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Action TO QUIT
Advancing Tobacco Cessation Policy

Q&A from the ActionToQuit Feb 10, 2011 Webinar, *The Role of Hospitals in Tobacco Cessation*

Speakers: Rob Adsit, Director of Education and Outreach Programs, University of Wisconsin Center for Tobacco Research and Intervention & Andrew Pipe, C.M., M.D., LL.D. (Hon), D.Sc. (Hon), Chief of the Division of Prevention and Rehabilitation at the University of Ottawa Heart Institute, Professor in the Faculty of Medicine at the University of Ottawa
Moderator: David Zauche, Senior Program Officer, Partnership for Prevention

Q&A for Rob Adsit, University of Wisconsin Center for Tobacco Research and Intervention

How important do you think it is for students in health care professions, specifically nursing, to learn about tobacco cessation in their programs?	This is very important. We work with our Medical School, our Nursing School, our Dental School as well as our dental hygiene training programs across Wisconsin. We cover the 5 A model for brief intervention, how to use the state quit line as a treatment extender, as well as the research and stats about why they should treat tobacco dependence from the Clinical Practice Guideline *Treating Tobacco Use and Dependence*. We strongly emphasize the role they play and the unprecedented opportunity to intervene.
In the (US/Canada) hospital bureaucracy, where does the leadership come from to adopt hospital screening AND who makes the decision to say yea or nea?	In our experience in Wisconsin, we rarely start at the top. We find a champion(s) within the hospital staff (QI, resp therapy, nurse, doctor) and work to cultivate and support their enthusiasm. They can then work from within the hospital/healthcare system to work through appropriate channels for approval.
How much are providers reimbursed for tobacco dependence treatment?	The reimbursement varies from health plan to health plan. Tobacco dependence treatment counseling is typically reimbursed in two categories: 3-10 minutes and greater than 10 minutes. The Clinical Practice Guideline, *Treating Tobacco Use and Dependence* offers a brief intervention (3 minutes) that is effective. Coupling this with a referral to a state tobacco quit line, which can do more intense counseling, is very successful.

To what extent are nurses involved in cessation support for smokers in the hospital?	In our experience in Wisconsin, nurses are very involved. In fact, when we do training and technical assistance, nurses are usually the largest percentage of the audience.
How was CTRI able to get thru/around any silos that may be limited or prevented these associations and UWSOM from working together?	Our strategy is to work with the willing and interested. They are willing to take on tobacco dependence treatment. We do not work in every hospital in the state and we do not work with every clinician or department within a hospital. We do some encouragement for the less willing, mostly by using peer pressure across clinicians or health plans or hospitals or associations.
Do the Ottawa or Wisconsin models work with psychiatric hospitals or do they need adaptation. If so what adaptations are needed?	Wisconsin has done a little work in this area. There are resources for clinicians who work with patients with mental health issues. One of the best is by Chad Morris in Colorado. That toolkit and other resources are at: http://www.ctri.wisc.edu/HC.Providers/healthcare_mental.health_toolkit.htm
In Wisconsin, what is the percentage of patients who smoke and what is the most common pharmacotherapy used? Do they use varenicline? If so, how does that process work?	The adult smoking rate in Wisconsin is 20%. The adult Medicaid smoking rate in Wisconsin is 38%. So, it's safe to assume that one-fifth to one-third of patients admitted to Wisconsin hospitals are smokers. It varies from hospital to hospital and I can share with you information from the hospital that Dr. Fiore (Director of our Center) practices in. They have a comprehensive plan and standing orders that include nicotine patch or nicotine gum for withdrawal relief. If the patient is there longer-term or if a short-term patient wants to use it, varenicline and bupropion are on the standing order. The goal being to have this be as comprehensive as possible so that any patient wanting to make a quit attempt could be supported by meds, as appropriate.

