Improving Tobacco Cessation with Adult Inpatient Psychiatric Clients

National Association of State Mental Health Program Directors Research Institute (NRI):
Glorimar Ortiz, PhD
Missy Rand, LPC, CSAC
Lucille Schacht, PhD, CPHQ

May 19, 2021
Moderator

Catherine Saucedo
Deputy Director

Smoking Cessation Leadership Center
University of California, San Francisco
A National Center of Excellence for Tobacco-Free Recovery

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Anita Browning, Christine Cheng, Brian Clark, Jennifer Matekuare, Glorimar Ortiz, PhD, Ma Krisanta Pamatmat, MPH, Missy Rand, LPC, CSAC, Jessica Safier, MA, Catherine Saucedo, Lucille Schacht, PhD, CPHQ, Steven A. Schroeder, MD, and Aria Yow, MA.
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Smoking Cessation Leadership Center
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▪ Visit [CABHWI.ucsf.edu](http://CABHWI.ucsf.edu) for more information
▪ CDC Tips Campaign 2021 – celebrating 10 years!

▪ SCLC will partner with the CDC to promote 1 800 QUIT NOW through new ads as well as some former favorites
I COVID QUIT!

- Launched March 31

- SCLC’s own campaign funded by Robert Wood Johnson Foundation

- Real people sharing their UNSCRIPTED experiences of improved mental health after quitting smoking—and they did it during the COVID-19 pandemic!

- FREE videos, digital images and toolkit for your use at ICOVIDQUIT.org
Today’s Presenter

Lucille Schacht, PhD, CPHQ

Senior Director
Performance and Quality Improvement

National Association of State Mental Health Program Directors Research Institute (NRI)
Today’s Presenter

Glorimar Ortiz, PhD

Principal Biostatistician

National Association of State Mental Health Program Directors Research Institute (NRI)
Today’s Presenter

Missy Rand, LPC, CSAC

Clinical Quality Educator

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IMPROVING TOBACCO CESSATION WITH ADULT INPATIENT PSYCHIATRIC CLIENTS

Glorimar Ortiz, PhD, NRI Principal Biostatistician
Missy Rand, LPC, CSAC, NRI Clinical Quality Educator
Lucille Schacht, PhD, CPHQ, NRI Senior Director Performance and Quality Improvement

May 2021
TOBACCO CESSATION PROJECT

• A NRI series focused on improving access to tobacco cessation recovery for persons in psychiatric hospitals.
  • Clinical Actions
  • Change Management
  • Comparisons/Benchmarking

http://www.nri-inc.org/focus-areas/performance-measurement/clinical-oversight/tobacco-cessation/

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WEBINAR OBJECTIVES:

Examine

Analyze two recommendations to extend momentum for referral for treatment post psychiatric hospitalization.

Demonstrate

Examine two effective system change interventions.

Apply

Examine the basic framework of the tobacco use and treatment measures developed by The Joint Commission and used by CMS for inpatient psychiatric facilities.

Demonstrate two current perceived needs and organizational barriers for tobacco use treatment and referral after inpatient discharge.

Examine two effective system change interventions.

Apply two clinical actions that may impact the offering of tobacco use treatment and the referral after inpatient discharge.

Analyze

Examine the basic framework of the tobacco use and treatment measures developed by The Joint Commission and used by CMS for inpatient psychiatric facilities.
• Adults with behavioral health conditions represent 25% of the U.S. population but account for 40% of all cigarettes smoked in the U.S.

• Tobacco contributes to more deaths than the primary behavioral health disorder McGinty 2012

• The most effective treatment for TUD is a combination of behavioral counseling and use of medication(s) DSM-5

• About 70% of individuals with mental health disorders are interested in quitting – the same as the general population CDC: MMRW Jan 2017

• Without treatment, only 3-6% of all smokers are able to quit on their own. CDC: MMRW Jan 2017
### National Survey on Drug Use and Health, 2018

