessation rates. The program is now being tested in a randomized controlled trial with funding from the National Institutes of Health (NIH).

With Extended Care, smokers who plan to quit are given a 30-day free supply of their preferred FDA-approved smoking cessation medication at discharge, with the option of two free refills (for a full 90-day course). After discharge, an interactive voice response (IVR) program conducts automated follow-up calls with patients who use tobacco to determine their status, converts the data into a database for staff to quickly review and to determine what type of follow-up to provide and to whom. It also allows smokers to order medication refills. Information about discharge medications is sent to the patient's primary care provider, whom the patient is told to contact in case there are any problems with the medication.

The IVR system is administered by TelAsk Technologies in Ottawa, Canada and is adapted from one pioneered by the Ottawa Heart Institute (see Ottawa case study on page 17). It provides automated telephone calls at 2, 14, 30, 60, and 90 days after discharge. Discharge dates and participant phone numbers are transferred securely to TelAsk by the hospital team. The IVR system makes up to eight attempts to reach participants for each scheduled call, at participants' preferred times.

Patients can request real time calls from tobacco treatment counselor at any time. In 2007, Massachusetts General did follow-up telephone surveys of 553 patients served by the tobacco cessation service. Among the 365 reached two weeks after discharge, 47% were not smoking. Among the 310 patients reached at three months post-discharge, 43% were not smoking. Using the conservative assumption that all patients who were not reached for the survey were smokers, the percent who had not smoked for the past week was 24% at two week follow up and 18% at three month follow up.

Outcomes of the program are being assessed at one, three and six months after hospital discharge. A pilot version of the IVR system has been published.[34]

Project Funding: Normal Operations/Grant (NIH)
Website: http://www.massgeneral.org/services/smokingcessation.aspx
Contact: Nancy Rigotti, MD, NRigotti@Partners.org

Replicating the example set by Massachusetts General Hospital may seem difficult—but other hospitals in North America are also making great strides in implementing evidence-based interventions that screen for and document tobacco use, offer bedside counseling and pharmacotherapy to inpatients, and provide post-discharge follow-up. The post-discharge follow-up is a new inpatient cessation program feature to be required by The Joint Commission and is critical to patient success. Several hospitals' approaches to meeting this requirement are described on the following pages.

Spanish Peaks Regional Health Center in Walsenburg, Colorado

Spanish Peaks is a small rural Critical Access Hospital in Southern Colorado, with 25 acute care beds and a 24-hour level IV trauma emergency care center. While the hospital is not Joint Commission accredited, their tobacco cessation program would meet many of the measures.

Respiratory Therapists visit each inpatient over the age of 13, ask about tobacco use, and document responses in the electronic health record. If a patient indicates tobacco use, the Respiratory Therapist spends about five minutes counseling each smoker, sharing a packet of information including a description of Quitline services. The patient has the opportunity to fill out a form that gives the hospital permission to follow-up after discharge.

The Respiratory Therapy Manager makes personal phone calls to all patients who express interest, asking if they tried calling the Quitline, if they have a coach, where they are in the quitting process, and if they are using pharmacotherapy.

Project Funding: Normal Operations
Website: http://www.sprhc.org/hospital.html
Contact: Jodi Gatlin, JGatlin@sprhc.org

State of Oklahoma

The Oklahoma Hospital Tobacco Cessation Systems Initiative, Hospitals Helping Patients Quit, began in January 2009. Current efforts are focused on implementing brief, effective evidence-based tobacco cessation interventions as outlined in the U.S. Public Health Service Clinical Practice Guideline, including referrals to the Oklahoma Tobacco Helpline. The Oklahoma Hospital Association (OHA) is establishing relationships with hospital leadership around the state and utilizes its knowledge of hospital culture, processes and systems to integrate screening and treatment into the hospital leadership structure. This ensures a systems approach to developing sustainable tobacco use cessation services with patients.

OHA is currently working with INTEGRIS Health, the largest hospital system in the state with twelve hospitals statewide, in implementing comprehensive cessation programs for patients, family members, and employees. INTEGRIS established a multi-disciplinary clinical team to develop an in-patient process, medication order set, a paper and an electronic health record process. Five questions are used to screen each patient through a health history conducted by the admitting nurse. Any positive response on tobacco use triggers a referral to the Respiratory Therapy Department, which then assesses patient readiness to quit. Respiratory Therapists counsel the patient, order medications for physician approval, if appropriate, and fax refer to the Oklahoma Tobacco Quitline. The Quitline conducts post-discharge follow-up with patients, including monthly reports back to the Oklahoma Hospital Association.

From October 2010 through March 2011, four INTEGRIS hospitals and 10 physician practices referred 971 patients to the Quitline, representing 57% of all health provider fax referrals received in the state. Forty-two percent (42%) of those referred accepted services through the Quitline. The Oklahoma Tobacco Settlement Endowment Trust and the Oklahoma Tobacco Research Center track and evaluate referrals to the Quitline. In 2010, research showed that one year after contacting the Quitline, 35% of those in the multiple-call program were tobacco-free. The remainder of INTEGRIS hospitals will phase in the implementation over the next 18 months.

