A PRACTICAL TOOL FOR HOSPITALS AND HEALTH SYSTEMS

➲ Introduction

Hundreds of health care facilities in the U.S. make it their business to combat the devastating impact of tobacco use, showing employees, patients, visitors and other community members their strong commitment to health. Their inspiring stories are peppered throughout ***Destination Tobacco-Free: A Practical Tool for Hospitals & Health Systems.*** *This tool is designed to help you and other health care leaders develop or improve tobacco-use policies and protocols. The actions you take will save lives, assist patients, bolster employee health, safety, and productivity and, eventually, boost the bottom line.*

Originally published in 2009, Destination Tobacco-Free was revised in 2013 to reflect changes spurred by health care reform, including the new Joint Commission tobacco use and treatment performance measure set, meaningful use of medical records, and changes in reimbursement.

The new Joint Commission performance measures for tobacco, which can offer an evidence-based infrastructure for patient treatment, are marked in this document:

CHART YOUR COURSE

Destination Tobacco-Free is a practical guide with five avenues, all leading toward a tobacco-free future. Each chapter contains step-by-step directions, examples and tools:

1. **Becoming and Remaining Tobacco-Free** focuses on creating a tobacco-free campus.
2. **Working with Employees** suggests ways to advance tobacco-free policies, through communications, training and health benefits.
3. **Working with Patients** looks at systems, protocols and trainings for addressing tobacco use that will help you improve patient outcomes and comply with the new Joint Commission performance measures.
4. **Working with Visitors** suggests ways to respectfully enforce your tobacco-free policy.
5. **Working in the Community** shows how to partner with neighbors, physicians, tobacco quit lines and others on this important health initiative.

Use *Destination Tobacco-Free* to map your journey. Explore policies and protocols chapter-by-chapter or choose a single area to develop or improve. Distribute pieces of the tool to leadership, staff, and other champions. Adapt appendices to meet your needs. Explore other routes.

EXCEED THE STANDARD; RAISE THE BAR

Hospitals historically have led other businesses in adopting healthy workplace policies. In the early 1990s, accredited health care organizations became the first industrial sector to address indoor smoking through a written and enforced policy. Today, the Joint Commission requires accredited hospitals to prohibit smoking in buildings and has adopted a new optional performance measure set for tobacco use assessment and treatment.

This toolkit describes how hospitals can demonstrate leadership in curbing tobacco use by:

- Adopting and expanding upon the new tobacco use and treatment performance measure set
- And creating a tobacco-free campus.

The new Joint Commission measure set is designed to offer proven tobacco cessation treatment to virtually every patient who could benefit. Hospitals adopting the measures, implemented in 2012, must assess all adult patients for tobacco use and offer quitting assistance during hospitalization, upon discharge, and within 15 to 30 days of leaving the hospital.

> See Appendix A: 2012 Joint Commission Tobacco Use Treatment Measurement Set

Hospitals that go beyond the new measures may be able to get a financial boost. The Meaningful Use of Electronic Health Records, part of the American Recovery and Reinvestment Act of 2009 (ARRA), offers financial incentives to medical providers who use electronic health records to screen patients 13 years or older for tobacco use, blood-pressure and weight with follow-up.[i]

Additionally, the Centers for Medicare and Medicaid Services (CMS) are considering the adoption of the new tobacco measure set it in the Inpatient Prospective Payment System Rule (IPPS). This rule determines Medicare payments to hospitals that implement specific quality standards.[ii] While hospitals have been slow to adopt the Joint Commission's Tobacco Cessation measure set, the National Quality Forum (NQF) is considering recommending they do so. Information should be forthcoming within the next few months, so stay tuned.

Another benefit of adopting the new Joint Commission tobacco use measure set is the potential to strengthen patient satisfaction—and financial incentives—as calculated through the *Hospital Consumer Assessment of Healthcare Providers and Systems* (HCAHPS) survey. HCAHPS, which tallied 3,851 participating hospitals in 2012, recently added questions about transitions of care, including how a patient would manage his/her health after discharge—an issue that is also addressed in the Joint Commission tobacco performance measure set.[iii]

Those that adopt or exceed the new Joint Commission measure set join a growing number of hospitals that model healthy behaviors by systematically addressing tobacco use with patients, employees and visitors.

CONNECT PATIENTS, PROVIDERS, TECHNOLOGIES

In an era of new technologies with a growing emphasis on coordinated care, health care providers of all sorts engage in this important work. Trained clinicians provide information and tools that motivate and empower patients to quit tobacco, including a national telephone quit line, 1-800 QUIT NOW and electronic referral systems. You and your colleagues can learn to partner across units and in the community to support a patient's decision to quit. The effort itself will help foster teamwork, meaningful measures and powerful messages that illustrate your commitment to health and reflect 21st century medicine.

THE CASE FOR ADDRESSING TOBACCO USE

Community members turn to you as a leader to help resolve pressing health issues. Every day, you see how tobacco use harms individuals and the people who love them. You have an image to uphold, a mission to accomplish and an opportunity to model best practices. You cannot ignore tobacco:

- Half of all smokers die from their addiction.[iv]
- Smoking causes 443,000 premature deaths in the U.S. each year.[v]
- For every death, another 20 people suffer from tobacco-related illnesses.[vi]
- Breathing secondhand smoke for even a short time can interfere with normal functioning of the heart, blood and vascular systems, increasing the risk of a heart attack.[vii]
- Medical procedures involving smokers pose added risks: Smoking retards wound healing, increases infection rates in surgeries, and is the most common cause of poor birth outcomes.[viii ix x]
- Tobacco use disproportionately impacts the nation's most vulnerable populations. More than 44 percent of adults with serious mental illness are smokers. And about half of the nation's tobacco-related deaths (200,000) are among people with mental illnesses.[xi]
- Hospitals can receive recognition and financial incentives for putting into place evidence-based tobacco cessation protocols for patients.[xii]
- Thousands of hospitals and psychiatric facilities have adopted tobacco-use policies that protect employees, patients and visitors from the risks of secondhand smoke and encourage tobacco users to quit.[xiii]

Hospitals and other businesses frequently begin a tobacco-free initiative with their own workforce. Employees are better partners if they are tobacco-free. Most hospital workers do not smoke and at least three-quarters of those who do smoke want to quit. If you help them, they can become your strongest allies. Furthermore, investing in tobacco dependence treatment for employees makes business sense:

1. Health care costs for smokers at any given age are as much as 40 percent higher than those for nonsmokers.[xiv]
2. Employees who take four 10-minute smoking breaks a day work one month less per year than workers who don't take smoking breaks.[xv]
3. On average, smokers cost company drug plans twice as much as nonsmokers.[xvi]
4. Smokers are absent from work for sickness at least 26 percent more than nonsmokers.[xvii]
5. Helping adult smokers quit is the most cost-effective preventive service that can be provided to employees.[xviii] Tobacco-cessation benefits pay for themselves and can save employers money immediately.[xix xx]
6. Smoking harms nearly every organ of the body, placing smokers at greater risk for many chronic diseases.[xx]
7. By creating a smoke-free workplace, a business not only can support workers in quitting tobacco, but may reduce fire insurance premiums as much as 30 percent.[xxi]
8. Children exposed to tobacco smoke are at increased risk of respiratory illnesses, middle-ear infections, and decreased lung function. Health care costs for a privately insured child of a smoker average $174 more per year than for the child of a nonsmoker.[xxii] Employers incur these costs and the costs of reduced productivity, as parents care for sick children.

FORGE AHEAD TO DESTINATION TOBACCO-FREE

When the road gets bumpy, take comfort that you are addressing an addiction that kills more than 1,000 Americans every day and erodes the health and productivity of your staff. Work with board members, employees and other partners to create a tobacco-free health care organization that effectively treats tobacco addictions. No other initiative could make a greater difference in the health of your employees, patients and community.

Destination Tobacco-Free was created by a team of professionals from various lines of work, hospitals of different types and sizes, and respected institutions scattered throughout the country. Team members generously shared their experience, research, documents, ideas, writing, feedback and funding for *Destination Tobacco-Free.* We gratefully acknowledge and thank them for their outstanding work.

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BECOMING
AND
REMAINING
TOBACCO-FREE

BECOMING AND REMAINING TOBACCO-FREE

Show your commitment to health, not only by how you design or redesign your tobacco-use policy, but by the ways you engage employees and community members to sustain and expand your efforts.

Winning strategies include visible commitment from the top and a strong team that includes a clinical champion, front-line workers from various departments and a respected manager to coordinate the day-to-day work. You can develop an initiative through a process that lasts anywhere from six to 18 months. Be sure to include clear and frequent communications through each of the three basic stages:

1. **Preparation**
2. **Implementation**
3. **Evaluation**

PREPARATION

First and foremost, be ready to succeed with your new tobacco-free policy. Preparation includes seven steps:

1. **Research the issue.**
2. **Demonstrate high-level enthusiasm, clinical support and partnership with labor.**
3. **Form a team to oversee the project.**
4. **Create a timetable.**
5. **Gain employee commitment through effective communication.**
6. **Develop a fair policy.**
7. **Align your policy and cessation protocol with complementary health benefits and treatment.**

1. Research the issue.

Collect information that will help you effectively make your case and guide your process. Ask questions within your workplace and community. Health risk appraisals can offer aggregate data about employee tobacco use. You may also poll employees directly about their tobacco use, perceptions of the current tobacco-use policy and ideas for policy changes. Consider conducting such surveys in partnership with the labor groups and professional associations that employees trust. To conduct a survey, check with your information technology staff or consider a web-based service such as *www.surveymonkey.com*

> See Appendix B: Understand your Community and Facility

2. Demonstrate high-level enthusiasm, clinical support and partnership with labor.

As a leader, your personal buy-in is critical to the success of your tobacco-free policy. Publicly embrace the new policy and remain visible throughout its development. Find a clinical champion to help carry the torch and integrate tobacco cessation into your procedures, including the Joint Commission tobacco measure set. Some hospitals secure a physician for this leading role, while others have engaged nurses, pharmacists or respiratory therapists. In any case, take a labor-management approach that frames the new policy as a health and safety issue, not a punitive action. Assign a respected manager to coordinate the effort, and work closely with the clinical champion and the rest of the team.

Ideally, a CEO or medical director will announce the policy in partnership with labor. The announcement, in-person and through a memo, needs to include the rationale behind the new policy, a target date and the name of the manager assigned to coordinate the effort. Engage partners by sharing and eliciting stories about how your efforts improve the quality of care you deliver and make a difference to individuals and the community.

> See Appendix C: Sample Announcement

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3. Form a team to oversee the project.

A strong team will build a successful initiative. Invite representatives from all segments of your organization. Your roster of 15 to 30 people may include your physician champion, a health educator, and representatives from nursing, pharmacy, security, facilities, personnel, intake, discharge, medical records, chemical dependency recovery, public affairs and unions. Include both employees who smoke and those who do not smoke. Tasks for this group may include conducting focus groups, revising the smoking policy and procedures, and developing tobacco cessation protocols, programs and resources for employees and patients.

> See Appendix D: Tobacco-Free Policy Template

4. Create a timetable.

Develop a clear process that engages workers and the community and respects the concerns of opponents, while maintaining a focus on health and safety. Forge a detailed plan that assigns clear responsibilities and timelines. Be sure to incorporate communication into every aspect of your work. Some organizations create a separate communications plan.

> See Appendix E: Sample Timetable

5. Gain employee commitment through effective communication.

You may encounter adamant opposition and resounding support, both from within the organization and from the outside community. You will be most successful if you allow ample time to discuss proposed changes and expected positive outcomes with a variety of audiences, engaging them in planning whenever possible.

Based on what you learn, develop an internal and external marketing plan. Craft three or four simple messages that explain why you want to address tobacco use in your facility, what you hope to accomplish and your underlying concern for constituents. Maintain a consistent message, but engage a variety of credible messengers who can frame the message for different audiences.