#### % Use in Past Year

<table>
<thead>
<tr>
<th></th>
<th>Tobacco Products</th>
<th>Smokeless Tobacco</th>
<th>Pipe Tobacco</th>
<th>Cigarettes</th>
<th>Cigars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Mental Illness</td>
<td>32.6</td>
<td>3.2</td>
<td>6.6</td>
<td>28.2</td>
<td>1.6</td>
</tr>
<tr>
<td>Serious Mental Illness</td>
<td>40</td>
<td>3.5</td>
<td>7.6</td>
<td>35.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Moderate/Mild Mental Illness</td>
<td>30.3</td>
<td>3.1</td>
<td>6.2</td>
<td>25.8</td>
<td>2.2</td>
</tr>
<tr>
<td>No Mental Illness</td>
<td>22.3</td>
<td>3.4</td>
<td>4.5</td>
<td>17.3</td>
<td>0.7</td>
</tr>
</tbody>
</table>

**Categories:**
- Any Mental Illness
- Serious Mental Illness
- Moderate/Mild Mental Illness
- No Mental Illness
Tobacco Use and Treatment Measures

• Developed by The Joint Commission
• Used by Inpatient Psychiatric Facilities in their reporting of required quality measures to the Centers for Medicare & Medicaid Services
• Measures look at the continuum of care from inpatient screening, to inpatient treatment, to referral for outpatient treatment
• **TOB1** - Screen for Tobacco Use – required reporting Jan 2015 thru Dec 2017. Screen for current tobacco use within one day after admission, identify type and volume of use.
  - Measure discontinued because performance was at least 95% for many providers
• **TOB2/2A** – Tobacco use treatment offered or provided – required reporting Jan 2015 to present. Treatment includes “Practical Counseling” and FDA-approved medications when appropriate.
• **TOB3/3A** – Tobacco use treatment offered or provided at discharge – required reporting Jan 2016 to present. Treatment includes evidence-based outpatient counseling and FDA-approved medication when appropriate.
SURVEY OF PSYCHIATRIC FACILITIES

Glorimar Ortiz, PhD
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Epidemiological Background

Compared to people in the general population, people with mental illness:
- Are more likely to use tobacco (CDC, 2013; Jamal et al., 2014)
- Are more likely to smoke more heavily (Szarkowski et al., 2015)
- Are 2-4 times more likely to be tobacco dependent (Chou et al, 2016; Ruther et al. 2014)
- Experience morbidity and mortality at 2-2.5 times greater rate (Blackwell et al., 2014; WHO, 2017)
- Have lower tobacco use cessation rates (Gildody et al., 2019)

NRI study found that tobacco use among individuals with mental illness served in a SMHA was a significant predictor of early mortality accounting for nearly 4 years lost (Ortiz, 2020).

\[ YPLL = 8.49 + 6.78(\text{Never married}) + 5.44(\text{Black}) + 3.85(\text{Tobacco user}) + 2.25(\text{Female}) \]
✓ 3 imperative aspects related to tobacco use cessation in hospitalized patients:

1. Screening for tobacco use (Tob-1)
   ✓ Initial practice for appropriate substance use/abuse diagnosis
   ✓ Has been successfully achieved by psychiatric hospitals

2. Offering active treatment (Tob-2/2a)

3. Referral at discharge (Tob-3/3a)
NRI FACILITY TOBACCO SURVEY 2020

✓ Designed using
  1- NRI’s Smoking Cessation Policies and Practices survey
  2- Guidelines for Treatment of Smoking in Hospitalized Patients
      (Jimenez Ruiz et al., 2017)
  3- Feedback from NRI’s Clinical Educator (Missy)

✓ Contains 52 questions that collect information about the:
  ✓ facility demographics
  ✓ current tobacco use policy
  ✓ tobacco use assessment protocol
  ✓ tobacco use treatment in hospitalized smokers that included
diagnostics and therapeutic interventions, and
  ✓ referral at discharge
➢ **Tobacco use** was defined as using a legalized form of tobacco in any form (e.g. cigarette, cigar, chewing, or pipe) regardless of the age of the client.

➢ **Light tobacco use:** The person smokes ≤4 cigarettes or <1/4 pack a day and/or uses smokeless tobacco and/or smokes cigarettes/pipes but not daily.

➢ **Heavy tobacco use:** The person smokes 5 or more cigarettes or ≥1/4 pack per day and/or cigars/pipes daily.

➢ **Active treatment:** includes counseling and pharmacological intervention.