Project Funding: Grant
(Tobacco Settlement Endowment Trust)
Additional support: Oklahoma State Department of Health, Tobacco Use Prevention Service and the Centers for Disease Control and Prevention.
Website: http://www.okhospitalquality.org/TobaccoCessationProject.aspx
Contact: Joy Leuthard, Leuthard@okoha.com

State of North Carolina

With the assistance of North Carolina Prevention Partners (NCPP), all 125 North Carolina hospitals have been successful in enacting tobacco-free campus policies. In 2009, NCPP, working in partnership with the North Carolina Hospital Association, expanded the focus of the hospital tobacco-free program to support patient cessation. Hospital CEO's are asked to sign an Executive Commitment to Establishing a Corporate Culture of Wellness, a contract created by NCPP to promote high level support for the initiative. The CEO identifies key hospital leaders for NCPP to work with on tobacco cessation, nutrition, and physical activity. Hospital wellness status is assessed through utilization of the web-based executive level planning tool, WorkHealthy America.[SM] Twenty-six North Carolina hospitals have earned the Gold Star status, having achieved all five key components of a comprehensive tobacco cessation system approach.

Working with national tobacco cessation experts, NCPP developed an executive-level planning tool, the Patient Quit-Tobacco System (PQTS). This tool assists hospital leaders in assessing, implementing, and evaluating efforts to support patient cessation. Upon completion of the assessment, the tool generates a grade, customized executive level recommendations, and an action plan. Participating hospitals have access to a resource toolbox including sample policies, case studies, and materials to enhance their system approach to patient cessation. The

> You might think that hospital-based tobacco cessation with patients and employees would be an impossible issue to address in a tobacco growing state. However, often where there is the greatest need, the greatest solution will be found. I'm very proud of what we have accomplished here and how the hospitals are serving their patients and communities.
>
> Melva Fager Okun,
> Senior Program Manager at NC Prevention Partners

Patient Quit-Tobacco System is aligned with the new Joint Commission Tobacco Measure Set and with Meaningful Use.

FirstHealth of the Carolinas is a hospital system consisting of three acute care hospitals and serving the central part of North Carolina. FirstHealth led North Carolina hospitals in adopting a tobacco-free campus policy so NCPP invited FirstHealth to serve as a Center of Excellence, assisting other hospitals in adopting wellness policies, environments, and benefits. The following describes their efforts to assist patients in quitting the use of tobacco.

ASK As part of the nursing assessment, all patients are asked if they have used any tobacco products in the last 12 months. This is a set protocol across all hospital units.

ADVISE Tobacco-using patients are advised to quit by their physician, other members of the healthcare team, and by the FirstQuit staff, an in-house program with Tobacco Treatment Specialists.

ASSESS Physicians can request a tobacco cessation consult from the FirstQuit in-house program. All FirstQuit staff members are certified Tobacco Treatment Specialists by the Mayo Clinic or University of Massachusetts. Patient education and assessment materials are offered, such as NCPP's Starting the Conversation on Tobacco tool. These materials are located in all patient rooms.

ASSIST The FirstQuit staff provides a bedside intervention to patients, along with family members, while in the hospital and recommends medications, when not contraindicated. The consultation and recommendations are recorded in the patient's electronic medical record for review by the health care team.

ARRANGE Patients are encouraged to enroll with the Quitline and, when possible, the first call is made by the patient during their appointment, in addition to enrolling with the FirstQuit outpatient program.

NCPP is working with the state Quitline to enable bi-directional electronic communication that will allow hospital staff to "e-refer" patients to the Quitline. Quitline staff would then follow-up with discharged patients and send data electronically to the hospital patient record, along with an e-mail to the provider.

Project Funding: Grant (Duke Endowment)
Website: http://www.ncpreventionpartners.org
Contact: Melva Fager Okun, Melva@ncpreventionpartners.org

Department of Veterans Affairs Health Care System

The Department of Veterans Affairs (VA) has a long history of attempting to reduce smoking among veterans and has worked very hard to make evidence-based smoking cessation a routine part of the health care it provides. The Veterans Health Administration (VHA) is the arm of the VA that provides health care for about six million veterans. Many veterans carry over tobacco use from their service in the military, where usage rates are higher than in the general population. The fact that people who have not started smoking by age 18 are unlikely to smoke as adults does not hold for those in the military. Many non-smokers begin to smoke after they join the military.

The Public Health Strategic Health Care Group of the VHA has undertaken a number of policy initiatives to make smoking cessation counseling and medications more accessible to veterans. The U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update* was adopted by the VA and the Department of Defense two years ago. All FDA-approved smoking cessation medications are available on the VHA National Formulary. To help veterans quit smoking and tobacco use, the VA offers screening for tobacco use during primary care visits; individual counseling; prescriptions for nicotine replacement therapy, such as a nicotine patch or gum, or other medications; and participation in evidence-based smoking cessation programs. All out-patients in Primary Care and Mental Health clinical settings are screened at least once a year for tobacco use in the last 12 months. If the patient is a current user, he or she is provided with brief counseling, offered medications to assist with quitting, and offered a referral for more intensive counseling.

An electronic clinical reminder is used to give a prompt to the provider on how to offer the appropriate care and then document the encounter in the electronic medical record. Electronic medical records facilitate promotion of cessation by providing electronic reminders to check for smoking status. Prompts can help providers work with the patient to set a quit date, offer medication to help with quitting, encourage patients to get rid of tobacco products in the home, and similar tips. These real time prompts are very useful, especially for those providers not trained in tobacco cessation.

Based on her experience with the VA smoking cessation program, Kim Hamlett-Berry, PhD, Director, Public Health Policy and Prevention, Public Health Strategic Health Care Group, VHA, has some important lessons learned to share with those who want to integrate cessation in health care settings.

- The need to identify and eliminate barriers to cessation care.