> See Appendix F: Frequently-Asked Questions

Here are some messages you may wish to adapt for different audiences:

"We are developing this policy to provide a healthy and safe environment for employees, patients and visitors and to promote positive health behaviors."

"Policies that discourage smoking can improve our outcomes: Smoking retards wound healing, increases infection rates in surgeries and is the most common cause of poor birth outcomes."

"We are not saying you must quit smoking. But we are saying you cannot use tobacco while you are at work. If you are ready to quit, we want to support your efforts."

Plan to incorporate communications into your timeline, engaging both internal and external audiences. Include in your plan:

- Advance notice (at least six months) of the implementation date
- Tobacco-free policy education sessions
- Tobacco dependence treatment trainings
- Brochures and posters announcing the countdown to implementation
- Letters and brochures for medical practices and other partners in the medical community
- Cards and table tents with information on the tobacco-free policy to share with visitors and patients upon implementation

- Cessation resources to assist tobacco users who want to quit
- Media strategy, including news releases, a news conference and human interest stories
- Permanent signs on grounds, entrances and inside all facilities

As your initiative unfolds, remember that success stories inspire people. Weave them into messages. Look for champions within your institution or at other facilities with strong tobacco cessation programs. Highlight staff who have quit smoking, motivated others to quit or improved quality of care in the institution and community by addressing the deadly addiction to smoking.

Look for champions within your institution or at other facilities with strong tobacco-cessation programs.

> See Appendix G: Sample Communications Plan

6. Develop a fair policy.

Craft a clear tobacco-free policy with accountability and periodic reviews. Effective policies include:

- Purpose of policy
- Products covered under policy (i.e. Does the policy apply to smokeless tobacco or E-cigarettes?)
- Definition of how policy applies to employees, patients and visitors
- Physical boundaries of policy (e.g. private vehicles, company equipment, etc.)
- Support to help employees, patients and visitors comply, including cessation services
- Clear enforcement rules and consequences
- Name of contact who can answer questions and address concerns
- Policy-review process

Some hospitals adopt a dress code that reinforces their tobacco-use policy. Employees at Regions Hospital in St. Paul, Minnesota can be sent home without pay if they smell like smoke: "Use of cologne, perfume, perfumed products (hand/body lotion, etc.) or after-shave is discouraged, and if worn should be minimal and not noticeable by others. Fragrance-free areas may be defined by individual departments. ***Smoke odors are prohibited.***"[xxiii]

If you allow exceptions to your policy, be sure to explain the process for granting them, such as a decision by a committee of two or three individuals. The purpose of setting up this seldom-used mechanism is to prevent individual physicians or others from granting routine exceptions.[xxiv]

Regions Hospital has developed a process for patients wanting to use tobacco for religious ceremonies:

"Certain religious groups may request to burn tobacco as part of their religious / spiritual practices. This will be allowed in the hospital chapel with prior approval from Pastoral Services. Pastoral Services staff must be present during the burning ceremony."[xxv]

> See Appendix D: Tobacco-Free Policy Template

7. Align your policy and cessation protocol with complementary health benefits and treatment.

It will be easier to sustain your policy if you align it with proven systems that measure and reduce tobacco use. These include employee assessments, health benefits, patient records, drug formularies, standing orders and billing.

The new Joint Commission tobacco measures can provide a roadmap for your facility as you align your policies, protocols, and health benefits to address tobacco use. (See The Patient's path: Hospital Tobacco dependence Treatment page 23.)

5

A. Assess employees.

If you want to measure your program's effectiveness, collect up-front data. Survey employees to find out how many use tobacco. Many companies use a health-risk assessment (HRA) tool to gauge employee tobacco use.

Evanston Hospital in Evanston, Illinois and many other hospitals and businesses offer financial incentives to employees who complete the HRA. The HRA vendor provides aggregate data to the human resources department and encourages individual tobacco users to quit.

(See below for information about wellness incentives and tobacco-user penalties allowed through the Affordable Care Act.)

B. Invest in effective tobacco-cessation benefits or services for employees.

Tobacco cessation is considered an essential benefit in all types of health plans under the Affordable Care Act. A precise definition of this benefit is scheduled for 2016.

Meanwhile, in structuring your benefit design, consider the challenge of breaking a tobacco addiction. Successful quitting can take multiple tries using a variety of aids. Reduce treatment barriers to encourage smokers to get help, prevent relapse and eventually quit. Tobacco-cessation benefits that have been found to be most effective cover the following:

- Counseling and medications, together or separately
- Counseling services, including telephone, individual, and group counseling
- Multiple counseling sessions over a period of several weeks or more
- FDA-approved medications, including bupropion, varenicline and both prescription and over-the-counter nicotine replacement medication

Show tobacco users you understand the chronic nature of tobacco dependence by designing a benefit that makes it easier for them to successfully quit:[xxvi]

- Require employees to pay no more than the standard co-payment. Data show that smokers are much more likely to try to quit when no co-payment is required.
- Provide at least two courses of treatment per year.
- Offer a variety of options for psychosocial treatment and medications.

The American Lung Association publishes an annual report on tobacco cessation coverage. See *Helping Smokers Quit: Tobacco Cessation Coverage 2012 Report.*

Employers increasingly offer employee incentives for healthy behaviors, including being tobacco-free.

The Affordable Care Act sets rules for how to structure wellness program incentives, including tobacco cessation. *http://www.ofr.gov/OFRUpload/OFRData/2013-12916.PI.pdf*

- For programs aimed at participation and not requiring specific health outcomes, employers may offer any level of incentive, including premium discounts or employee reimbursement, provided the program is available to all employees. This includes participation in a tobacco cessation program.
- If, however, a wellness program has a specific health expectation, such as quitting smoking or being tobacco free, the Affordable Care Act caps the incentive at 30 percent of the health benefit costs. However, the cap is 50 percent for programs designed to prevent or reduce tobacco use. These "health contingent" programs also must: be available to all employees, offer reasonable alternatives for those needing special accommodation, offer enrollment opportunities annually, and clearly communicate the availability of the program and the alternatives, (Previously, the incentive cap for such programs was 20 percent.)[xxvii]

C. Routinely identify a patient's tobacco use status.

Systematically assessing patient tobacco use is a key first step in meeting the new Joint Commission standard for patient tobacco use. Your system can identify a patient's tobacco use status during intake so staff can tap into "teachable moments" and help patients begin the quitting process. Electronic health records with tobacco use as a vital sign can prompt clinicians to advise smokers to quit and help them when they are ready. A vital sign indicating that a patient is a tobacco user can trigger an electronic or fax order to treat the patient. You may also be eligible for a financial incentive.

The Joint Commission's new standard for measuring tobacco use can help shape your process. Hospitals that choose to adopt this standard must assess all patients who are 18 and older for tobacco use and offer quitting assistance during hospitalization, upon discharge, and within 15 to 30 days of leaving the hospital.

Selecting the Joint Commission substance use measures, which are similar to the tobacco measure set, can complement your efforts, streamlining your procedures and protocols.[xxxviii]

> See Appendix A: Joint Commission Tobacco Use Treatment Measurement Set

Financial incentives may be available to hospitals that exceed the new standard. The Meaningful Use of Electronic Health Records (EHR), part of the American Recovery and Reinvestment Act of 2009 (ARRA), offers medical providers incentives to use electronic health records to screen patients 13 years or older for tobacco use, blood-pressure and weight with follow-up.[xxix]

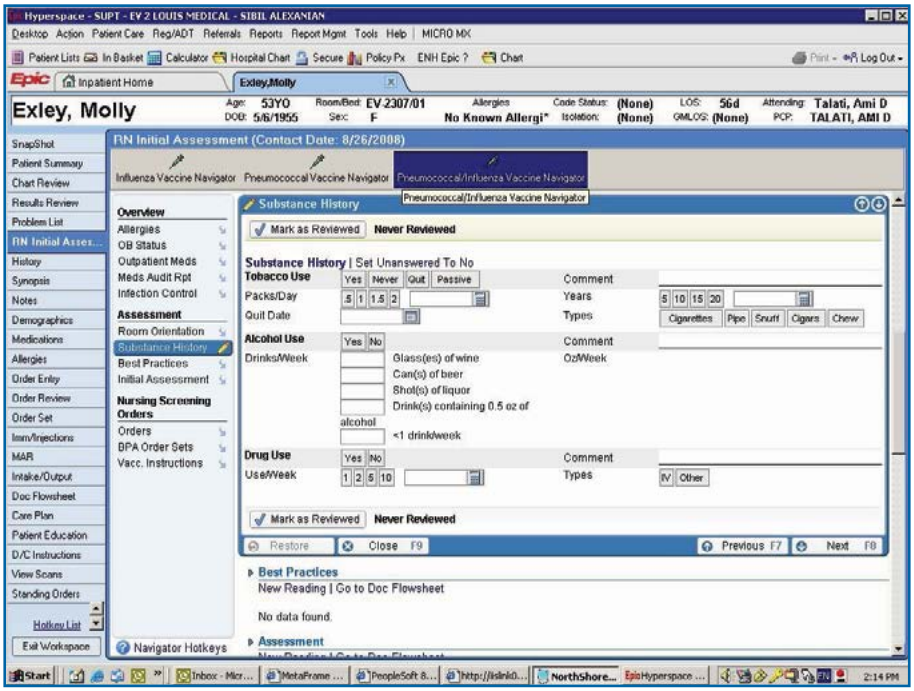
Meaningful Use requires up-front time and preparation.[xxx] You will need to:

- Confer with key clinical staff as you select clinical quality measures that reflect your patient population
- Configure your EHR to meet your institutional needs
- Upload information to the health record, including local pharmacies and area providers
- Train employees and staff to collect complete and accurate data
- Develop a plan to improve measures of interest.

Additionally, the Centers for Medicare and Medicaid Services (CMS) are considering the adoption of the new tobacco measure set in the Inpatient Prospective Payment System Rule (IPPS) This rule determines Medicare payments to hospitals that implement specific quality standards.[xxxii]

> See Appendix H: Electronic Health Records

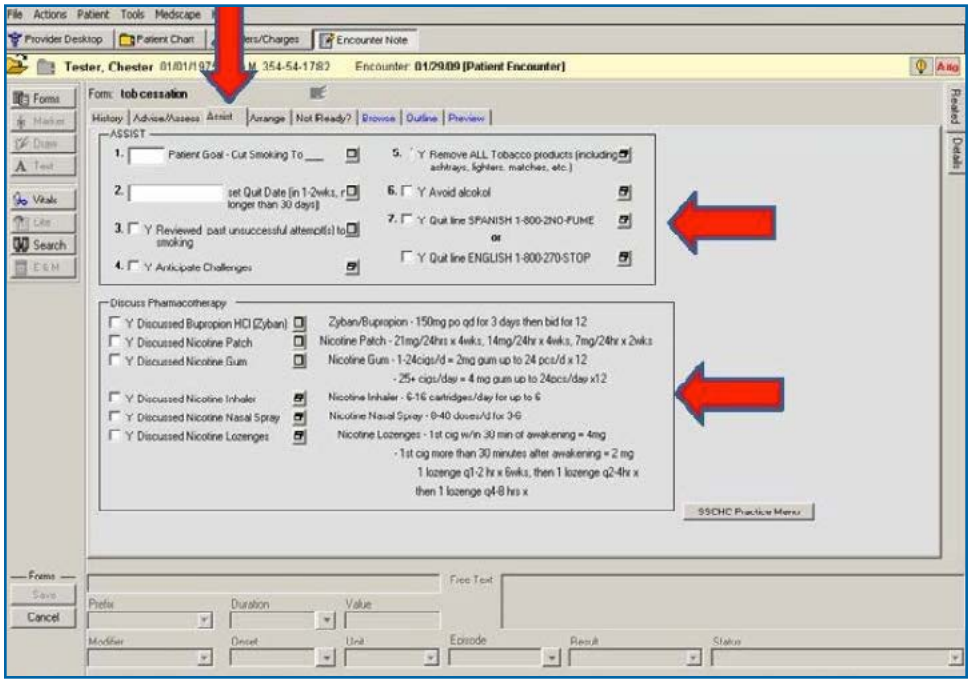
Prior to the new Joint Commission standard, Evanston Hospital incorporated tobacco use status, clinician prompts and community resources into its electronic health records.