➢ **Practical counseling:** Face-to-face interaction with the patients to address all of the following: recognizing danger situations, developing coping skills, and providing basic information about quitting.
Investigate **staff needs** and **organizational barriers** to:

1. offer active treatment for tobacco cessation
2. refer patients for tobacco use cessation treatment after discharge

Survey period: July 21 – August 21, 2020

165 facilities surveyed

108 surveys received

70 facilities responded

42% response rate
What age group does the facility serve?

- less than 13 years
- 13-17 years
- 18-64 years
- 65 years and older

N=70
What level of care service is provided at the facility level?

- Longterm care
- Acute care
- Forensic
- Other type of care

N=69
What is the facility's **CURRENT** tobacco use policy?

- Tobacco use is not allowed: 95.7%
- Allow tobacco use outdoors but not indoors: 4.3%

N = 70
What did staff say they need to offer active treatment for tobacco cessation?

**Resources**

**Educational & training materials:**
- success stories, coping skills, how addictive nicotine is, pharmacotherapy and interaction with psychiatric disorders and their treatment, evidenced-based tobacco use cessation programs, treatment intervention templates, training about change in staff behavior and attitude towards tobacco use

**Time**

**People:**
- certified staff, tobacco cessation counselors, substance use disorder specialists
What did staff say are organizational barriers to offering active treatment for tobacco cessation?

- Lack of funds
  - Shortages of trained/certified staff
  - Limited time dedicated for active treatment and counseling services
  - Scarce tobacco use cessation resources
  - Decreased pharmacotherapy/medication options

- Frail tobacco use cessation culture
  - Tobacco use cessation treatment is not a priority
  - Tobacco use cessation is not taken seriously
  - Physicians are reluctant to prescribe medication for tobacco cessation
  - Inappropriate use of some medications
What did staff say they need to refer patients for tobacco cessation treatment after discharge?

**Information**
- Consistent patient contact information
- List of outpatient programs available with contact information
- List of community resources for patients to use at discharge

**Training**
- On evidence-based pharmacological interventions
- About requirements for treatment at discharge
- Related to specialized treatment programs

**Partnership**
- Active relationship with personnel at the tobacco cessation treatment centers
- Improve direction from physicians
What did staff say are organizational barriers to referring patients for tobacco cessation treatment after discharge?

<table>
<thead>
<tr>
<th><strong>Patient Level</strong></th>
<th><strong>In-patient Level</strong></th>
<th><strong>Out-patient Level</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>* (Perceived) Resistance to quit</td>
<td>*Staff: Not trained/enough staff</td>
<td>*No or limited community resources</td>
</tr>
<tr>
<td>* (Perceived) Lack of interest/motivation</td>
<td>*Time: Not enough time to make referrals</td>
<td>*Scarce specialized treatments for tobacco cessation</td>
</tr>
<tr>
<td>*No reliable contact information at discharge</td>
<td>*Costs: Not enough funds to cover required training costs</td>
<td>*Lack of appropriate programs</td>
</tr>
<tr>
<td>*Confidentiality issues: unable to refer</td>
<td></td>
<td>*Quitlines are not interactive</td>
</tr>
</tbody>
</table>
• References
  • Chou SP, Goldstein RB, Smith SM et al. (2016). The epidemiology of DSM-5 nicotine use disorder: Results from the National Epidemiologic Survey on alcohol and related conditions-III. The Journal of Clinical Psychiatry, 77(10), 1404-1412.
  • Ruther T, Bobes J, De Heart, M et al. (2014). EPA guidance on tobacco dependence and strategies for smoking cessation in people with mental illness. European Psychiatry, 29(2), 65-82.
CLINICAL ACTIONS

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Clinical Quality Educator
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WHAT IS THE GOLDEN THREAD?
TARGETING ALL LAYERS OF STAFF

- Survey suggests that Prescribers (Psychiatrists/PA/NP/MD) are the most common professional level used for screening, practical counseling, and interventions (more than 2/3 of facilities reported using Prescribers)
- Nurses are used in more than half of facilities for practical counseling, and almost 2/3 of facilities for screening and other interventions
- Prescribers and Nurses are then supplemented by licensed mental health provider/social worker/psychologist

- Resource materials need to be developed for use by various professionals
  - [http://www.nri-inc.org/focus-areas/performance-measurement/clinical-oversight/tobacco-cessation/clinical-action/](http://www.nri-inc.org/focus-areas/performance-measurement/clinical-oversight/tobacco-cessation/clinical-action/)

- Peer providers and mental health aides appear to be an under-used resource
Screening/Assessment completed by multiple staff, each recorded in a separate place in the medical record

Practical counseling offered by only 36% of facilities immediately after the screen.
  - Practical counseling includes recognizing danger situations, developing coping skills, and providing basic information about quitting.