- Provide models of care that can be integrated easily into the care that is already delivered.
- Adopt a public health approach to extend the reach of tobacco cessation care so that all care providers, not just specialists, are involved:
  - Work with mental health and substance use disorder providers to help them with integrating smoking cessation treatment into routine care.
  - Enlist health care professionals other than physicians.
- Electronic health records should have a readily identifiable field to determine current smoking status. This can be an important tool in prompting providers and documenting care.
- Develop gender-specific messages to appeal to women who smoke and want help with quitting.

Dr. Hamlett-Berry also stresses the importance of providing training for health care professionals. She notes that many health care providers do not receive any training in evidence-based tobacco cessation as part of their formal curriculum. As a result, they may not know the basics and, if they do, they may not be confident in their ability to deliver care. Training is an important tool in addressing health care professionals' attitudes about the efficacy of tobacco cessation care and in helping them recognize this as a chronic, relapsing disorder.

Website: http://www.publichealth.va.gov/smoking
Contact: Public Health Strategic Health Care Group, publichealth@va.gov

Ottawa Model for Smoking Cessation in Ontario, Canada

While hospitals in Canada are not accredited by The Joint Commission, the comprehensive approach to treating tobacco use developed at the University of Ottawa Heart Institute would meet The Joint Commission's new measure set. Much has been reported about this exemplary model—the Ottawa Model for Smoking Cessation (OMSC). [35, 36]

Researchers at the University of Ottawa Heart Institute developed a successful tobacco cessation model, initially as part of an effort to improve cardiac outcomes. They developed a comprehensive approach to treating tobacco use among the inpatient population and evaluated it through several research studies. The team implemented the program hospital-wide, and subsequently presented their findings at national conferences. They were approached by the Ontario Ministry of Health to spread the model to other hospitals across Canada. The Ottawa Heart Institute is now a centralized location that provides technical assistance, training, and follow-up to seventy sites that have implemented the Ottawa Model.

Researchers began by designing an inpatient program that systematically identifies, provides treatment, and offers follow-up to all admitted smokers. Unlike most hospital-based cessation programs, the Ottawa Heart Institute places a priority on following up with their patients who smoke post-discharge, and offering support to encourage long-term cessation.

The Ottawa Model is a variation on the 5A's:

- During admissions, patients are ASKED about tobacco use during the preceding six months. Those who have recently quit are congratulated on their success, encouraged to remain smoke-free, and provided with a list of community resources and phone numbers for cessation assistance if they experience difficulty. Smoking status and data on prior quit attempts for all patients is documented in a cessation database.

- All smokers are ADVISED to quit, ASSESSED for willingness to quit, and ASSISTED with brief counseling and pharmacotherapy. A consult form is used to cue clinicians about appropriate assistance for patients who are interested and those who are not interested to standardize data collection for process and outcome evaluation.

- Follow-up after hospitalization is offered to all smokers and is ARRANGED by registering the patient into an interactive voice response (IVR)-mediated telephone system and database. The IVR places three automated telephone follow-up calls to patients to inquire about their smoking status and confidence in remaining smoke-free. The responses are recorded in a database that nurse counselors review for necessary follow-up. The results of all IVR calls can be examined quickly and efficiently in order to respond appropriately to patient needs or requests.

The IVR calls have three goals:

1. Assessing smoking status and medication use
2. Providing tailored motivational messages
3. Triaging participants to additional smoking cessation resources

Criteria that trigger the system to recommend a return call from a live counselor include:

1. Changes in plan to use prescribed quit smoking medication prior to quit date
2. Concerns about starting the quit smoking medication
3. Patients who resume smoking after discharge but still want to quit
4. Patients who are quit but have a low level of confidence in their ability to stay quit

Implementation of the OMSC has led to an absolute 15% increase in the long-term quit rates at the University of Ottawa Heart Institute (from 29% to 44% at 6 months).

The success of the program has led to expanding its reach to numerous inpatient, outpatient, and primary care settings throughout Canada. A key component of the outreach involves the use of expert outreach facilitators or consultants who work directly with participating sites to adapt their clinical practices using a detailed implementation work plan. The phases of implementation they encourage sites to follow are: 1) Gaining commitment; 2) Baseline audit and assessment; 3) Consensus building and planning; 4) Frontline training; 5) Delivery of Service; 6) Ongoing Audit and Feedback.

> Over the years, I have convinced myself that I would never be able to quit smoking. Thankfully I was wrong. The kindness, encouragement and patience of the smoking cessation team enabled me to finally conquer my smoking addiction. I could not have done it without them."
>
> Lisa Frankel, UOHI Patient

Project Funding: Ministry of Health and Health Canada

Website: www.ottawaheart.ca

Contact: Robert Reid, MBA, PhD, breid@ottawaheart.ca

Section 6

Sample Resources

The hospital resources on the following pages have been contributed by colleagues around the country. They are offered as samples to stimulate thinking about how to best implement a comprehensive tobacco treatment intervention program. They may be adapted for use by other hospitals.

Healthy NC Hospitals
NC PREVENTION PARTNERS™

Executive Commitment to Establishing a Corporate Culture of Wellness

I, _____ , hereby affirm my commitment to provide a culture of wellness for hospital patients, employees and visitors. As the executive leader of this hospital, I am dedicated to making healthy policy changes, including creating a comprehensive system to help all patients and employees quit tobacco. I understand this is a professional and personal commitment and will lead this initiative by modeling responsible, healthy behaviors. I will include tobacco cessation and other strategic wellness goals in my hospital's business plan. I will actively encourage and support patients, employees and visitors to adopt healthier lifestyles.