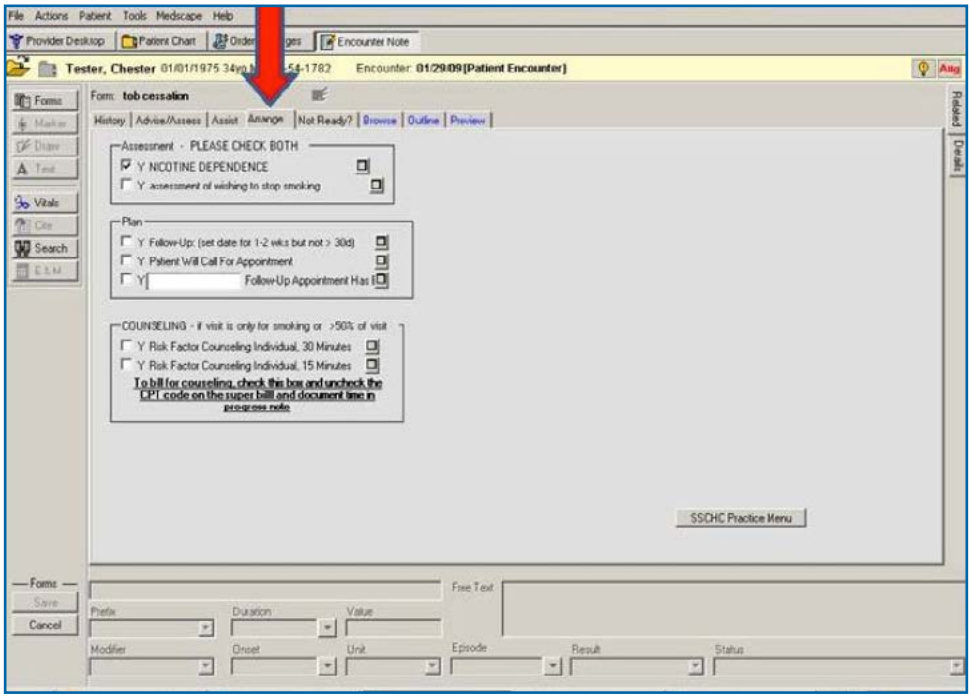
D. Assure that effective tobacco cessation treatment is included in your formulary and routinely delivered to smokers who want to quit.

Thousands of studies show that tobacco-cessation medications and counseling are safe, efficacious and cost-effective ways to help tobacco users quit. Work with your pharmacy and therapeutics committee to assure that the full range of tobacco-cessation medications are part of your formulary. Assign staff to help tobacco users begin the quitting process while in the hospital or refer them to community resources they can use when they are ready. Develop standing orders so hospital staff can use that teachable moment in your facility to help tobacco users quit.

The University of Wisconsin Medical Center includes in its EHR the types of assistance required by the Joint Commission tobacco performance measure set.



The Medical Center's EHR also provide prompts for patient discharge and follow-up (15 to 30 days), which comply with the Joint Commission performance measures.



> See Appendix I: Pharmacologic Product Guide
> See Appendix J: Sample Standing Orders to Initiate Tobacco-Cessation Treatment

E. Reimbursement for tobacco-dependence treatment.

Reimbursement for tobacco-dependence treatment, though inconsistent both in terms of coverage and level of reimbursement from plan to plan and state to state, is improving. Insurance payments are generally low, but public or private insurers may cover at least some aspects of treatment, generally as a medical benefit.

Medicare now covers both counseling and medications for all tobacco users, regardless of other diagnoses. But other insurance plans may still require tobacco-dependence treatment to be associated with another medical concern.

Medicaid rules also are changing. Every state Medicaid plan offers some tobacco cessation benefits, but only six states offer the full array of proven treatments.[xxxii] The Affordable Care Act (ACA) recently added mandatory tobacco cessation coverage without cost sharing for pregnant women. In 2014, tobacco cessation counseling and coverage for all seven FDA-approved smoking cessation medications will become available for all Medicaid-covered adults.

The ACA requires all new **private insurance** plans to cover tobacco cessation treatment, but coverage for counseling and medications can vary from plan to plan. Some private health plans cover the full range of tobacco-dependence treatments. Others explicitly exclude tobacco-related addiction from any coverage. Insurance exchanges, scheduled to be in place for the unemployed, self-employed, and uninsured by 2014, are required to cover tobacco cessation in general, though the specific benefits have not yet been defined.

For patients admitted with psychiatric or chemical-dependency issues, you may be able to integrate smoking cessation into routine addiction psychosocial treatment, and bill for those services.[xxxiii]

Your billing department will need to investigate tobacco-dependence treatment coverage in your locale and integrate billing into your system. For further details on reimbursement, including codes, see Working with Patients, page 25

You and your colleagues can use your knowledge and experience to advocate for better tobacco-dependence treatment coverage. As both employers and providers, you can demand, use and bill for these important services, considered best-practices in the Public Health Service Guideline.[xxxiv]

> See Appendix P: HCPCS, CPT, & ICD-9 Codes.

IMPLEMENTATION

If you adequately prepare staff, patients, and community members for your transition to a tobacco-free environment, you will find partners eager to help implement your new policy. Implementation includes four critical steps:

1. **Train staff.**
2. **Post effective signs.**
3. **Celebrate your commitment to health.**
4. **Enforce your policy.**

1. Train staff.

Before you implement your policy, be sure that all employees, from intake to post-discharge, understand their responsibilities and have the tools and training they need to succeed. Staff will feel more pride in their work if they see how their contribution fits within the context of your broader health mission. It also is important that they understand how treatment protocols are entwined with the tobacco-free policy.

In addition to formal trainings on the policy, consider ways to share information as part of regular meetings, in-services and through Grand Rounds. Remember to set up periodic trainings to accommodate new staff and changing circumstances.

Don't forget to train employees on how to enforce the tobacco-free policy.

> See Appendix K: Enforcement Scripts

For trainings related to patient care, see Working with Patients, page 27.

2. Post effective signs.

The most important way to publicize your smoke-free policy is by posting visible signs with clear messages. Before you purchase and post signs consider:

- Your budget for signs
- Number of signs you need
- Type of material you want (e.g., wood, metal, plastic)
- Your message
- Logos you need on the signs
- Necessary approvals for signs
- Language considerations
- Timeline

Experience from hospitals shows that simpler messages are more effective. Some hospitals have observed that people become "sign blind" over time, creating a need to post different images or reminders.

> *See Appendix L: How much will it cost?*

For more information about signs, see Working with Visitors, page 29

3. Celebrate your commitment to health.

Celebrate your first tobacco-free day. Thank partners, build support, educate staff and employees, publicize your efforts, and have some fun.

The 14,000-employee University of Michigan Health System devised a six-month countdown before "Happy & Healthy Heart Day," February 14, 1999, when it established a tobacco-free policy for all 67 sites. As the countdown numbers on the website declined, the tobacco program stepped up communications. Every week during the six months prior to implementation, tobacco program staff launched a communiqué. These ranged from pig lung displays in the lunchroom to advertisements on local radio stations. The night before the big day, grounds crews eliminated every last ash urn and smoking area, posting signs welcoming Happy & Healthy Heart Day. All employees, patients and visitors were invited to share the sheet cake that marked the big day.

Since then, the hospital tobacco program has continued to celebrate with Happy & Healthy Heart Day anniversaries and November celebrations to honor inspirational employees and help staff quit tobacco.

4. Enforce your policy.

Enforcement procedures need to be clearly delineated in your tobacco-free policy. Deter potential problems by differentiating enforcement methods for employees, patients and visitors.

EMPLOYEES

Most hospitals handle a staff or employee violation of the policy as a personnel issue. In some facilities, an employee who observes a co-worker smoking is asked to make a confidential, "good faith" report to a supervisor, manager or human resources specialist. Supervisors need to consistently enforce the rules, which need to be clearly delineated and explained.

PATIENTS

Tobacco use by patients is generally viewed within the context of care. If your hospital does not permit tobacco use, you must enforce the ban. Nicotine-replacement therapy can relieve withdrawal symptoms while you are treating a

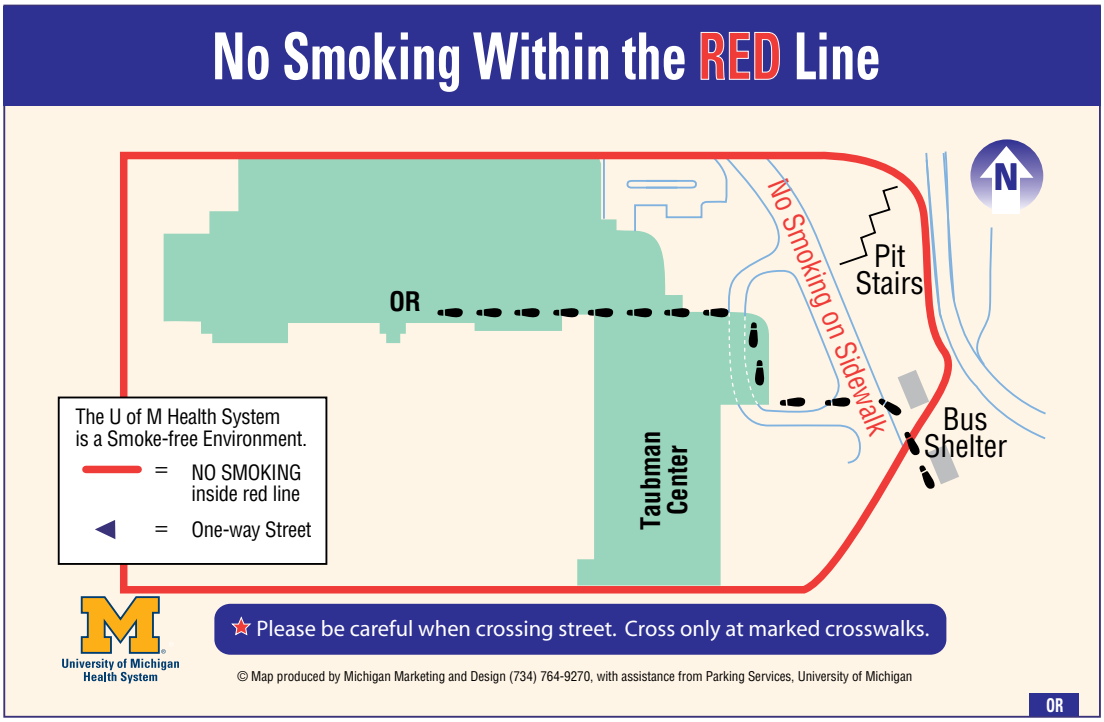
patient in the hospital. Some hospitals stipulate that patients who leave the facility to smoke are discharged for leaving "against medical authorization." This can relieve the hospital of liability for any adverse event that may occur while the patient is off-campus using tobacco. Whatever your policy, inform all patients at intake or earlier if possible.

See Appendix M: Sample Patient Release Form

VISITORS

Visitors generally comply easily when informed of a tobacco-free policy.[xxxv] Encourage employees to take a gentle approach with visitors. If visitors refuse to comply, ask them to please pick up their cigarette butts. Consider having a procedure in place in the rare case that a tobacco use violation poses a potential safety threat to the property or to another person. In such cases, security staff generally intervenes.

Hospitals may expect staff to inform visitors of the tobacco-free policy. Employees generally appreciate having a card or brochure they can hand to the visitor that explains the hospital's rationale for its policy and provides information about quitting.