Is counseling an important part of the smoking cessation models in hospitals?	Absolutely. We know that combining medication(s) with counseling greatly increases a patient's success. The counseling can be brief and still be effective. Please see pages 144-145 and 149-150 of the Clinical Practice Guideline *Treating Tobacco Use and Dependence* (http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf)
Does Wisconsin offer interventions to staff as well? What does that program look like if it exists?	As a matter of practice, we do not. The exception is that we did a program for the employees of the hospital/clinic system that Dr. Fiore (Director of our Center) practices in. It lasted three years and was paid for by the hospital. They invested resources in helping their employees who wanted to quit. Convenient, barrier-free employee access was a priority and was addressed in the following ways: •Medications including nicotine patch, gum, lozenge, inhaler, Bupropion SR and Varenicline were available free to all enrolled employees. No co-pay for those with health insurance; cost free to those without insurance. •On-site sessions were conducted at multiple locations, including, on-the-spot counseling, enrollment, and distribution of the first month's supply of patches, gum and/or lozenges. Prescriptions were written for inhalers, Varenicline, and Bupropion SR. •Nine pharmacies participated as distribution centers for prescription medications and refills. •A cell phone number and email address were dedicated for counseling and enrollment purposes. •The Wisconsin Tobacco Quit Line was used for ongoing counseling. •Ongoing support, enrollment, and program management was provided with a dedicated outreach coordinator from UW-CTRI. •Enrollees were contacted prior to their quit date, around their quit date as well as 6 months after their quit date. •Information was provided for spouses and significant others wanting to quit.

Is there any future plan for an electronic EMR referral to the Quitline instead of Fax?	Several states are already doing e-referral to their state quitline. Massachusetts is one and for more details you can contact: Donna Warner, Donna.Warner@state.ma.us. The University of Wisconsin Center for Tobacco Research and Intervention is working with Epic Systems and a health system on piloting e-referral from the EHR to our state tobacco quit line. This work will be done later this year.
Is there any work being done for hospitals to be able to bill for cessation in the in-patient setting?	Hospitals can be reimbursed for in-patient tobacco cessation. There are some details about billing for in-patient tobacco cessation on pages 13 – 14 at: http://www.ctri.wisc.edu/HC.Providers/Guideline%20Hospital%20Info.pdf
Wisconsin, is the intervention program promoted to the public? If so, how?	We have focused our energies on adoption and implementation by clinicians and systems and have not promoted tobacco cessation in hospitals with the general public/potential patients.
Does the manual have a section on making a case for smoking cessation (business case) to Executive and Clinical Director of hospitals?	Our current hospital manual does not, but we plan to include that when we update it in 2011. There is quite a bit of information available for making the business case to treat tobacco dependence. Here are some resources related to that: http://www.businesscaseroi.org/roi/apps/calculator/calcintro.aspx http://www.ctri.wisc.edu/Insurers/Business.Case.Insurance.pdf
Is there an effort to educate health care professionals on "other tobacco products" of which most are unfamiliar?	We are frequently asked for information about other tobacco products, especially the e-cigarette. Legacy has a good fact sheet on the e-cigarette (http://www.legacyforhealth.org/3228.aspx). We tell clinicians that e-cigarettes have not been tested, that the CDC found carcinogens in e-cigarettes, and that they are not a safe alternative to smoking.
Can you share smoking-related elements in electronic health records (EHRs)?	Good examples of incorporating evidence-based tobacco dependence treatment into EHRs exist. If you contact me (ra1@ctri.medicine.wisc.edu), I can share some examples.