I commit my institution to benchmark and strengthen our wellness capacity with NC Prevention Partners' WorkHealthy America℠ and Patient Quit Tobacco System executive planning tools, and to work to achieve a comprehensive wellness environment, supported by policies and procedures.

I have identified the following hospital leaders and corporate officers to lead this comprehensive Quit-Tobacco systems effort:

- Corporate liaison to wellness team _____ (name)
- HR/Wellness staff _____ (name)
- Administrator over Operations _____ (name)
- Physician Champion _____ (name)
- Administrator over Patient Care _____ (name)
- Executive Assistant to CEO _____ (name)

_____ Print Name

_____ Organization

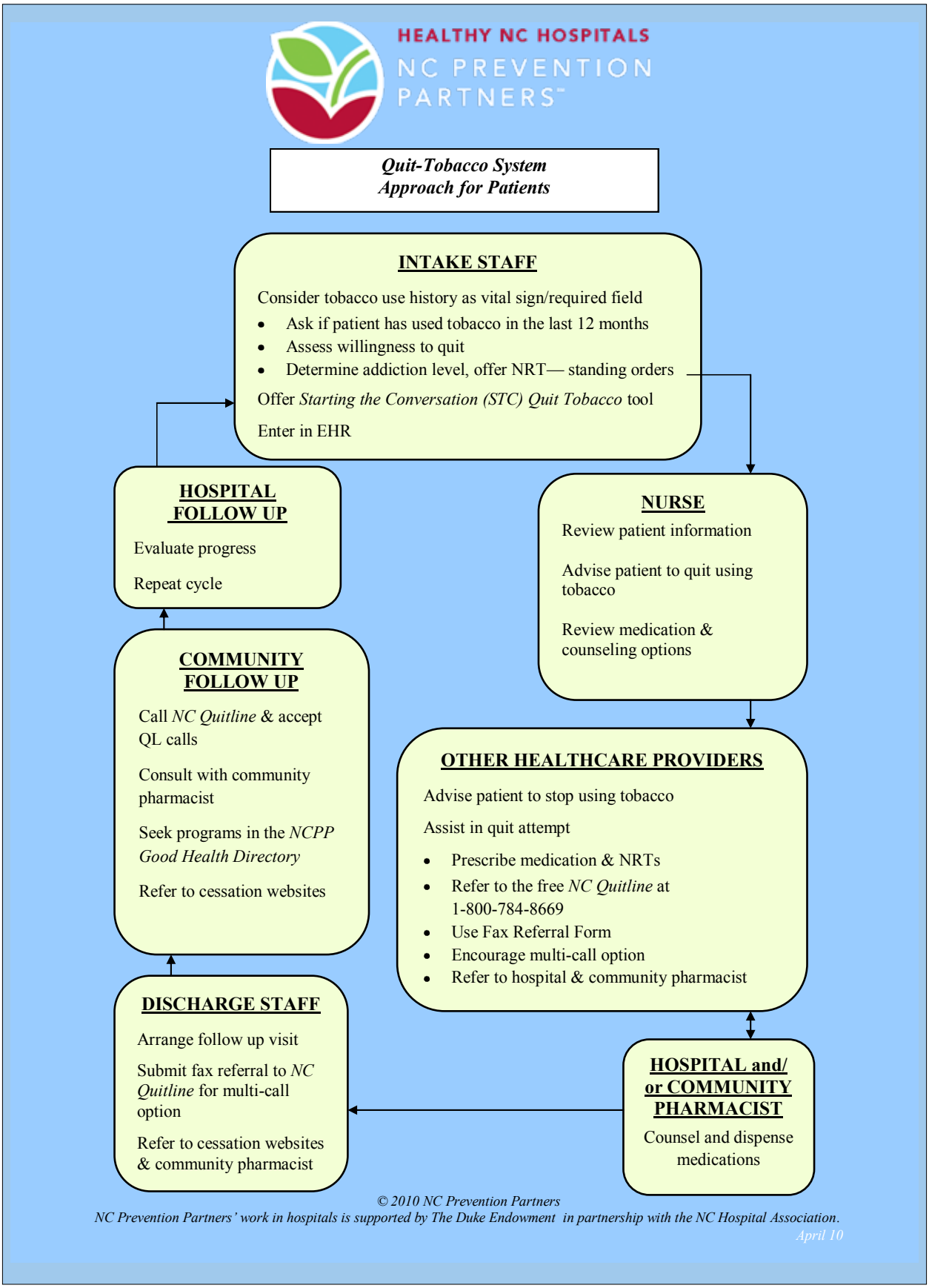
_____ Signature

_____ Date

Please sign, retain one copy for your records and return to:
Melva Fager Okun DrPH NC Prevention Partners
88 Vilcom Circle, Suite 110, Chapel Hill, North Carolina 27514
Phone: (919) 969-7022 Ext. 224; Fax: (919) 960-0592

Please turn over to complete contact information.

System Approach Flow Chart



Helping Smokers Quit: A Guide for Clinicians

Ask: Ask about tobacco use at every visit.

Implement a system in your clinic that ensures that tobacco-use status is obtained and recorded at every patient visit.

Vital Signs

Blood Pressure: _____

Pulse: _____ **Weight:** _____

Temperature: _____

Respiratory Rate: _____

Tobacco Use: **Current** **Former** **Never** *(circle one)*

Advise: Advise all tobacco users to quit.