The University of Michigan Health system provides visitors with a map of its smoke-free campus.

EVALUATION

Plan team meetings after you implement your new policy, aimed not at pointing fingers or placing blame for errors, but achieving better results. Experts suggest meeting a week after the policy goes into effect, monthly for three months, and every six months thereafter. Use the information you gather to report your progress, plan future projects, improve your efforts and sustain the initiative.

In your ongoing evaluation:

1. **Assess your process.**
2. **Monitor your outcomes.**
3. **Consider your lessons.**
4. **Forge recommendations.**

1. Assess your process.

- Did you set goals and put measures into place?
- What tasks are missing?
- Did you communicate aptly and often with staff on every relevant item?
- Did you allot adequate time to do a quality job?
- Did you assign responsibility to an appropriate and responsible person?

2. Monitor your outcomes.

Compare your goals with your outcomes. Here are some questions to consider:

- What is the impact of the new policy on visible smoking?
- How many violations have you had?
- Are there fewer violations over time?
- How has the new policy impacted staff tobacco use?
- How many employees have attempted to quit tobacco?
- How many have succeeded?
- How many patients have been assessed for tobacco use?
- How many of the tobacco users were offered tobacco cessation counseling and medications to help them quit while they were at the hospital?
- How many tobacco users were offered tobacco cessation counseling and medications upon discharge?
- How many of tobacco users, within 15 to 30 days of discharge, received follow-up calls to assess the status of their tobacco cessation efforts, including counseling, medications, and smoking status?
- How many patients have been discharged for smoking against medical authorization?

3. Consider your lessons.

- What factors contributed to your success?
- What barriers limited or threatened success?
- How were barriers addressed?
- What were the relative costs, including staff time, and results of different aspects of your efforts?
- Did some activities appear to work as well as others but cost less?

4. Forge recommendations.

- What are the next steps?
- How can you expand your efforts into the broader community?
- What new partners can help you?
- What would you like to do differently?


WORKING WITH
EMPLOYEES

WORKING WITH EMPLOYEES

A keen understanding of workforce tobacco use will help you develop a successful tobacco-free initiative. (See Appendix B: Understand Your Community and Facility.) At the outset, employees who see on-campus smoking as a hindrance to quality care will resoundingly support the effort. Staff members who oppose the tobacco-free initiative are less likely to enforce the policy or help patients quit. You will need to lead both supporters and detractors with resolve and understanding.

Your efforts will be more successful if you:

1. **Clearly communicate your intention to become tobacco-free, explaining why.**
2. **Elicit, listen to, and respond to employee concerns.**
3. **Support employees who want to quit tobacco.**
4. **Educate employees about the policy and enforce it fairly.**
5. **Develop clear lines of responsibility, providing appropriate training for employees at each level.**
6. **Give employees the tools and training to help patients quit.**
7. **Celebrate employee successes.**
8. **Provide ongoing support and training.**

1. Clearly communicate your intention to become tobacco-free, explaining why.

Inform all employees of your plans early in your process. Smokers and other tobacco users need time to get used to the idea of a tobacco-free campus. Tobacco users who want to quit will be more successful if they have time to prepare. Provide employees with information about other hospitals and businesses in your area that have taken similar actions.

Craft a few simple messages that explain why you want to address tobacco use in your facility, what you hope to accomplish, and your underlying concern for constituents. Key messages to employees may include:

- *"We are developing this policy to provide a healthy and safe environment for employees, patients and visitors and to promote positive health behaviors."*
- *"Policies that discourage smoking can improve our outcomes: Smoking retards wound healing, increases infection rates in surgeries and is the most common cause of poor birth outcomes"*
- *"We hope you will help us adopt new (Joint Commission) tobacco use treatment protocols that offer patients a consistent message that we care about their health."*
- *"We are not saying you must quit smoking. But we are saying you cannot use tobacco while you are at work. If you are ready to quit, we want to support your efforts."*
- *Starting (DATE), we will no longer permit use of tobacco products on our campus.*
- *(Name of a trusted manager) will be responsible for this initiative. Please contact her/him if you have suggestions to improve our process or if you have questions or concerns.*

As you discuss this initiative, remember that success stories inspire. Weave them into messages. Look for champions within your institution or at other facilities with strong tobacco dependence treatment programs. Highlight staff who have quit smoking, motivated others to quit, or improved quality of care in the institution and community by addressing the deadly addiction to smoking.

> *See Appendix C: Sample Announcement*

2. Elicit, listen to and respond to employee concerns.

Allow employees and managers time to express concerns and prepare for changes. Hold discussions with individuals, groups, departments and the public, emphasizing how an addiction to smoking impacts health, safety and recovery.

Tobacco-use policies can raise prickly issues between labor and management. Some labor unions voice concerns that new rules infringe upon member rights. The fact is, there is no constitutional right to smoke, but you have a right to create a tobacco-free environment within your buildings and grounds.[xxxvi] Prior to adopting a tobacco ban, some hospitals express fears that the initiative will drive employees to leave the facility or organize a union. Reports from across the country show that such fears are largely unfounded and, in most cases, labor organizations are effective and trusted partners who do not oppose tobacco-free efforts.

It is important that employees who are not ready to quit tobacco are educated about ways to endure their shifts without using tobacco. They also need to know what the rules are about using tobacco while on the clock.

See Develop a fair policy, page 4, Enforce your policy, page 10; and Appendix D: Tobacco-Free Policy Template.

Listen to employee concerns, while moving the policy forward. Successful tobacco-free initiatives engage labor and management as partners, frame smoking as a health and safety issue, support tobacco users who want to quit, and enforce the rules fairly with all employees and managers.

Listen to employee concerns, while moving the policy forward.

> *See Appendix F: Frequently-Asked Questions*

3. Support employees who want to quit tobacco.

Staff members who smoke may be more likely to oppose the tobacco-free campus initiative and less likely to help patients quit. Show them you understand the challenges they face by investing in support that can help them quit. By providing quitting help prior to implementing a tobacco-free policy, you can prepare employees for the change and begin honing a cessation delivery system for patients.

The most effective tobacco-dependence treatments include counseling or coaching, cessation medications and social support.[xxxvii] Structure your tobacco-cessation benefits and services, including your employee assistance program, to:

- Cover counseling services, including telephone, group and individual counseling
- Offer several counseling sessions over a period of several weeks
- Offer the FDA-approved medications, including bupropion, varenicline, and prescription and over-the-counter nicotine-replacement medication,

Design a benefit that makes it easier for tobacco-users to successfully quit:

- Require employees to pay no more than the standard co-payment. Data show that smokers are much more likely to try to quit when no co-payment is required.
- Provide at least two courses of treatment per year.
- Offer a variety of options for counseling and medications.
- Provide tobacco-dependence treatment for spouses, significant others and dependents.

Consider tobacco-dependence treatment an investment. Kaiser Permanente of Northern California subsidizes tobacco-dependence treatment because it determined that the costs of smoking are much greater than the costs of encouraging quit attempts. Employees and members enrolled in an approved tobacco-dependence treatment program can obtain cessation medications for a standard co-payment.[xxxviii]

In addition to the assistance you provide, be sure to tell employees about 1-800-QUIT NOW, a national portal to a quit line in your state. To learn what your state quit line offers, visit http://map.naquitline.org/

For more information about quit lines, see State Tobacco Quit Lines, page 32 .

4. Educate employees about the policy and enforce it fairly.

Share the policy with employees as early as possible in multiple forms. Be sure employees understand how the policy will impact them, including:

- Stages of implementation
- Their role in enforcement
- Consequences for not complying with the policy
- How the policy fits with treatment protocols
- Ways to join planning efforts
- Trainings available about the policy
- Measures and celebrations of successes
- Who to speak with about concerns or problems

Your tobacco-free policy is designed to provide a safe and healthy environment and model healthy behaviors. As you enforce the policy, provide as much help as possible.

Provide employees with copies of the policy as soon as it is available. Take the opportunity to educate employees of the policy through meetings, internal communications, banners and signs.

5. Develop clear lines of responsibility, providing appropriate training for employees at each level.

In many hospitals, the entire staff is expected to educate patients, co-workers and visitors about the tobacco-use policy. Although hospital personnel are accustomed to instructing patients on how to take care of themselves, they sometimes feel awkward talking about tobacco use. Equip employees with a clear understanding of your tobacco-use policy and how it applies differently to co-workers, patients and visitors.

Intake staff, human resources, supervisors and security need training to perform particular roles:

- Intake staff informs all patients of the tobacco-use policy, its purpose, the assistance that will be available and the consequences of unauthorized smoking.
- The human resources department educates all job applicants and new employees about the policy.
- Supervisors consistently follow procedures in working with those who violate the policy.
- Security staff intervenes with visitors in the rare instances that simple education is not enough.

Make sure those most likely to have contact with other employees and visitors are trained in helpful, positive approaches to enforcing the policy. This could include greeters or security staff stationed near exits or entrances. They will need to learn to respectfully escort tobacco users from the campus and invite them to return when they have finished smoking.

Your tobacco-free policy is designed to provide a safe and healthy environment and model healthy behaviors. As you enforce the policy, provide as much help as possible. Educate people about the policy. As appropriate, offer symptom relief for tobacco users during their stay, encourage tobacco users to quit when they are ready or direct visitors to places where they are allowed to smoke. Keep discussions about the tobacco-use policy brief and non-confrontational.

> *See Appendix K: Enforcement Scripts*

6. Give employees the tools and training to help patients quit.

Every tobacco user who steps into your hospital presents a "teachable moment."[xxxix] Most smokers want to quit.[xl] And patients who are in the hospital because of tobacco-related illness can be particularly motivated to break their addiction.[xli]

Make sure staff members understand how they fit into a cohesive health and safety strategy that addresses patient tobacco use. Train clinicians on the protocols, systems, coaching, medications, and follow-up conversations that can help patients begin the quitting process. A variety of live or on-line trainings in tobacco-dependence treatment is available for different types of clinicians. In addition to formal trainings, consider ways to share information in regular meetings, in-services, and through Grand Rounds.

Regardless of how you treat tobacco dependence, patients are more likely to remain abstinent if they have community support.

Regardless of how you treat tobacco dependence, patients are more likely to remain abstinent if they have community support. Provide hospital staff with information about community resources, including the telephone quit line, which can be reached by calling 1-800-QUIT NOW.

See Working with Patients, Train Clinicians, page 27.

7. Celebrate employee successes.

Some things are worth celebrating: health, safety, clean air. New systems that lead to excellence. New partners that improve health. A person's first day without tobacco.

Look for ways to celebrate employees who do battle with their nicotine addiction and those who help create and sustain a tobacco-free campus. Share good news about improved outcomes for your facility.

Consider how celebration can shift the culture from turning a blind eye to smoking to honoring those who assist the people who fight the gripping addiction.

8. Provide ongoing support and training.

Tobacco use and dependence is a chronic issue you will need to address on an ongoing basis. Employees who quit using tobacco for a time, then relapse, will need support to quit again. New employees will need training on how to address tobacco use at your facility. Finally, as you evaluate your process for addressing tobacco, you may need to change elements of your work. Such changes will require additional training.