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Q&A for Dr. Andrew Pipe, University of Ottawa Heart Institute

Is there a demo of the automated telephone follow-up? Can we get the name of the company that offers this service?	The company is TelASK Technologies (www.telask.com). They can provide a demo upon request.
Where can I find documentation supporting giving NRT to acute coronary syndromes patients?	Meine, Patel, Washam, Pappas, & Jollis. *Safety and effectiveness of transdermal nicotine patch in smokers admitted with acute coronary syndromes*; Am J Cardiol. 2005 Apr 15;95(8):976-8.
Where does the funding come from for the Ottawa program?	The University of Ottawa Heart Institute funds our institutional program (1.0 FTE nursing, administrative support, pharmacotherapies). Funding for the support we provide to other hospitals throughout our province and country comes from various sources (a combination of government, research, and industry funding).
Do you use any kind of physiologic markers (CO monitoring, hair, urine or blood cotinine) to verify smoking status?	Yes. We use CO monitoring in our clinical program and both CO and blood cotinine in our research studies.
Will there be information about reduced LOS in hospital and reduced costs?	Yes. A case study we just completed at our institute (looking at providing the Ottawa Model to 1491 smokers in 2009) concluded that 476 bed-days were saved as a result of offering the Ottawa Model - resulting in a net potential cost-savings of $512,895 (estimated by subtracting the cost of the program ($201,105) from the potential cost-savings due to reduced hospitalizations ($714,000)).
Is other treatment offered besides NRT (i.e. varenicline or bupropion)?	Yes. All medications (NRT, varenicline, and bupropion) are offered and available through our hospital formulary. One of the first practices that we apply when working to implement the Ottawa Model in other hospitals is ensuring that all first-line quit smoking medications are made available.

Does the hospital need to have 1 FTE staff to oversee the program?	We typically recommend 1 FTE per 1500-2000 smokers (to consult at the bedside as well as complete some follow up support post-hospitalization).
Is the presenter using "smoker" synonymously with "tobacco user" to include chew, dip, spit, etc.	Yes. Nearly 99% of tobacco users seen in hospital will be smokers of some-kind. However, a tobacco-user is identified on admission by the question "have you used any form of tobacco in the past 6 months", thus identifying all tobacco users.
How do you deal with the patient that refuses NRT but is clearly in withdrawal?	Provide necessary information. State "it never hurts to try it - even if you're not ready to quit smoking right now, this may help you deal with withdrawal while you're here." Talk about other strategies for dealing with withdrawal (e.g. the 4 Ds); however, always leaving the door open and revisiting the issue at a later time during the admission to see if they've changed their mind.
What is the impact of providing designated smoking areas for patients vs. smoke free properties?	We have not studied this. Designated smoking areas are often just as far as the property line. Rigotti and colleagues (2000) found that nicotine withdrawal was a strong predictor of whether smokers would go outside to smoke during hospital admission; therefore, being able to offer pharmacological treatment would support cessation.
In Canada, who pays for NRT products? Is it free for patients and how much product do they receive?	Currently, only one Canadian province provides cost-free quit smoking medications to residents. Medication is free for patients while they are admitted to hospital (the hospital pays) but not covered post-hospitalization.

I am interested in your evaluation system. What are the indicators? Do you have an electronic system that automatically generates evaluation measures?	Yes. We have a central database that allows each hospital with the Ottawa Model to enter their smoking cessation assessment information. This database is the same system that places the automated follow up calls, whereby allowing to track patients from initial contact to 6 month follow-up. The system generates reports on numbers reached, patient quit rates, etc. In addition, we have staff dedicated to providing evaluation support to partner sites. We report annually to sites on program impact using a REAIM framework (see Reid et al. 2010 Nicotine and Tobacco Research; 1(12))
I work in a psychiatric hospital; many staff smoke and are resistant to smoking restrictions & policy development involving treatment- how do you address personal bias?	We try to address these types of predisposing attitudes in training, explaining that this program is about withdrawal management as much as it is about cessation. We want patients to be comfortable and safe while hospitalized, and part of that is helping to manage their nicotine withdrawal. In addition, most smokers want to quit and this includes staff. Many sites make sure to offer cessation support to staff when implementing a cessation program for patients. Anecdotally, many staff who smoke are the most compassionate and understanding when addressing cessation with patients.
How did you confirm commitment from hospitals that use the OMSC?	We have site agreements with each participating site that is renewed annually and specifies what support UOHI provides and what activities each site agrees to perform.
In the (US/Canada) hospital bureaucracy where does the leadership come from to adopt hospital screening AND who makes the decision to say yea or nea?	It differs across Canada. In Ontario, for instance, individual hospital leadership makes the decisions as to what interventions to adopt and where to allocate funding; however, this may be strongly influenced by regional health authorities. In eastern Ontario, the Ottawa Model intervention is included in hospital accountability agreements with our regional health authority (the authority through which hospital funding flows). In other provinces, regional health authorities have more direct influence on what policies and interventions hospitals are to adopt.
How much are providers reimbursed for tobacco dependence treatment?	An initial visit is $15.40 and follow up visit $33.45 in Ontario.