Use clear, strong, and personalized language. For example:

"Quitting tobacco is the most important thing you can do to protect your health."

Assess: Assess readiness to quit.

Ask every tobacco user if he/she is willing to quit at this time.

- If willing to quit, provide resources and assistance (go to Assist section).
- If unwilling to quit at this time, help motivate the patient:
  - Identify reasons to quit in a supportive manner.
  - Build patient's confidence about quitting.

Assist: Assist tobacco users with a quit plan.

Assist the smoker to:

- Set a quit date, ideally within 2 weeks.
- Remove tobacco products from their environment.
- Get support from family, friends, and coworkers.
- Review past quit attempts—what helped, what led to relapse.
- Anticipate challenges, particularly during the critical first few weeks, including nicotine withdrawal.
- Identify reasons for quitting and benefits of quitting.

Give advice on successful quitting:

- Total abstinence is essential—not even a single puff.
- Drinking alcohol is strongly associated with relapse.
- Allowing others to smoke in the household hinders successful quitting.

Encourage use of medication:

- Recommend use of over-the-counter nicotine patch, gum, or lozenge; or give prescription for varenicline, bupropion SR, nicotine inhaler, or nasal spray, unless contraindicated.

Select for Suggestions for the Clinical Use of Medications for Tobacco Dependence Treatment.

Provide resources:

- Recommend toll free 1-800-QUIT NOW (784-8669), the national access number to State-based quitline services.

Refer to Web sites for free materials:

- Agency for Healthcare Research and Quality: www.ahrq.gov/path/tobacco.htm
- U.S. Department of Health and Human Services: www.smokefree.gov

Arrange: Arrange followup visits.

Schedule followup visits to review progress toward quitting.

If a relapse occurs, encourage repeat quit attempt.

- Review circumstances that caused relapse. Use relapse as a learning experience.
- Review medication use and problems.
- Refer to 1-800-QUIT NOW (784-8669).

For more information on prescribing, precautions, and side effects, go to the Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, www.ahrq.gov/path/tobacco.htm.

Source: *Helping Smokers Quit: A Guide for Clinicians*. Revised May 2008. Agency for Healthcare Research and Quality. Rockville, MD. http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm

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

www.askandact.org

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

❑ 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

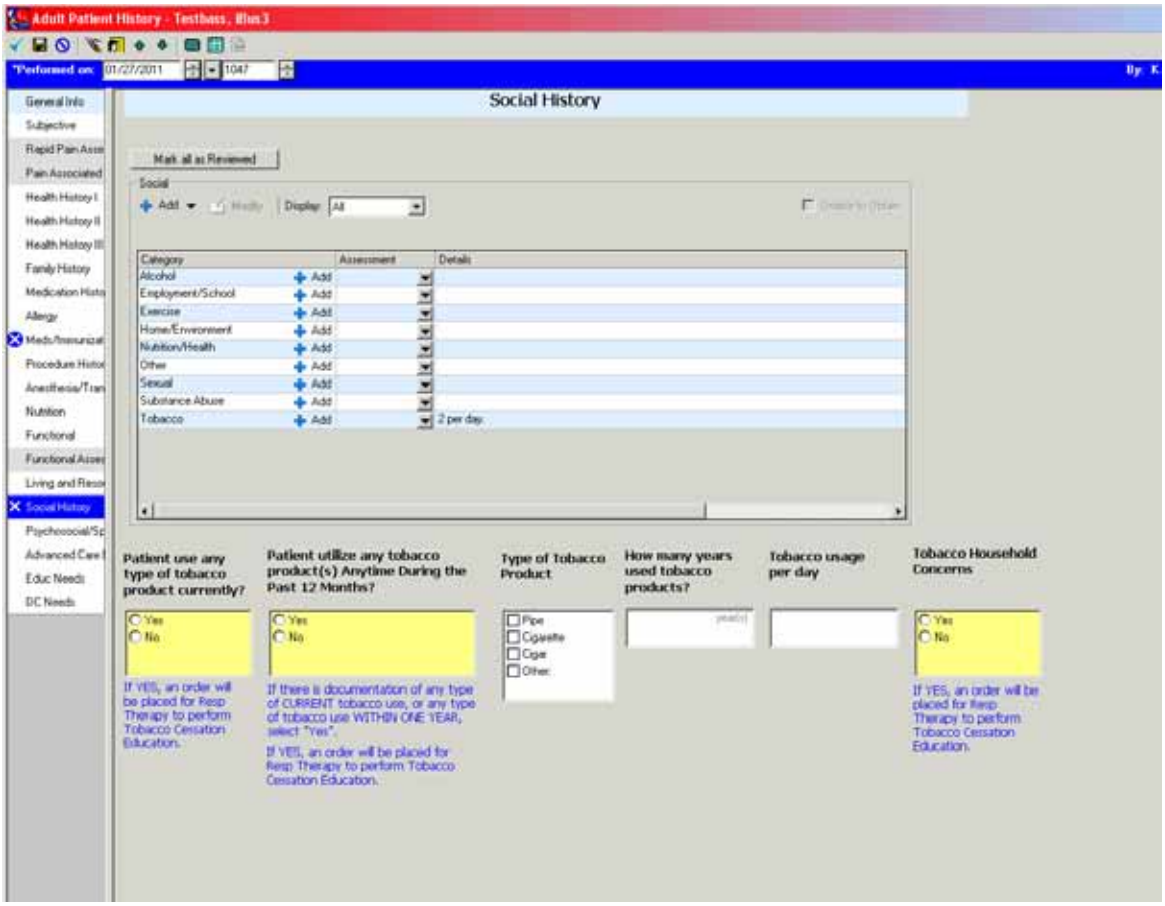
❑ Bupropion SR
Dosing: Begin 1–2 weeks prior to quit date; 150 mg po q AM x 3 days, then increase to 150 mg po bid. Contraindications: head injury, seizures, eating disorders, MAO inhibitor therapy.