WORKING WITH
PATIENTS

WORKING WITH PATIENTS

Every tobacco user who steps into your hospital presents a "teachable moment."[xlii] Most smokers want to quit.[xliii] And patients who are in the hospital because of tobacco-related illness can be particularly motivated to break their addiction.[xlv] Hospital patients are essentially captive in a facility that bans smoking, with staff who can support them.[xlv] Some studies suggest that these patients have relatively few difficulties with nicotine withdrawal symptoms, making it an opportune time for them to try to quit for good.[xlvi] [xlvii]

Clinicians can help hospitalized patients understand how smoking directly impacts their health. Continued smoking heightens the risk of successive heart attacks or second primary tumors in cases of cancer of the lung, head, or neck. Even if tobacco use is not the cause of the hospital admission, continued smoking can impair health in other ways, including:[xviii]

- Delayed wound healing
- Increased risk of infection
- Cardiopulmonary complications, including hospital readmissions
- Longer postoperative care
- Poor surgical results
- Increased mortality

Demonstrate your commitment to health by systematically addressing tobacco use with every patient at every opportunity. Follow these steps, developed by hospitals around the country, to create and sustain an evidence-based program:

1. **Build a multi-disciplinary team with strong champions.**
2. **Establish systems for identifying, treating and referring patients to help.**
3. **Train clinicians in how to treat patients who use tobacco.**
4. **Evaluate your tobacco treatment process and its impact, adjusting your program to optimize effectiveness.**

1. Build a multi-disciplinary team with strong champions.

An action-focused team with members from all segments of your organization will propel your initiative to success. Be sure your committee includes a respected physician or other clinical champion who can rally support for your tobacco treatment program, link various departments of the hospital and help navigate clinical challenges for patients and health care workers.

Over time, engage more champions as they emerge.

Over time, engage more champions as they emerge. They may be health educators, nurses, pharmacists, physicians, or people who work in security, facilities, personnel, intake, medical records, chemical dependency recovery, public affairs or as union representatives.

Assign treatment issues to a subcommittee of your tobacco-free campus team (See Becoming and Remaining Tobacco-Free, Form a Team, page 3). A qualified team from various disciplines can define clinical goals, forge protocols and systems and develop evaluation criteria. Members may include clinicians from a variety of disciplines, including cardiologists, oncologists, hospitalists, physical therapists, pharmacists, nurses, respiratory therapists, anesthesiologists and emergency physicians. Your team also may include representatives from quality improvement, patient education, medical records and labor unions.

Consider using a pharmacy resident or intern, required to work on a special project, to document processes or develop protocols for your tobacco treatment program.[xlix]

2. Establish systems for identifying, treating, referring patients to help and following up with patients after discharge.

Your patient treatment team can assess how you address tobacco use, then develop or improve systems to optimize your teachable moment. Some hospitals test treatment protocols with employees who want to quit tobacco, and then hone the protocols for patients. Regardless of your systems, incorporate respectful interactions about tobacco with every patient at every opportunity.

Ask yourselves, "How do we address tobacco use?" in the following situations:

a. Before a patient is admitted to the hospital
b. At inpatient and emergency department admissions
c. Upon transfer to other floors and departments
d. Through medical records
e. In your formulary
f. Through patient protocols
g. While a patient is in the hospital
h. When you discharge a patient
i. After a patient is discharged
j. In your billing system

There's a teachable moment for a patient having elective surgery or another scheduled procedure before he or she ever sets foot in the hospital.

Before a patient is admitted to the hospital

There's a teachable moment for a patient having elective surgery or another scheduled procedure before he or she ever sets foot in the hospital. If you tell a patient he can't smoke at the hospital and that quitting could improve the results of the procedure, he may cut back or even quit for good. A Swedish researcher found that quitting smoking at least four weeks prior to surgery decreased surgical complications by almost half. Complications, such as wound infections, add significantly to the length and cost of a hospital stay, providing patients with both a health and economic incentive to quit before hospitalization. In the study from Sweden, 58 percent of those who were offered assistance, quit smoking prior to surgery. One-third of those who quit remained abstinent for more than a year after surgery.[1]

Incorporate information about your tobacco-free policy and the benefits of quitting tobacco in patient correspondence and surgical practices. Pre-surgical evaluation clinics also are effective locations to routinely incorporate tobacco-cessation interventions.

The American Society of Anesthesiologists website posts resources that your hospital or clinic can use to help patients quit smoking before and after surgery, including brochures and cards directing patients to the tobacco quit-line number, 1-800-QUIT NOW. *www.asahq.org/stopsmoking* These materials can be licensed, branded and systematically distributed to preoperative patients, helping you meet and exceed regulatory requirements to provide tobacco-cessation information.

At inpatient and emergency department admissions

Include questions about tobacco use on your inpatient and emergency-department admissions forms. Patient responses can trigger appropriate interactions about tobacco-use policies, ways to alleviate withdrawal symptoms and quitting assistance.

The new Joint Commission measure set on tobacco use and treatment requires you to assess tobacco use for every patient over 18. The Meaningful Use of Medical Records requires assessment of every patient over 13. How and when a hospital assesses patient tobacco use varies.

Massachusetts General Hospital has a three-step system to address tobacco use. The hospital assesses patients for tobacco use, need for nicotine replacement for withdrawals, and interest in quitting. The system directs this information to the pharmacy, where medications can be ordered for the patient with a click on the computer. Meanwhile, through the system, a tobacco treatment specialist can access the names of patients who use tobacco. The following day, a tobacco treatment specialist provides bedside cessation counseling to all smokers, a process lasting less than five minutes for those not ready to quit and about 20 minutes for those who want to quit. In addition to offering counseling, the tobacco treatment specialist orders nicotine replacement to reduce withdrawal symptoms for patients and medications, where appropriate, for those ready to quit. Notes from these sessions are included in the electronic health record. The final step in the process is to arrange community treatment when patients are discharged.

At the University of Michigan Health System, within 24 hours after a tobacco user is admitted to the hospital, a tobacco treatment counselor will visit. The counselor notifies the patient of the hospital's smoke-free policy, offers nicotine-replacement therapy to alleviate withdrawal symptoms during the hospital stay and assesses the patient's readiness to quit using tobacco.

Upon transfer to other floors and departments

A patient's motivation to relieve nicotine-withdrawal symptoms or quit tobacco may change once admitted to the hospital or moved to another department. Develop systems to reassess a patient's motivation to quit.

Bedside nurses at Mayo Clinic initiate discussions about tobacco use with patients. They are trained and empowered to ask patients about tobacco use, order nicotine-replacement therapy to relieve withdrawal symptoms, provide information about tobacco-dependence treatment and initiate a more intensive treatment by a tobacco treatment specialist. This system does not depend upon physician referral. Mayo Clinic, which increased specialist referrals by 50 percent in the first two years of adopting this protocol, has incorporated its tobacco treatment protocols into an electronic health records system.[li]

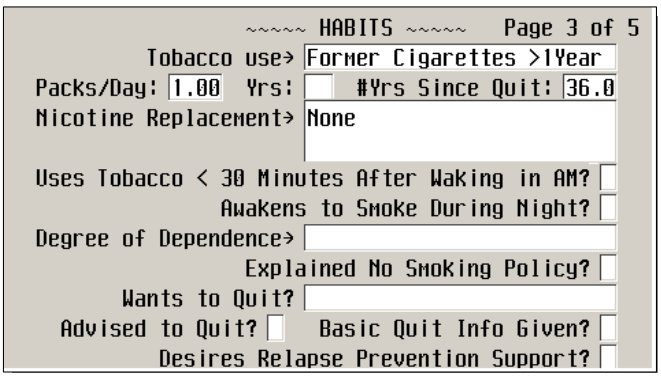
Through health records

If your facility uses paper health records, now might be the time to convert to an electronic system. The Meaningful Use of Electronic Health Records, part of the American Recovery and Reinvestment Act of 2009 (ARRA), offers financial incentives to medical providers who use electronic health records to screen patients 13 years or older for tobacco use, blood-pressure and weight with follow-up.[lii]

Identification and treatment for tobacco cessation also is an optional Joint Commission performance measurement set.

However you manage patient medical records, include tobacco use as a vital sign. In Oregon's Silverton Hospital, the electronic health record is designed to initiate help for a patient who uses tobacco. The record calculates the appropriate dose of nicotine-replacement therapy, based on a patient's degree of addiction. This information is faxed to the pharmacist. A tobacco treatment specialist assists every patient who expresses a desire to quit.

Electronic health records can trigger help for smokers who want symptom relief or who feel ready to quit.



In your formulary

The Food and Drug Administration has approved seven medications to help people quit tobacco. Patients entering your facility may already use some of these or may have found one of the medications effective in relieving cravings. Work with your hospital and therapeutics committee to assure that these patients and others who want to quit have access to the full range of evidence-based options.

Include all seven of these FDA-approved medications in your formulary:

- Five nicotine-replacement therapies relieve cravings and withdrawal symptoms. They are available in different forms, including gum, lozenges, nasal spray, inhaler, or patch, both as prescription and over-the-counter.
- Bupropion SR, a sustained-release tablet, reduces withdrawal symptoms by preparing the body for the stress of quitting. It is commonly used to treat depression.
- Varenicline, an oral medication, reduces the pleasant effects of nicotine on the brain.

> See Appendix I: Pharmalogic Product Guide

Through patient protocols

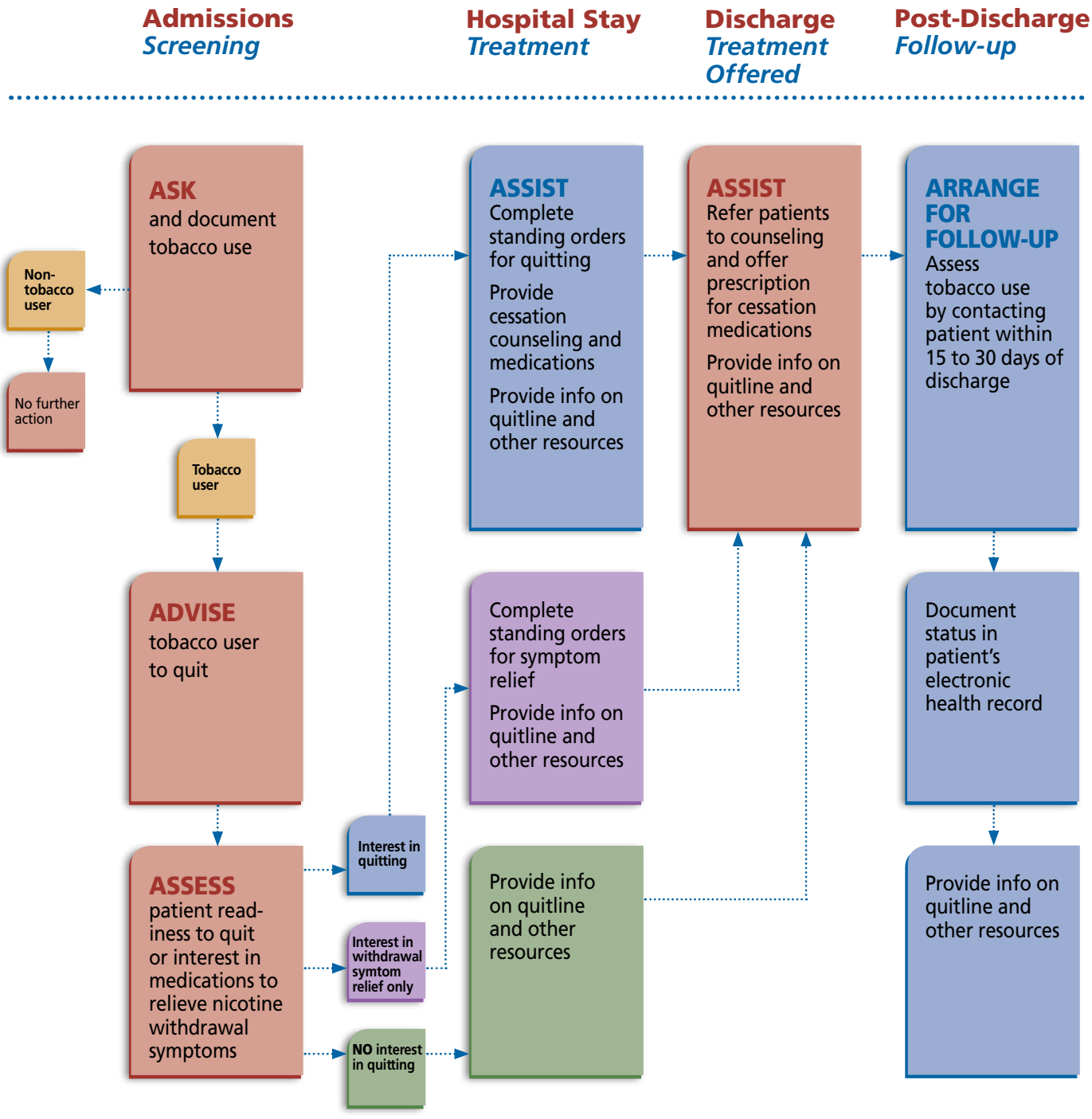
The patient treatment team can develop protocols that integrate the Joint Commission tobacco measure set, assuring the protocols are connected, evaluated and continuously improved.

