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Will Hospitals Finally “Do the Right Thing”? – Providing Evidence-Based Tobacco Dependence Treatments to Hospitalized Patients who Smoke

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In 2008, the United States Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence*¹ described the chronic disease of tobacco dependence in this way,

“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”.

In that one sentence, the Guideline highlighted both a common and unfortunate missed opportunity –evidence-based tobacco dependence treatment is not consistently provided to patients visiting healthcare settings, including patients who are hospitalized.

Since the publication of the Guideline in 2008, some important progress has been made and that progress may reverse this opportunity lost. Two policy areas hold particular promise. First, in January 2012, the Joint Commission released its new Tobacco Cessation Performance Measure-Set², which was predicated on some key findings, such as the fact that many patients’ hospitalizations are directly caused by smoking, making intervention during this time particularly salient. In addition, because all Joint Commission-accredited hospitals are required to be generally, smoke-free,^{3*} admission to a hospital forces an individual who smokes to abstain during the hospitalization so that he or she may be open during this time to making a quit attempt. Finally, the body of evidence guiding a hospital-based smoking cessation intervention is growing, and such comprehensive interventions have been shown to markedly enhance quit rates⁴. Also, in 2012 Fiore, Goplerud and Steven Schroeder called on hospitals to, “do the right thing” and implement the Joint Commission’s new tobacco-cessation measures⁵. Although initial adoption was minimal, more hospitals have recently signed onto them. According to Joint Commission staff, as of March 2016, 768 hospitals out of 3,705 are now reporting their performance on the tobacco cessation measure set. Hopefully, we are finally moving toward a standard of care in which hospitals are delivering evidence-based tobacco cessation services to their patients and reporting the performance data.

*Environment of Care (EC) Standard EC.02.01.03 states, “The hospital prohibits smoking except in specific circumstances”; Elements of Performance (EP) 1. The hospital develops a written policy prohibiting smoking in all buildings. Exceptions for patients in specific circumstances are defined; EP4. If the hospital decides that patients may smoke in specific circumstances, it designated smoking areas that are physically separate from care, treatment, and service areas (*see also* EC.02.03.01, EP2); EP6. The hospital takes action to maintain compliance with its smoking policy.

The second key policy change that is advancing the treatment of tobacco dependence was the passage of the Affordable Care Act (ACA) with its mandate that insurers provide coverage for evidence-based prevention services including smoking cessation, without barriers and without co-pays.⁶ Guidance regarding the specificity of the smoking cessation coverage requirement was missing from the ACA language in 2010. To address that, in 2014, the Departments of Health and Human Services, Labor, and the Treasury jointly released a document that provided necessary specificity in the form of a response to a “Frequently Asked Question or FAQ”⁷, a commonly used guidance document to assist insurers and others to implement the ACA. In that guidance document, insurers were informed that they would be in compliance with the ACA’s prevention requirement to cover tobacco-use counseling and medications if they, for example, provided without cost sharing or prior authorization: a) two courses of tobacco dependence treatment per year (two “quit attempts”) with each course of treatment including at least four tobacco cessation counseling sessions (telephone, group, or individual), each at least 10 minutes long; and, b) any of the seven FDA-approved tobacco-cessation medications for a 90-day treatment regimen when prescribed by a health care provider⁸. The guidance document has some limitations. For instance, use of the terminology “for example” regarding the ACA prevention requirement to provide tobacco use counseling and medications has less impact than more specific legislative language or a simple formal regulation that states the criteria for compliance.

However, this FAQ, for the first time, established an evidence-based standard for what constitutes ACA-consistent insurance coverage of smoking cessation treatment. Over time, it has the potential to markedly enhance the proportion of patients whose insurance provides comprehensive coverage for treating the leading preventable cause of illness and death in the United States. In this issue of *The Joint Commission Journal on Quality and Patient Safety*, two articles provide additional information and guidance as hospitals move to implement the Joint Commission Tobacco Cessation Performance Measure Set and use the ACA insurance coverage mandate to help more of their patients quit tobacco. In “Two Years in the Life of a University Hospital Tobacco Cessation Service: Recommendations for Improving the Quality of Referrals,” Bjornson and colleagues⁹ describe two years of experience of the Oregon Health and Science University (OHSU) Tobacco Cessation Consult Service, a comprehensive program to help hospitalized OHSU smokers quit. Although this program was established in 2007 – well before the release of the Joint Commission Tobacco Cessation Performance Measure Set – it has applicability as a model for how such treatment services can be organized. Bjornson et al. article focus on a particular challenge – how to improve the reach and effectiveness of hospital-based smoking cessation consult services. The authors recognize the particular challenges of deciding whether to focus those services on “all-comers” versus focusing on selected patient populations, given the low proportion of smokers who complete all four components of the originally recommended Joint Commission Tobacco Cessation Performance Measure Set (that is, including TOB-4, Tobacco Use: Assessing Status After Discharge, temporarily suspended as of January 1, 2015). While their results were sobering – only about 1/3 of current smokers were referred for a tobacco cessation consult, with even lower rates completing all components of the intervention – they did demonstrate that such services can be effectively integrated into

hospital workflows. Their work also helps to identify which patient characteristics result in higher or lower rates of referral.

In a second article in this issue of *The Joint Commission Journal on Quality and Patient Safety*, “Improving Quality of Care for Hospitalized Smokers with HIV: Tobacco Dependence Treatment Referral and Utilization,” Fitzgerald and colleagues¹⁰ highlight a tragic paradox – although treatments for HIV disease have improved dramatically over the last decade, smoking rates among these patients remain high, and only a small proportion of such patients receive treatment for their tobacco dependence. As a result, increasing numbers of HIV patients are dying from a tobacco-caused disease, rather than from their HIV infection. Fitzgerald et al. assessed tobacco cessation treatment among HIV patients hospitalized at a large academic medical center over a five-year period. They found extraordinarily high smoking rates among persons admitted with HIV – 55%. Moreover, a disappointingly small proportion of those patients – 22% – were referred to inpatient tobacco treatment services during their hospitalization. Their findings highlight once again that as a healthcare delivery community, we are too often ignoring the greatest preventable risks to our patient’s health.

The year 2016 may reflect a tipping point in terms of seizing hospitalization as an opportunity to help more patients addicted to tobacco to quit. The policy changes represented for example, by the ACA and the Joint Commission Tobacco Cessation Measure Set, in combination with the experience in treating smokers who are hospitalized, as reported by the Bjornson et al. and Fitzgerald et al. articles, can help guide us in identifying and implementing the most efficient and effective ways to treat hospitalized patients who smoke. What is missing is a binding expectation – an expectation that such treatment constitutes a minimal standard of care. With policy and research advances, such a minimal standard of care now appears achievable.

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