❑ 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 neuopsychiatric symptoms.

Follow Up Plan:
❑ Follow up visit in 2 weeks
❑ Staff to follow up in ___ weeks
❑ Address at next visit

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**.



Tobacco Cessation Screening Process

On admission, the Social History page will have the following questions. The six questions at the bottom of the page, depending on how the patient answers them, will task Respiratory Therapy to meet the patient and talk with them and/or family members about tobacco cessation.

Depending on how the questions are answered, we ask nursing to ask the patient/family member if they are willing to make a quit attempt. They can then let them know that someone from respiratory will be coming to talk with them and bring them information about quitting. This will help the process flow better when RT does come speak to the patient. RT will also send a fax referral to the Oklahoma Tobacco Helpline for the patient/family member. The Helpline coordinator will contact the patient within 48 hours to continue the process and follow up.

Please contact Kim Olson, System Program Coordinator at Kim.Olson@Integrisok.com or any of the RT staff in your facility if you would like more information about this process.

INTEGRIS Health

Respiratory Therapy Referral
Tobacco Cessation Intervention and Education

To be completed by RN with Admission History:

Admitting RN to ask the following questions of patient:

1. Do you use any type of tobacco product?
   _____Yes _____No

2. How long have you used tobacco products?
   _____

3. How much and how often?
   _____per day (packs or individual tobacco items)
   _____dips or chews per day

4. Have you used any tobacco product within the past 12 months?
   _____Yes _____No

5. Do any household members use tobacco products or smoke?
   _____Yes _____No

If answer "Yes" to any question, admitting RN to give form to Unit Clerk to put "order" in for Respiratory Therapy "Tobacco Cessation Education consult".

Affix patient label here

Referred by: (RN Signature) _____

Date: _____ **Time:** _____

Place form under RT tab in patients chart.

INTEGRIS Health

10028264

Tobacco Cessation Orders

ANOTHER GENERICALLY EQUIVALENT PRODUCT WITHIN THE APPROVED FORMULARY MAY BE ADMINISTERED FOR DRUGS ORDERED UNLESS CHECKED HERE ❑

Tobacco Cessation Orders (Adult)

- Confirm that the patient has no known allergies or contraindications to the therapy ordered below
- For patients receiving nicotine replacement therapies, provide patient education that no further tobacco intake should occur once the nicotine replacement product(s) are started. (Note: patch may be used with gum or lozenge)

Nicotine pharmacologic therapy

Nicotine Patch (OTC (7 mg, 14 mg and 21 mg); may be removed at night to prevent insomnia)

❑ Greater than 10 cigarettes/day or 1 can/pouch per week: 21 mg/day x 4 to 6 wks, then 14 mg/day x 2 wks, then 7 mg/day x 2 wks
❑ 10 cigarettes or less per day or less than 1 can/pouch per week: 14mg/day x 6 wks, then 7 mg/day x 2 wks

Nicotine gum (OTC (2 mg and 4 mg); also may use PRN in conjunction with nicotine patch; max 24 pieces/day)

❑ Greater than 25 cigarettes/day: 4 mg Q 1- 2 H x weeks 1-6, then 4 mg Q 2 - 4 H x weeks 7-9, then 4 mg Q 4 - 8 H x weeks 10-12
❑ 25 cigarettes or less per day: 2 mg Q 1 - 2 H x weeks 1-6, then 2 mg Q 2 - 4 H x weeks 7-9, then 2 mg Q 4 - 8 H x weeks 10-12

Nicotine lozenges (OTC; avoid food/drink 15 min before and after use; max 5 lozenges/6 H or 20 lozenges/24H)

❑ Greater than 25 cigarettes/day: 4 mg Q 1 - 2 H x wks 1-6, then 4 mg Q 2 - 4 H x wks 7-9, then 4 mg Q 4 - 8 H x wks 10-12
❑ 25 cigarettes or less per day: 2 mg Q 1 - 2 H x wks 1-6, then 2 mg Q 2 - 4 H x wks 7-9, then 2 mg Q 4 - 8 H x wks 10-12

Non-nicotine pharmacologic therapy

Bupropion SR (Zyban) (Rx (generic available); may combine with patch to increase abstinence rate)

- must be prescreened and observed for neuropsychiatric symptoms (hostility, agitation, depression, etc.)

❑ 150 mg qDay x days 1-3, then 150 mg BID (at least 8 hours apart) up to 7 to 12 wks

Varenicline (Chantix) (Rx; monitor neurological changes; most common side effects (nausea & insomnia)

❑ initial: 0.5 mg qDay on days 1-3, then 0.5 mg BID on days 4-7, then 1 mg BID on day 8 x 11 more weeks (evaluate at week 12, if successfully stopped, may use 12 more weeks to increase likelihood of long-term abstinence)
❑ maintenance: 1 mg BID

Physician Signature **Date/Time**

TOBACCO CESSATION
CERNER:
NEW: 08/2010
Page 1 of 2

INTEGRIS Health.

Quitting Helps You Heal Faster

Your hospital visit is a great time to quit smoking.