Include these key steps measured by the Joint Commission:

1. Tobacco Use Screening (TOB1) for all patients
2. Tobacco Treatment, including medications (TOB2) and counseling (TOB2a), offered or provided to all patients who have used tobacco within the past 30 days
3. Tobacco Treatment, including medications (TOB3) and counseling (TOB3a) offered or provided at discharge
4. Assessing Status after Discharge (Tob4) of tobacco users within 15 to 30 days of discharge to determine use of treatment, including medications and counseling, and tobacco use status

> See Appendix A: Joint Commission Tobacco Use Treatment Measurement Set
> See Appendix N: Sample Clinical Practice Guideline

THE PATIENT'S PATH: *HOSPITAL TOBACCO DEPENDENCE TREATMENT*



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

This chart complies with the Joint Commission performance measure set.

1-800-QUIT NOW (1-800-784-8669) is the national router number for all quitlines

While a patient is in the hospital

Assure that every patient receives clear and respectful messages about the health benefits of quitting tobacco and has opportunities to quit, including counseling and medications, as required in the Joint Commission tobacco measure set.[liii]

Henry Ford Health System in Detroit, Michigan provides tobacco-users with a 10-minute DVD. "You can Quit and We can Help!" explains nicotine addiction and the quitting process, introducing the health system's six-month telephone treatment program. Patients can initiate the quit process while in the hospital.

Clinicians at Kaiser Permanente of Northern California wear buttons saying, "Go smoke-free. Ask me about our free programs to help you quit."

When you discharge a patient

When a patient leaves the hospital, discharge him or her with continued support for quitting tobacco, including a referral to evidence-based counseling and a prescription for approved cessation medications.[liv]

The Joint Commission standard recognizes a variety of counseling protocols, including tobacco quit lines and web-based programs. In addition, the measure requires that you offer a prescription for medication to support the quitting process. You are measured upon whether you offer these supports—not whether they are accepted.

Massachusetts General and other hospitals that helped test the Joint Commission measures are looking for ways to integrate patient follow-up into their systems. Massachusetts General is testing a follow-up system: Upon discharge, a patient can receive a 30-day supply of cessation medication, which can be renewed, based on information received through an interactive voice response system. The system, developed by the Ottawa, Canada-based TelAsk, follows up with patients at two, 14, 30, 60 and 90 days. Through the system, patients can request calls from a tobacco cessation treatment coach at any time.[lv]

Leverage each quit attempt by systematically including support in your discharge materials.

Leverage each quit attempt by systematically including support in your discharge materials. Send the patient's discharge summary to his or her primary care provider,

In addition, consider other ways to support a patient in quitting tobacco:

- Enroll the patient in your tobacco-dependence treatment program.
- Ask for patient permission, then email or fax a referral to your state Tobacco Quit Line.
- Promote the tobacco quit line, which can be reached by calling 1-800-QUIT NOW. Alert the patient about virtual cessation treatment, including web- or text-based treatment.
- Connect with another tobacco treatment program in your community.
- Send home a quit pack with pharmacotherapy and information about community support.
- Let patients know about Nicotine Anonymous, which offers 12-Step groups, similar and compatible with Alcoholics Anonymous. *http://www.nicotine-anonymous.org/*
- Talk with family members about why and how to support a patient's decision to become tobacco-free and suggest they join the patient in quitting.

> See Appendix O: Discharge-Planning Form Template

After you discharge a patient

Patients who receive at least one month of professional support after leaving the hospital nearly double their odds of remaining abstinent from tobacco.[lvi] That is why the Joint Commission tobacco use and treatment measure set requires that you arrange support and follow-up for tobacco users within 15 to 30 days of discharge. You are

required to see whether the patient is continuing to use tobacco and, if they are trying to quit, whether or not they are using counseling and medications. *You are measured upon whether you follow up with the patient—not upon the patient's behavior after discharge.*

Many hospitals, following a surgery or birth, call patients within a few days of discharge. Questions about tobacco use and treatment can add another dimension to these calls, demonstrating your concern for a patient's health.

Tobacco quit lines also may provide a convenient avenue to help your patients quit successfully and help you meet the Joint Commission standard for follow-up. Most state quit lines have a fax referral system and a growing number are piloting a referral system connected to electronic health records. Your hospital could arrange a system whereby a patient can provide permission for the tobacco quit line to follow up with them and the quit line can provide you with the necessary information for your medical records. This innovation, recommended for the 2016 Stage 3 implementation of the Meaningful Use of Medical Records, offers an efficacious option with possible future financial incentives.[lvii]

This protocol complies with the Joint Commission measure requirements for patient follow-up, as do interactive voice response (a.k.a. robo-calls) and email.[lviii]

Alert the patient about virtual cessation treatment, including web- or text-based treatment.

In your billing system

Reimbursement for tobacco-dependence treatment, though inconsistent from plan to plan and state to state, is improving. Insurance payments are generally low, but public or private insurers may cover at least some aspects of treatment.

In a hospital, tobacco use is generally a secondary diagnosis billed through medical, rather than behavioral health. Medicare provides coverage for both counseling and prescription medications. Medicaid coverage for tobacco use is expanding. Private insurance coverage varies. With the community's growing interest in prevention, insurers for both physical and behavioral health increasingly offer some services to help tobacco users quit.

Hospitals can elevate attention to the issue of tobacco dependence by consistently offering and billing for tobacco treatment. Include tobacco use on the discharge summary using the ICD-9 code 305.1 for tobacco-use disorder or V15.82 for personal history of tobacco use.

> *See Appendix P:* **HCPCS, CPT, & ICD-9 Codes**

Related to Tobacco Cessation Counseling: Medicare covers prescription cessation medications, face-to-face counseling, but not groups. Coverage is now available for all tobacco users, regardless of how smoking affects the disease. Tobacco dependence treatment must be provided by a Medicare-certified physician, physician assistant, nurse practitioner, clinical nurse specialist, qualified psychologist, certified nurse midwife, or clinical social worker.

Medicare will cover up to eight face-to-face counseling sessions during a one-year period. If you provide such counseling, use the CPT code that correlates with the length of the counseling sessions:

99406 Smoking and tobacco use cessation counseling visit; intermediate, three to 10 minutes

99407 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

These codes can be billed with a visit for another diagnosis **on the same day** if:

- The counseling is greater than 3 minutes **in addition to** the time already used to code for the initially billed service
- The counseling is provided by the same provider or by another qualified healthcare provider who can bill for services, such as a physician nurse practitioner or physician assistant

Tobacco cessation services, provided in conjunction with other conditions, also may be billed to insurers. To do so, use a modifier code of 25 (significant, separately identifiable evaluation and management [E/M] service on the same day of a procedure or other service). For example, you see a patient for hypertension and bill the visit as a level 2, established patient (99212). You or another qualified provider in your clinic then provides smoking cessation counseling for 15 minutes as a separate, significant intervention. Documentation would include separate visit notes, the first coded for hypertension and second for tobacco dependence treatment. Be sure to include documentation of the time counseled specifically for tobacco use (in this example, 15 minutes). The coding for the hypertension visit is 99212-25 and 99407 for cessation counseling.

A single counseling session of less than three minutes is considered to be part of a standard evaluation and does not qualify for separate Medicare reimbursement.

A physician or other Medicare certified provider who consults during an inpatient hospital stay can bill for tobacco cessation counseling using **CPT codes 99406** for a session lasting three to 10 minutes or **99407** for a session lasting thirty minutes or more, provided the consultation meets

Medicare standards:

1. The physician's advice is requested by another physician.
2. The need for the consultation is documented in the patient's medical record.
3. The consultant provides a written report to the referring physician.

As both health care providers and employers, find ways to demand, use and bill for tobacco treatment services.

In 2012, **Medicaid** programs started offering full coverage for tobacco cessation counseling and medications for pregnant women, under new provisions in the Affordable Care Act (ACA). Tobacco cessation coverage is scheduled to expand to all Medicaid recipients in 2014, though the details of that coverage had not been determined at publication.

A growing number of **private health plans** cover tobacco dependence counseling or medications. The ACA requires all new plans to include tobacco cessation coverage, but does not spell out what this will include. Other plans explicitly exclude tobacco-related addiction from coverage. Your billing department will need to inquire directly to private plans to see whether tobacco treatment services are covered and, if coverage is inadequate, can encourage improved reimbursement. Reimbursement may be more readily available if the tobacco treatment is associated with another medical problem.

Public and private health insurers respond to market demand. As both health care providers and employers, find ways to demand, use and bill for tobacco treatment services. Insurance coverage for tobacco cessation counseling and medications is listed as a best-practice in the Public Health Service Guideline.

3. Train clinicians in how to treat patients who use tobacco.

Smoking is a chronic, relapsing condition—an addiction that can be difficult to break. Thus, it is useful to think of tobacco-dependence treatment as a process rather than an event. Determine how you can best leverage your role in this process.

Physician advice doubles the rate of quitting success.[lix] However, the gold standard of care supports advice with assistance through a process known as the **5As:**[lx]

ASK patients about tobacco use

ADVISE all patients who smoke to quit

ASSESS a patient's willingness to quit

ASSIST those who are ready to quit with medications and counseling

ARRANGE for follow-up as part of your treatment

Regardless of your protocol, find practical training that staff can use immediately to integrate tobacco treatment into every department of your health system.

Some health care providers find it simpler to **ASK, ADVISE** and **REFER** tobacco users to an internal system, a community resource, or a tobacco quit line that can assist them.[lxii] Train clinicians in your rubric of choice, keeping them apprised of opportunities to learn about tobacco. You can find a variety of on-site, on-line or self-study trainings for clinicians of all sorts. In addition to formal trainings, consider ways to share information in regular meetings, in-services and through Grand Rounds.

> See Appendix Q: Tobacco Treatment Trainings

RX for Change offers free curricula in either protocol that can be taken on-line or in-person.

Regardless of your protocol, find practical training that staff can use immediately to integrate tobacco treatment into every department of your health system. Consider assigning bedside treatment counseling to a nurse, respiratory therapist or health educator, who works closely with a pharmacist, the physician champion and other members of the treatment team. Provide clinicians with the trainings they need. And remember to include interactions with patients around tobacco use in their health records.

Within your broad effort, tailor messages for specific audiences:

The American Society for Anesthesiologists website includes resources anesthesiologists, surgeons, perioperative nurses and other surgical providers can use to help patients quit smoking. *http://www.asahq.org/For-Members/Clinical-Information/ASA-Stop-Smoking-Initiative.aspx*

Those who work with pregnant women know how smoking is a health risk to both mother and baby. Research shows that about half of all pregnant smokers will quit during pregnancy.[lxii] The National Partnership for Smokefree Families has tools for health care providers and patients on its website *http://www.smokefreefamilies.tobacco-cessation.org/* Another tool for pregnant smokers is Great Start, a national tobacco quit line operated by the American Cancer Society aimed at helping pregnant smokers quit, **1-866-66 START**.