Only 14% of facilities reported adding the Tobacco Status to the Problem Assessment

Various interventions are used, but there does not seem to be a clear leader

<table>
<thead>
<tr>
<th>Psychological Treatment Approaches</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoeducation for tobacco use impact/cessation</td>
<td>62.5%</td>
</tr>
<tr>
<td>Stress Management Skills Training</td>
<td>48.4%</td>
</tr>
<tr>
<td>Relapse prevention skills training</td>
<td>45.3%</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>43.8%</td>
</tr>
<tr>
<td>Brief therapy</td>
<td>35.9%</td>
</tr>
<tr>
<td>Tobacco specific self-help resources (audio/video/peer groups/apps/books/workbooks)</td>
<td>29.7%</td>
</tr>
<tr>
<td>CBT/DBT</td>
<td>21.9%</td>
</tr>
<tr>
<td>Peer support counseling</td>
<td>12.5%</td>
</tr>
</tbody>
</table>
IMPROVEMENT STRATEGIES FOR INPATIENT PSYCHIATRIC FACILITIES

Lucille Schacht, PhD, CPHQ
Senior Director Performance and Quality Improvement
Lschacht@nri-inc.org
Tobacco Cessation Change Process

Clinicians endeavor to extend individual client’s tobacco cessation gains during inpatient psychiatric hospitalization to ongoing recovery management. Change management theory, coupled with action steps, enable organizational change that can lead quality efforts to have a greater and more enduring impact on tobacco cessation outcomes beyond the point of discharge.

Change Models

- **Unfreeze**
  - CDC/MI Tobacco Use and Quitting
  - KE Tobacco: Drug Readiness Assessment
  - PMI Change Readiness
  - NASMHPD Tobacco Cessation Policy
  - Smoking Cessation Leadership Center
  - State Psych Hospital Smoke-free Policy 2000
  - State Psych Hospital Smoke-free Policy 2012
  - State by State Tobacco Status
  - HHS 2006 Tobacco Use Treatment Guidelines
  - Tobacco Control Policies 2000
- **Change**
  - CDC Tobacco Cessation Change Package
  - NSPA Blending Initiative Infographic
  - MI: Supervision Curriculum
  - BY for Change
  - Stage Based Smoking Interventions
  - OK Cessation Promising Practices
  - Pharmacist Prescribing Map
  - OK Office Tobacco Interventions
  - Tobacco Cessation Clinical Actions
- **Refreeze**
  - NRI Performance Measurement Guidance
  - OK Peer Specialists Enhance Workforce
  - Lewin Change Model
  - Kotter Change Model
  - IIM and Stages of Change Model

http://www.nri-inc.org/focus-areas/performance-measurement/clinical-oversight/tobacco-cessation/change-management/
LEADERSHIP

• Establishing vision
  • Clear vision of the future AND strategies for producing needed changes
  • Providing the “why now” case and defining why “status quo is not good enough”
  • Connecting new behaviors with organizational success
  • Dealing directly with resistance

• Aligning people
  • Communicating direction in words and deeds
  • Inclusive of all staff who need to be “on-board” with new vision, especially people with power (title, SME, relationships)
  • Creating teams/coalitions that agree with the validity of the vision – serve as role models for other staff

• Motivating and inspiring
  • Encourage outside-the-box thinking and approaches
  • Energizing staff to overcome barriers to change
  • Removing obstacles (outdated policies/procedures)
  • Reinforcing/acknowledging basic human needs (rewards, recognition, respect)
IDENTIFY AREAS FOR IMPROVEMENT

