

**Q&A from the ActionToQuit Nov 3, 2011 Webinar, *Helping Patients Quit: Implementing The Joint Commission Tobacco Measure Set in Your Hospital***

*Speakers:* Nancy A. Rigotti, M.D., Director, Tobacco Research and Treatment Unit, Massachusetts General Hospital  
Nancy Lawler, R.N., Associate Project Director, The Joint Commission  
*Moderator:* David Zauche, Senior Program Officer, Partnership for Prevention

**Q&A for Nancy Rigotti, Massachusetts General Hospital**

<p><i>Which medication is used in the 30 day free supply?</i></p>	<p>Any FDA approved smoking cessation medication can be used and the decision is made by counselor and patient together. In practice, about 90% of the time it is NRT, often a combination of patch and gum or lozenge.</p>
<p><i>How do you sustain (financially) offering discharged patients the 30 day trial supply of NRT?</i></p>	<p>Our current project is funded by a grant from the National Heart Lung and Blood Institute, which covers the cost of the intervention. If we are able to show that it improves quit rates and/or clinical outcomes, the next step will be to approach hospitals or insurers to seek coverage for this as a benefit.</p>
<p><i>Is there a good way to have continuity of NRT on discharge? It was mentioned that patients can be discharged with a month of free NRT. I can connect patients with the quitline but it takes 5-10 days before NRT is received in the mail.</i></p>	<p>This is exactly why we give the patients the medication in hand at discharge. We have the hospital physician order the NRT before the patient is discharged. The order is sent to the hospital pharmacy, where it is filled and delivered to the floor where it is stored until discharge, when it is given to the patients.</p>

<p><i>How were the smoking cessation counselors funded - initially and on an ongoing basis?</i></p>	<p>Our hospitals had low scores on the smoking quality measure in 2004, and hospital leaders wanted to see this problem fixed. We worked with the quality improvement team to propose this as an evidence-based solution to fix the QI problem. We created a model for how many counselors would be needed based on estimated number of smokers admitted per year. Hospital administration (Patient Care Services) agreed to fund this to meet quality standards. Without that push, I do not know whether we would have been funded. Each year, we have to make a case to keep our counselors funded and it is always a challenge.</p>
<p><i>What is the standard amount of time that counselors spend doing a bedside visit? How many patients are typically seen in a day by one counselor?</i></p>	<p>These are excellent questions. We are currently developing standards for counselor performance. We spend less than 5 minutes with smokers who are not interested in quitting and an average of 20-25 minutes with those who are. This does not include time for documentation in chart or time to find the patients, who may be off the floor at a test or treatment.</p>
<p><i>What is the cost per patient of providing these cessation services?</i></p>	<p>Excellent question. We have not calculated this.</p>
<p><i>You state telephone support increases cessation rates post discharge. What was the frequency of telephone calls?</i></p>	<p>In the systematic review that we published, there was a range of duration and frequency of calls. However, many programs offered 3-5 calls made in the 3 months after discharge.</p>

<p><i>What company provided the IVR follow-up? Can their system be used to link smokers to quitlines? And, can a system like this be integrated with electronic medical record systems?</i></p>	<p>TelASK Technologies of Ottawa, Canada, is our IVR vendor. We have a grant proposal at NIH/NHLBI to integrate the IVR system with a quitline vendor to make a seamless program. We hope to have the opportunity to build this system. An IVR system could in theory be linked directly, without human input, to an EMR system. We currently have the hospital counselor put a message in our outpatient EMR system about the hospital smoking consultation.</p>
<p><i>How do you stay within HIPPA guidelines when implementing the IVR process? How are the calls made?</i></p>	<p>We use secure file transfer protocol (FTP) to transfer patient data electronically to the IVR vendor, and the vendor is HIPPA compliant.</p>

### **Q&A for Nancy Lawler, The Joint Commission**

<p><i>Can the "bedside" conversation be a phone counseling session?</i></p>	<p>The purpose of the measure is for hospitals themselves to provide counseling and medication to their patients who use tobacco. We believe this needs to be a hospital-delivered intervention, ideally in person (just as a cardiology consult must include a bedside assessment).</p>
<p><i>Can Quitlines be used to implement TOB4 (follow up after 30 days)?</i></p>	<p>Yes, Quitlines can be used to implement TOB4. However, they must provide the hospital with the follow-up information.</p>

<p><i>When patients admitted to the hospital are identified as tobacco users, counseled at bedside, prescribed medications and referred via fax to a Helpline, are they also required to receive this again at discharge? Or just verified to be in compliance?</i></p>	<p>TOB 2 addresses treatment during the hospital stay which is bedside counseling and administration of one of the FDA approved tobacco cessation medications. This is different from TOB 3 which addresses treatment at discharge (referral to outpatient tobacco cessation counseling and a prescription for one of the FDA approved cessation medications). A patient may receive an FDA approved tobacco cessation medication during the hospital stay and may not receive a prescription for it at discharge. The two activities are different, just as the bedside counseling and referral to outpatient counseling following discharge.</p>
<p><i>Can a hospital select only one of these four measures or do they have to select all four (understanding that these are voluntary)?</i></p>	<p>If the measure set is selected, all four measures must be done.</p>
<p><i>I had heard that the new guidelines would encompass all patients 12 years old and above - is this still being discussed?</i></p>	<p>Making a change to the age requirements to determine the population for the measure set is not under discussion at this time.</p>
<p><i>Do you see this measure set affecting outpatients or only inpatients?</i></p>	<p>Presently, the measure set applies only to hospitalized inpatients.</p>
<p><i>Will this measure set apply to psychiatric/mental health facilities/inpatient units?</i></p>	<p>The measure set can be used by psychiatric/mental health facilities. The usefulness of the measure set will most likely be based on the average length of stay (LOS) for these types of patients. Many of those psychiatric hospitals who participated in the pilot test did not find the measure set helpful as the data are based on discharge date. So if the LOS is quite long, to look back</p>

	<p>for the initial screening, a single brief counseling and then the referral and prescription several months later just didn't seem to work out. Following the pilot we did add some parameters around LOS. Patients who have a length of stay less than or equal to one day or greater than 120 days will be excluded from the measure set. The facility will need to review the measure set specifications and determine if the measures will be useful for improvement purposes.</p>
<p><i>How can we find out which hospitals select the tobacco measure set?</i></p>	<p>This is not information that The Joint Commission routinely shares. The use of the TOB measure set will become evident when measure results are posted on Quality Check, but that will not be until after 2 quarters of data have been collected.</p>
<p><i>Shouldn't your facility be totally smoke-free to implement this measure set?</i></p>	<p>Tobacco use cessation is a matter of public health and should be encouraged regardless of any smoke-free standards or requirements.</p>
<p><i>Is it possible that implementation of the tobacco measures may become mandatory to receive federal payments in the future? In 2012 will there be any incentive from Medicare or The Joint Commission to implement this measure set?</i></p>	<p>There really is no way to know if the tobacco measures will become mandatory to receive federal payment in the future. I am not aware of any 2012 incentives from Medicare to select the measure set. For the Joint Commission, the measure set simply joins the complement of existing measure sets that hospitals can select to meet accreditation requirements. As always, hospitals have a choice of which measure sets to select that will best meet their needs for quality improvement efforts.</p>