Unfortunately, about half of the mothers who quit smoking, resume their addiction within six months after the baby is born. This suggests the need for linking the work of obstetricians, pediatricians and lactation experts, who can talk with parents about the importance of quitting, not only for their personal health, but to protect the child from second-hand smoke. Consider, also, engaging other household members in quitting tobacco to prevent relapse after the baby is born.[lxiii]

Hospital emergency departments are ripe with teachable moments. More than 110 million patients visit emergency departments each year.[lxiv] These patients generally smoke at a rate of up to 40 percent, nearly twice the rate of the general population.[lxv] Consider including a brief tobacco dependence intervention as part of your protocol. Also,

patients tend to wait 30 minutes or more for emergency care.[lxii] Strategically place flyers and posters about the tobacco quit line and other quitting resources in the waiting area.

Don't shy away from providing tobacco treatment to psychiatric and substance abuse patients.

Finally, don't shy away from providing tobacco treatment to psychiatric and substance abuse patients. They use tobacco exponentially more than the national average, by and large want to quit tobacco, and are more likely to die from tobacco use than from issues stemming from their psychiatric diagnoses.[lxvii] During the quitting process, the dosage of tobacco cessation or other medications may need to be moderated because the tars in tobacco smoke change the metabolism of many antipsychotics, antidepressants, and anxiolytic medications.[lxviii] For more information about working with psychiatric and substance abuse patients, see *http://smokingcessationleadership.ucsf.edu/MH_Resources.htm*

4. Evaluate your tobacco treatment process and its impact, adjusting your program to optimize effectiveness.

Measure both processes and outcomes, making changes as you fine-tune your tobacco cessation efforts. Here are some possible measures:

- Joint Commission Tobacco Use and Treatment Standards (See Appendix A)
- Percentage of patients asked about tobacco
- Percentage of patients advised to quit
- Percentage of patients who try to quit while in the hospital
- Use of pharmacotherapy to quit
- Use of counseling to quit
- Impact of hospital protocol on quitting
- Percentage of patients who receive prescriptions to tobacco cessation medications and referrals to counseling advice at discharge
- Percentage of patients who receive follow-up about tobacco use and treatment after discharge
- Quit rate
- Tobacco use reduction
- Patient satisfaction

You can evaluate your measures by age, gender, ethnicity and diagnosis, adjusting processes to improve outcomes.

If you don't have an evaluator available to analyze your program, consider these options:

- An evaluation team from your local, state, or county tobacco program.
- A contractor who can help in development and ongoing reporting
- A graduate student from a local university


WORKING WITH
VISITORS

WORKING WITH VISITORS

You have neither a contract with them nor formal authority over their behavior, yet visitors can be your partners in sustaining a smoke-free environment. A visitor who understands and follows your tobacco-use policy can improve a patient's well being during the hospital stay—and maybe even support a quit attempt afterwards. Consider taking these four steps to help build an effective partnership with every visitor who uses tobacco:

1. **Inform the visitor about your tobacco use policy.**
2. **Respectfully enforce the policy.**
3. **Help visitors manage nicotine cravings and learn about quitting options.**
4. **Provide tools to help staff enforce the policy.**

1. Inform the visitor about your tobacco use policy.

Every visitor that comes to your hospital forms an impression before walking through the door. Consider both the subliminal and direct messages you deliver about tobacco use.

For starters, remove smoking shelters and ashtrays. Even the most addicted visitor is not likely to question the absence of these vestiges of smoking in a health care facility. It's also a good idea, particularly during the initial stages of your tobacco-free initiative, to sweep up cigarette butts as you find them.

But you can't rely on subtleties to communicate your policy. Provide visible, concise signs that tell visitors they can't smoke. Hospitals report that *clearly communicated* smoke-free policies are largely self-enforcing.[lxix] Post a 'no smoking' sign at every entryway, exit, parking lot and other area where visitors are likely to smoke. Develop signs in languages that can reach visitors. Almost everyone understands the universal 'No Smoking' symbol.

Experience shows, however, that employees and visitors can become "sign blind" over time. Change your signs so people will notice them.

Give careful thought to the wording, placement and size of your signs. Your investment in effective signage will ease the enforcement of your tobacco use policy.

See Becoming and Remaining Tobacco-Free, Post Effective Signs, page 10.

2. Respectfully enforce the policy.

A visitor, unfamiliar with your rules and stressed about a loved one's health, may fail to notice your humongous banner or the no-smoking symbol at your entryway, but likely has been to many places that ban smoking.

In any case, attaining visitor compliance is usually easy. Most smokers will immediately put out a cigarette when informed of the no-tobacco policy.[lxx] Hospitals may encourage and expect all staff to inform visitors of the policy. Employees may appreciate a card or brochure that explains the hospital's rationale for its tobacco-free policy and provides information about quitting. Create such tools in multiple languages.

If policy information does not deter smoking, have employees take a non-confrontational approach, asking the visitor to please pick up the cigarette butt. Most hospitals also have a procedure in place in the rare case that a tobacco-use violation poses a potential safety threat to the property or to another person. Security staff generally intervenes in those circumstances.[lxxi] These security personnel need to be trained to enforce the policy with a helpful, positive approach. This could include providing a visitor with the cards you developed, a map that shows where the visitor can smoke or, if necessary, escorting the visitor from the hospital grounds.

See examples of visitor cards in Becoming & Remaining Tobacco-Free, Enforce Your Policy, Visitors, Page 11.

3. Help visitors manage nicotine cravings and learn about quitting options.

One approach with visitors is to provide them with short-term symptom relief so they can spend more time visiting a hospitalized loved one. At the same time, don't miss a teachable moment. Many hospitals include information about quitting tobacco in materials about the hospital's tobacco-use policy.

Nicotine replacement therapy (NRT) can be a tool for maintaining a tobacco-free policy. A visitor who uses NRT can most likely sustain a longer, more comfortable hospital visit than one who needs to leave the hospital to smoke. Find out whether over-the-counter NRT is available through the hospital gift shop or pharmacy or at a store in your neighborhood. Nicotine replacement lozenges or gum can provide more immediate relief than the longer-term patches.

Employees at Oregon Health & Science University (OHSU) give visitors who smoke a card that shows them where to find free NRT, while providing the tobacco quit line telephone number, 1-800 QUIT NOW. Trained staff distributes relief packets with two four-milligram nicotine replacement lozenges, repackaged for the hospital by the Louis, Ohio-based Shamrock Medical Solutions. The lozenge packets, approved by OHSU's legal counsel, include hospital disclaimers and FDA-required information about the medication.

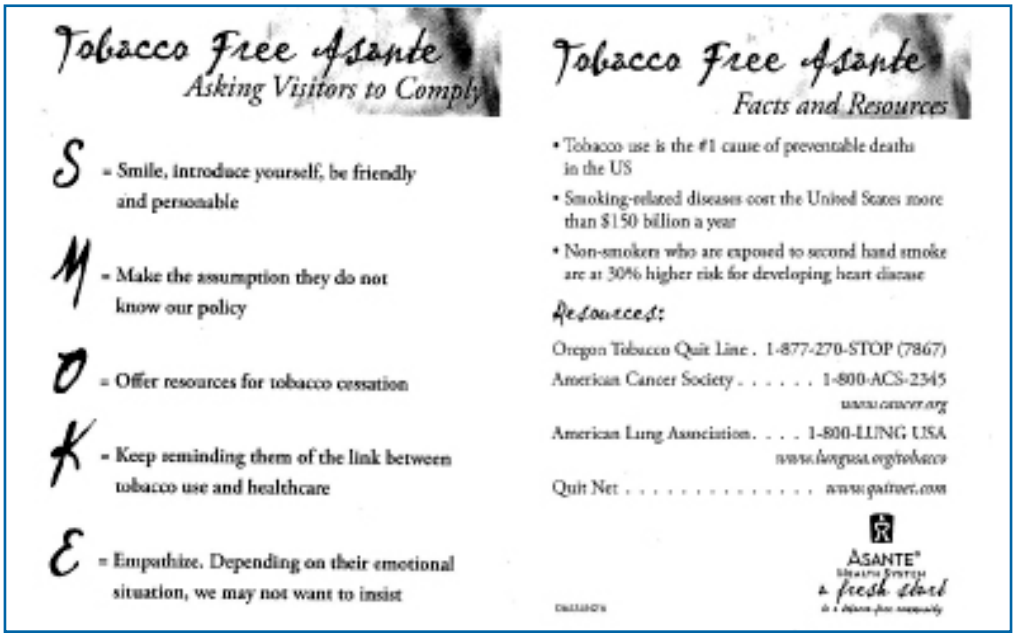
A visitor may not be ready to quit, but having a loved one in the hospital can catalyze the quitting process. Include in your visitor communications information about the Tobacco Quit Line and other community resources so the visitor can find help when he or she is ready to quit.

Encouraging visitors to quit tobacco may offer health dividends for patients. Caregivers need to know that those with heart disease are at especially high risk of suffering adverse effects from breathing secondhand smoke and should avoid even brief exposures.[lxxii] Women who quit smoking during pregnancy are much more likely to resume smoking if their husbands, mothers or mothers-in-law smoke.[lxxiii] Your tobacco use intervention with a visitor could later protect a patient from second-hand smoke or support the patient in breaking the addiction to nicotine.

4. Provide tools to help staff enforce the policy.

Staff likely will appreciate cards or brochures they can give to a visitor or co-worker who is violating the policy. These usually include a message about the policy with information about how to quit, including the quit line phone number.

Asante Health System, in Southern Oregon provides staff with a card, explaining how to respectfully ask visitors to comply with the tobacco-free policy.