• Transition record provided to patient and next provider – is tobacco use clearly identified as an issue?
  • 86% of facilities indicate it is documented
  • 62% of facilities recommend continued evidence-based counseling for at least one month after discharge
  • 43% of facilities provide prescription for tobacco cessation medication
  • 59% of facilities provide take-home medications (most commonly for only 7 days)

• Most common referral are the Quit Line (55%) and community mental health center (39%)
SYSTEM CHANGE INTERVENTIONS

• Conduct a self-assessment of your readiness for change (see example from Kansas)
• Provide clear evidence of current risk (prevalence of tobacco use) and effective interventions (see example from Georgia)
• Couple efforts that easily align, for example a change in the EHR documentation and adding resources as visible options for the clinical staff (e.g., Quit Line added to the Discharge Plan) (see example from Illinois)
• Imbed in a whole health or integrated care re-visioning of the department (see example from Oklahoma)
Benchmark or Goal

- Benchmark, by definition, is the best performer on a measure
  - Perfect performance is not required
  - Assumed that the processes used to achieve the best performer status can be clearly stated and replicated

- Goal is a value statement of the desired target value on a measure
  - Perfect performance is not required
  - Assumed that goal is achievable within a specified time period

- Measuring achievement of benchmark or goal
  - Incremental movement
  - Within X% of benchmark

- Monitor impact of local change and share results so that other providers can benefit from your experience – this is how we build knowledge base on best practices
RECOMMENDATIONS

✓ While more disciplines are involved in the “interventions,” there could be more use of peer providers, Art/Rec/OT, and mental health aide/tech
✓ Request for evidence-based tobacco cessation programs and treatment intervention templates. Evidence of effectiveness of different programs needs to be accessible to the clinical staff. Treatment templates may also support mental health tech, peer support, and other paraprofessionals to deliver effective services.
✓ Peer support may be under-utilized. More needs to be known.
✓ Tobacco cessation needs to be a priority item. Leadership commitment needs to support staff behavior change (including supporting staff Quit attempts), training in specific tools and techniques, optimizing mental health aides/techs and peer support to provide cessation interventions, collaboration with community providers and state Quit Lines to understand the specific needs of these patients.
Next Steps

• Look at how resources are packaged for uptake across a range of clinical staff. Do not limit to prescribers as other clinical staff have regular interactions with patients and these are excellent opportunities for engagement.
  • See clinical actions and change management info-graphs developed by NRI that bring together resources from a number of experts
  • [http://www.nri-inc.org/focus-areas/performance-measurement/clinical-oversight/tobacco-cessation/change-management/](http://www.nri-inc.org/focus-areas/performance-measurement/clinical-oversight/tobacco-cessation/change-management/)

• Teach-back model. Stress management. Relapse triggers and response. Yoga. Meditation. Training patients to use medication differently post discharge than while a patient. Contact calls and appointment setting prior to discharge with Quit Lines.

• Commit to action (change) that is well defined and measured. Share the learning. There is no single best practice. We need research to systematically track interventions/approaches used and if this impacts willingness to continue Tobacco cessation post discharge and ongoing cessation after IPF stay.
LEARN MORE

https://www.nri-inc.org/focus-areas/performance-measurement/clinical-oversight/tobacco-cessation/
• Submit questions via the ‘Ask a Question’ box
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▪ Visit [CABHWI.ucsf.edu](http://cabhwI.ucsf.edu) for more information
Post Webinar Information

• You will receive the following in our post webinar email:
  • Webinar recording
  • PDF of the presentation slides
  • Instructions on how to claim FREE CME/CEUs
  • Information on certificates of attendance
  • Other resources as needed

• All of this information will be posted to our website!
Save the Date!

SCLC’s next live webinar is co-hosted by ATTUD and will be on, *e-Cigarettes with Dr. Nancy Rigotti*

- Monday, June 21, 2021, 1-2 pm EDT
- Registration will open soon!
Contact us for technical assistance

- Visit us online at smokingcessationleadership.ucsf.edu
- Call us toll-free at 877-509-3786
- Copy and paste the post webinar survey link: https://ucsf.co1.qualtrics.com/jfe/form/SV_6RMsYyNPdS1xr2m into your browser to complete the evaluation