Why should I quit now?

Smoking may slow your recovery from surgery and illness. it may also slow bone and wound healing.

All hospitals in the United States are smoke free. You will be told NOT to smoke during your hospital stay – now is a great time to quit!

How do I quit in the hospital?

Talk to your doctor or other hospital staff about a plan for quitting. Ask for help right away.

Your doctor may give you medicine to help you handle withdrawal while in the hospital and beyond.

Helpful hints to stay quit

Ask your friends and family for support.

Continue your quit plan after your hospital stay.

Make sure you leave the hospital with the right medicines or prescriptions.

If you "slip" and smoke, don't give up. Set a new date to get back on track.

For help in quitting smoking, call the National Quitline toll free: 1-800-QUIT NOW.

U.S. Department of Health and Human Services
Public Health Service

July 2003

Making a Plan

What goal(s) can you set for yourself now?
Before my next visit, I am going to:

- ☐ Quit all tobacco use (Quit date: ____ / ____ / _____)
- ☐ Call the NC Quitline (1-800-784-8669)
- ☐ Reduce my tobacco use (How?_____)
- ☐ Start medicine to help me quit tobacco use (Which medicine?_____)
- ☐ Make my home tobacco-free
- ☐ Make my car tobacco-free
- ☐ Contact a local program and make an appointment
- ☐ Other _____

Is there someone who can help you in reaching your goal(s)?
Name(s): _____

More Help

For help in quitting tobacco use, call the NC Quitline at: **1-800-QUIT-NOW (1-800-784-8669)** or get online counseling at **www.smokefree.gov.**

To find local resources and information to help you quit, go to **www.quitnownc.org**, call *Quit Now NC!* at 919-969-7022, or e-mail **info@quitnownc.org.**

To find local programs to help you quit, visit the NC Good Health Directory at **www.ncgoodhealthdirectory.com.**

For more information about the Starting the Conversation series or to order customized Quit Tobacco tools like this one for your organization, please go to the NC Prevention Partners website: ***http://bit.ly/qd3DiV***

We thank the Starting the Conversation Partners

NC Prevention Partners · AFC · Start Your Heart · UNC Center for Health Promotion and Disease Prevention

Starting the Conversation

Quit Tobacco

Are you ready to **quit using tobacco**?

- ☐ I am ready to quit, and I would like help.
- ☐ I'm not sure if I'm ready to quit, but I would like to start the conversation.
- ☐ I am not ready to try to quit at this time.

Stop using tobacco now.

Stop using tobacco for life.

Remember who you're saving your life for!

Why do you use tobacco?	Tips to help you quit
I use tobacco to perk me up or give me a lift. ☐ Rarely ☐ Sometimes ☐ Often	**Look for another way to give yourself a boost.** • Go for a brisk walk. • Try stretches or deep breathing.
I use tobacco when I am with friends or drinking socially. ☐ Rarely ☐ Sometimes ☐ Often	**Ask your friends for support.** • Spend time with family, friends, and co-workers who don't use tobacco. • Choose a tobacco-free place to eat.
Tobacco helps me feel comfortable and relaxed. ☐ Rarely ☐ Sometimes ☐ Often	**Find other ways to feel good.** • Treat yourself to something else that you enjoy: listen to music, take a walk, read a book or magazine. • Grab the phone and call a friend.
I use tobacco when I'm anxious, worried, depressed, or angry. ☐ Rarely ☐ Sometimes ☐ Often	**Reach for something else when you're feeling down.** • Call the NC Quitline at 1-800-QUIT-NOW (1-800-784-8669). • Exercise to blow off steam.
I use tobacco within half an hour after I wake up. ☐ Rarely ☐ Sometimes ☐ Often	**Recognize that you're hooked and try to make a change.** • Ask your doctor or pharmacist about medicine to help you quit such as a prescription, the patch, or gum. • Set a goal and reward yourself when you reach it.
I use tobacco without really thinking about it. ☐ Rarely ☐ Sometimes ☐ Often	**Focus on kicking the habit.** • Pay attention to your patterns. Notice when you use tobacco and why. • When you reach for tobacco, say, "Do I really want this?"

0 x (____) +1 x (____) + 2 x (____) = Total Score _____

If you feel this way	Try these things
I'm worried about gaining weight if I quit.	**Don't let the fear of gaining weight keep you from quitting.** • Using tobacco is much worse for your health than gaining a few extra pounds. • Drink lots of water and eat healthy snacks. Try chewing gum, a toothpick, carrots, or celery sticks.
It's hard for me to quit because my friends, family, and/or co-workers still use tobacco.	**Talk to your friends, family, and/or co-workers about your plans to quit.** • Ask them not to use tobacco around you. • Try to get others to quit with you. • Spend time with people who don't use tobacco.
Willpower is a problem for me.	**Tell yourself you can do it.** • Call the NC Quitline when you need help at 1-800-QUIT-NOW (1-800-784-8669). Services are available every day from 8:00 am until midnight in both English and Spanish. • Remember that most people try several times before they really quit.
I use tobacco to help me when I'm feeling stressed.	**Find other things to help you cope.** • Try walking, deep breathing, relaxation exercises, or squeezing a stress ball. • Talk to someone you trust.
I can't stand how I feel when I first quit.	**Hang in there. You can get through the tough times after you first quit.** • Remember that, in the long run, your body will feel better and heal faster without tobacco. • Think about how to spend the money you will save. A pack a day smoker who quits will save more than $100,000 over 30 years.