To what extent are nurses involved in cessation support for smokers in the hospital?	Frontline nurses are most often involved in identifying smoking status, completing the standardized consultation form, and recommending quit smoking medication (by completing a standard order for the attending physician to sign). In some hospitals, the more intensive consultation becomes the role of respiratory therapists or other allied health workers (i.e. social work, etc).
Is counseling an important part of the smoking cessation models in hospitals?	Yes. Advice from a health professional is important as a first step. In addition, while patients may find they are successful at remaining smoke-free while in hospital, relapse is high in the first days and weeks following hospital discharge; therefore, brief counseling to discuss strategies to help prevent relapse is important.
Have any of you developed a business case to help convince health care facilities?	Yes. Important arguments to help convince health care administrators include: 1) Tobacco-use is an addiction and smokers need help with withdrawal as other addicts would need such support; 2) Cessation interventions are cheap relative to other interventions; 3) smoking is a leading cause of hospitalization and re-hospitalization - there is evidence that cessation interventions reduce both re-hospitalization and mortality, thus saving bed-days and potentially reducing wait-times.
How about help for the staff who are also dealing with smoking addictions? How do we support them?	Many hospitals offer cessation support to staff, often enrolling staff in the automated follow up program. Occupational health departments have become involved in providing programs to staff. Human resource departments have become involved by ensuring that quit smoking medications are including in employee benefits plans.
How much does this automated telephone system cost?	$15 per patient.
Do you have a list of references for the Ottawa model that you spoke of, if so can that be shared?	1. Reid, R. D., Mullen, K. A., Slovinec D'Angelo, M. E., Aitken, D. A., Papadakis, S., Haley, P. M., . . . Pipe, A. L. (2010). *Smoking cessation for hospitalized smokers: an evaluation of the "Ottawa Model".* Nicotine and Tobacco Research, 12(1), 11-18. 2. Reid, R. D., Pipe, A. L., & Quinlan, B. (2006). *Promoting smoking cessation during hospitalization for coronary artery disease.* Can J Cardiol, 22(9), 775-780.

	3. Reid, R. D., Pipe, A. L., Quinlan, B., & Oda, J. (2007). Interactive voice response telephony to promote smoking cessation in patients with heart disease: a pilot study. Patient Education and Counseling, 66(3), 319-326.
Please share in writing Dr. Pipe's final words regarding hospitals' failure to address tobacco use systematically as a failure in their mission to be health champions in their communities.	See: Pipe. Curr Opin Cardiol. 2008 Sep;23(5):462-4 and Pipe, Papadakis, Reid. Curr Atheroscler Rep. 2010 Mar;12(2):145-50

Q&A for David Zauche, Partnership for Prevention

Technically all Joint Commission standards are voluntary, with wanting accreditation as the basis. Same application to the new standards?	Yes, the tobacco cessation measure set, if approved by the Joint Commission, will be an optional set (just like all the others). Hospitals choose four as the basis for their certification. There are currently nine measure sets, with the proposed tobacco and alcohol sets (if approved) becoming numbers ten and eleven.