Discharge Plan

Patient:_____
ID number:_____

Referred by:_____

Discharge plan:

Quit date:_____

Consult visit date:_____

Comments:

_____
_____
_____
_____
_____
_____
_____
_____

Medications recommended:

_____
_____
_____
_____

Follow-up
plan:_____
_____
_____
_____
_____

Signature:_____

Date:_____

Source: Treating Tobacco Use and Dependence in Hospitalized Smokers. Center for Tobacco Research and Intervention, University of Wisconsin Medical School.

Sample Letter to Primary Care Provider

Tobacco Consultation Service
Hospital Address
Hospital Address
Hospital Phone

Date

(Primary Care Provider Name)
(Primary Care Provider Address)
(City, State, Zip)

Re Patient Name: **Jane Smith** Patient Identification No:_____

Dear Healthcare Provider:

Your patient was recently admitted to the (Hospital Name). While here, she was identified as a current tobacco user and received tobacco treatment counseling on (date).

Your patient was assessed for her readiness to quit tobacco. The following is the result of that interview and recommendations of your involvement to assist her quitting tobacco. **Your participation in this patient's quit attempt or movement toward a quit attempt is very important.**

Patient's readiness to quit:

__Not contemplating smoking cessation
__Wanting to quit in the next 6 months but still very ambivalent
__Taking steps to quit within the next month (e.g., cut back number of cigarettes)
__Has currently quit tobacco Quit date:_____
__Has quit tobacco and is in maintenance phase

Recommended medications:
__Patches Dosage: __21mg __14mg __7mg
__Nicotine Gum Dosage: __4mg __2mg
__Nicotine Inhaler
__Nicotine Spray
__Zyban/Wellbutrin SR
__Chantix

A brief word from you regarding his/her tobacco use is invaluable. A suggested statement is:
"Congratulations on thinking about quitting in the next month. Are you ready to set a quit date within the next two weeks? Would you like to learn more about nicotine replacement, Zyban or Chantix, or referral to a tobacco treatment program? We can take care of that today."

Just your act of showing interest and concern for her tobacco use can increase her chances of quitting by 10%. Please let us know how we can assist this process.

Sincerely,

(Name)
Tobacco Treatment Counselor

Source: Tobacco Consultation Service, University of Michigan Health System

References for Sample Resources

Executive Commitment to Establishing a Corporate Culture of Wellness, NC Prevention Partners

Quit-Tobacco System Approach for Patients, NC Prevention Partners

Helping Smokers Quit: A Guide For Clinicians, Agency for Healthcare Research and Quality

Integrating Tobacco Cessation Into Electronic Health Records, American Academy of Family Physicians

Tobacco Cessation Screening Process, INTEGRIS Health

Respiratory Therapy Referral: Tobacco Cessation, INTEGRIS Health

Suggestions for the Clinical Use of Medications for Tobacco Dependence Treatment, Agency for Healthcare Research and Quality

Tobacco Cessation Orders, INTEGRIS Health

Quitting Helps You Heal Faster, U.S. Department of Health and Human Services

Starting the Conversation: Quit Tobacco, Starting the Conversation Partners

Patient Discharge Plan, Treating Tobacco Use and Dependence in Hospitalized Smokers, Center for Tobacco Research and Intervention, University of Wisconsin Medical School

Sample Letter to Primary Care Provider, Tobacco Consultation Service, University of Michigan Health System

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Online Resources

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2. The Joint Commission – Specifications Manual for Joint Commission National Quality Core Measures
http://www.jointcommission.org/specifications_manual_for_joint_commission_national_quality_core_measures

3. Agency for Healthcare Research and Quality – Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians
http://www.ahrq.gov/clinic/tobacco/tobaqrg.htm

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5. University of Wisconsin Center for Tobacco Research and Intervention Resources
http://www.ctri.wisc.edu/HC.Providers/healthcare_education_cme.htm

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http://www.prevent.org/data/files/initiatives/tobaccousetreatment.pdf

7. Smoking Cessation Leadership Center—Tools and Resources
http://smokingcessationleadership.ucsf.edu/Resources.htm

8. Agency for Healthcare Research and Quality — Helping Smokers Quit: A Guide for Clinicians
http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.pdf

9. Agency for Healthcare Research and Quality — System Change: Treating Tobacco Use and Dependence Strategies
http://www.ahrq.gov/clinic/tobacco/systems.htm

10. Centers for Medicare & Medicaid Services — EHR Incentive Program for Medicare Hospitals
https://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_Medicare_Hosp.pdf

11. Centers for Medicare & Medicaid Services — Medicaid Hospital Incentive Payments Calculations
https://www.cms.gov/MLNProducts/downloads/Medicaid_Hosp_Incentive_Payments_Tip_Sheets.pdf

Because of your efforts
I get to celebrate today!

I get to celebrate one year of not smoking

for the first time since I was 10 years old.

I get to feel the sense of satisfaction that comes with a one-year anniversary.

I get to breathe a little easier.

I get to smile a little "whiter".

I get to feel proud of accomplishing a goal that I have tried to accomplish

four or five times over the years but failed to accomplish.

I get to spend much less time in line at convenience stores buying cigarettes.

I get to taste a little more.

I get to spend that money on something that I want rather than something that I need.

I get to smell a little better.

I get to hold my head up and feel like a non smoker.

Because of your efforts I get to celebrate today!

— By Steve Rotar, Winston-Salem resident, who was assisted in his successful quit by the tobacco cessation staff at Wake Forest Baptist Medical Center

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