Tobacco Free Asante
Asking Visitors to Comply

S = Smile, introduce yourself, be friendly and personable

M = Make the assumption they do not know our policy

O = Offer resources for tobacco cessation

K = Keep reminding them of the link between tobacco use and healthcare

E = Empathize. Depending on their emotional situation, we may not want to insist

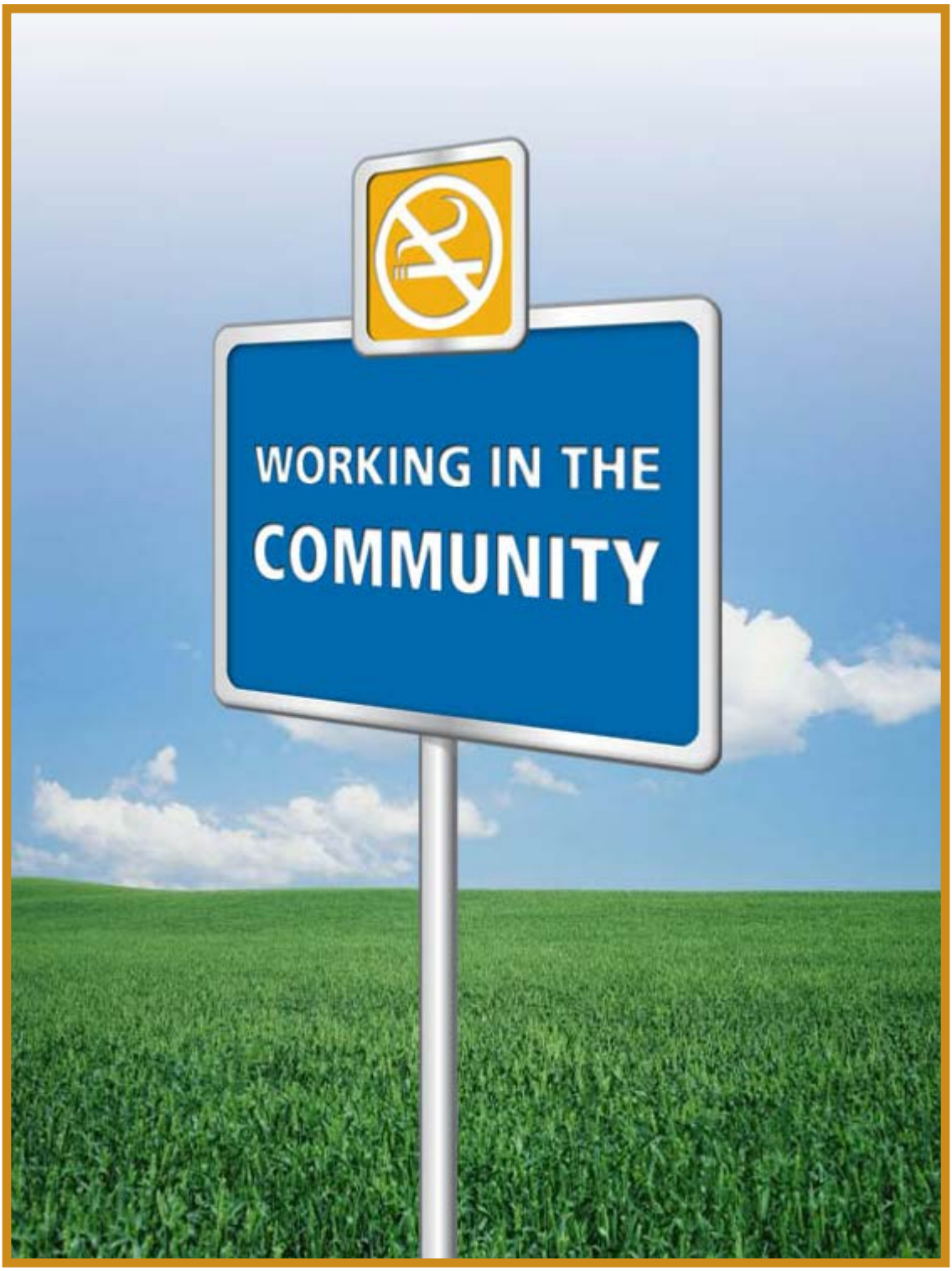
Tobacco Free Asante
Facts and Resources

- Tobacco use is the #1 cause of preventable deaths in the US
- Smoking-related diseases cost the United States more than $150 billion a year
- Non-smokers who are exposed to second hand smoke are at 30% higher risk for developing heart disease

Resources:

Oregon Tobacco Quit Line . 1-877-270-STOP (7867)
American Cancer Society 1-800-ACS-2345
www.cancer.org
American Lung Association. . . . 1-800-LUNG USA
www.lungusa.org/tobacco
Quit Net . . . . . www.quitnet.com

ASANTE
a fresh start


WORKING IN THE
COMMUNITY

WORKING IN THE COMMUNITY

As you step up to the challenge of forging tobacco-free policies and protocols, work with partners to avert problems, augment teachable moments, and increase your impact. Here's a list of likely partners that can help you with your efforts:

1. **Neighbors, including businesses**
2. **Physicians' offices and health plans**
3. **State tobacco quit lines**
4. **Colleagues, competitors and other interested parties**
5. **Local and state health departments and tobacco-free coalitions**
6. **Media**

1. Neighbors, including businesses

Anticipate potential problems with neighbors. Cigarette butts, litter, and loitering have fueled the ire of hospital neighbors from Florida to Washington.[lxxiv] Successful hospitals discuss these issues with staff and reach out to neighborhood residents and businesses before there is a problem.

Take the same basic steps in working with the neighbors as you have with employees: Explain your rationale. Provide plenty of notice. And offer a personal contact should neighbors have concerns. You may even want to invite neighbors to the kick-off celebration or award prizes purchased from neighboring businesses.

Even as you maintain your focus on health, depending upon your neighborhood, you may have to make concessions: One hospital purchased receptacles that were placed in the new "unofficial" smoking areas. Revisit such concessions and consider other options as part of your ongoing evaluation.

See Appendix R: Letter to Neighbor Template

2. Physicians' offices and health plans

A physician who refers a patient to your hospital can be a key partner both before and after a hospital stay. Before a scheduled procedure, the referring physician can tell a prospective patient of your hospital's tobacco use policy, opening up the conversation about why, both in the short-term and the long-term, now is a good time for the patient to quit tobacco. The clinician can then assist the patient in quitting or refer him or her to the tobacco quit line, 1-800 QUIT NOW, or other effective services.

After the procedure, the physician report you send will remind the medical practice to follow up with the patient about the enforced abstinence during the hospital stay and support the patient to remain tobacco-free or quit.

Research shows that the patient is much more likely to remain tobacco-free with support and assistance.[lxxv] Encourage health plans in your community to provide tobacco dependence treatment as part of standard benefits. This will open a clinical pathway for both you and your partners to provide one of the most cost-effective clinical treatments available.[lxxvi]

> *See Appendix S: Letter to Physicians Template*
> *See Appendix T: Letter to Patients Template*

3. State tobacco quit lines

Hospitals and health care systems may not have the time or training to treat patients for tobacco dependence, but they can begin the process. Hospital professionals can ask every patient about tobacco use and advise all users to quit. They then can refer those who are ready to quit to a state tobacco quit line.

Any state tobacco quit line can be accessed through the national portal, 1-800 QUIT NOW.

Every state has one, and virtually all of them have devised a fax referral system to work with hospitals and other health care providers. About half of all state quit lines have an E-mail referral process as well. Here's how it works: A clinician who finds a patient is ready to quit tobacco, encourages the patient to get treatment and support. Patients ready to quit are asked to sign a referral form, which is faxed or e-mailed to the state tobacco quit line. This can trigger a call from a tobacco treatment coach to the patient within a day or so. The clinician needs to explain how the quit line operates and remind the patient at discharge so he or she is not surprised when the quit coach calls.

Any state tobacco quit line can be accessed through the national portal, 1-800 QUIT NOW. Services vary, depending upon state budgets. Find out what your quit line offers by visiting the North American Quitline Consortium, *http://www.naquitline.org/* or contacting your state health department.

See if your quit line can provide you with materials and training to launch a fax or E-mail referral system. The quit line also may be able to provide you with materials you can share with patients who are not yet ready to quit. Hospitals that choose to refer patients directly to the quit line, can order cards with the national telephone number, 1-800 QUIT NOW, from *http://smokingcessationleadership.ucsf.edu/cardorderform.htm*

Walla Walla General Hospital and several other health care providers worked with the Washington State Tobacco Quit Line to improve tobacco dependence treatment systems. The rural Walla Walla hospital's electronic medical records identified tobacco users, triggering treatment orders to respiratory therapists. The respiratory therapists, however, frequently had neither the time nor the training to provide comprehensive tobacco dependence treatment. As a result of this analysis, the quit line, operated by Alere Wellbeing, trained respiratory therapists to ASK patients if they use tobacco, ADVISE every tobacco user to quit, then REFER tobacco users to the quit line for assistance. Now, every new respiratory therapist is trained in the ASK-ADVISE-REFER protocol through an on-line module on HealthStream. In addition, all respiratory therapists must stay up to date on tobacco dependence treatment through an annual on-line review module with a pre- and post-test. This pilot was funded by the Washington Tobacco Prevention & Control Program.[lxxvii]

In another quit line partnership, the Ohio Hospital Association worked with the Ohio Tobacco Quit Line to train 243 hospital providers on tobacco addiction, treatment, and the impact of tobacco use on chronic disease. After the training, 48 hospitals partnered with Ohio Quit Line, operated by the National Jewish Medical & Research Center, to become "Ohio Quit Sites." These hospitals received a $1,000 incentive for integrating tobacco control into protocols, training all respiratory and cardiopulmonary staff, referring calls to the tobacco quit line and tracking such referrals.[lxxviii]

> See Appendix U: Sample Fax Referral Form

4. Colleagues, competitors and other interested parties

Health care organizations, from North Carolina's tobacco country, through Kansas, Ohio and Michigan are setting aside turf issues to jointly address the single-most preventable cause of premature death and disability: smoking. Psychiatric facilities, prisons, nursing homes, and chemical dependency treatment programs increasingly are joining the ranks of the tobacco-free as well.

As your facility becomes tobacco-free and helps tobacco users quit, you provide a model for businesses, including competitors and colleagues. Forge partnerships that enhance training and expand tobacco dependence treatment options for all members of the community.

The University of Michigan Health System's tobacco-free initiative launched a partnership effort in 2000 that snow-balled throughout the state and provided the hospital with a new treatment specialty. After banning on-campus tobacco use, the health system created a CD tool and offered technical assistance to ease tobacco-free efforts by other facilities. This work was funded by a grant from the Michigan Department of Community Health. Initially, at least five hospitals became tobacco-free each year. After 2006, when the Michigan Hospital Association joined the partnership, progress accelerated quickly. Between 2000 and 2008, the number of smoke-free hospitals in Michigan grew from

four to nearly 160. The University of Michigan Health System's tobacco cessation treatment program has directly helped more than 50,000 people with their quitting journey. The statewide partnership has enabled countless others to receive help as well.

As your facility becomes tobacco-free and helps tobacco-users quit, you provide a model for businesses, including competitors and colleagues.

The effort that started with the University of Michigan Health System expanded to all university facilities. For more information and materials, go to: *http://www.hr.umich.edu/smokefree/*

5. Local and state health departments and tobacco-free coalitions

Partners in local and state health departments and coalitions can help your tobacco-free initiative, particularly in engaging the community. Invite health department and community representatives to join your team. Even if they can't provide financial support like the Michigan project, they likely will have materials you can use to promote the tobacco quit line and provide information about tobacco use. Consider ways public health officials and coalitions can help measure community impact, reach out to the media, promote community events, convene partners and provide other assistance.

The Oregon Tobacco Prevention & Education Program assisted the state's hospitals by offering a day long Rx for Change train-the-trainer course in tobacco dependence treatment. The training was available free to one professional from every hospital in the state, provided the participant train additional staff at the home institution within a year. Students received teaching materials, food, transportation and lodging. Continuing education credits were available to nurses, pharmacists and respiratory therapists. A grant from the Smoking Cessation Leadership Center supported the trainers. The Oregon Association of Hospitals & Health Systems helped publicize the event.

6. National health quality advocates and regulators

As states and communities transform the health care delivery system, it is critical that facilities like yours speak out for initiatives that improve quality through integrated initiatives. An aligned system that consistently addresses and treats the addiction to tobacco, over time, can make a marked difference in improving population health and reducing health care costs.

Consider contacting the National Quality Forum, the Joint Commission, Centers for Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or those working to transform health care in your state or community to advocate for mandatory and consistent measurements for tobacco use and treatment

7. Media

As you plan and implement your tobacco-free policy, the media can help you promote a positive image, educate the community about tobacco use and model leadership among health care providers and other businesses.

Incorporate a proactive media strategy in your plans. Begin with a simple, consistent message and use it in interviews and articles, reframing the message and selecting apt messengers as you communicate with different audiences. For news conferences or interviews, showcasing both an administrative and clinical champion can optimize your reach and credibility.

Include in your releases information about why you are implementing the policy, when it will be implemented and how to learn more. Here are some standard messages you can adapt for the media:

"We are developing this policy to provide a healthy and safe environment for employees, patients and visitors and to promote positive health behaviors."

"Continued tobacco use can cause problems for hospitalized patients: Smoking retards wound healing, increases infection rates in surgeries and is the most common cause of poor birth outcomes."

http://smokingcessationleadership.ucsf.edu/

"We are not telling anyone, 'you must quit smoking.' We are saying, 'Don't use tobacco at our hospital.' While you are a patient or visitor at this hospital, we can suggest ways to ease nicotine withdrawal symptoms. And if you are ready to quit, we have trained professionals and community partners who can help you."

Your proactive approach with the media will help frame tobacco issues in the community. Consider these and other media opportunities as ways to inform the community of your efforts and engage new partners:

- Announcement of tobacco-free policy (one month ahead)
- Tobacco-free policy launch and celebration
- Opinion piece or editorial about your hospital's decision to ban tobacco
- Expert interviews on new community policies or research

Most hospitals will encounter some opposition to a new tobacco-free policy, generally from those touting the "right to smoke." As a health care institution, continue to emphasize the health and safety issues. Be clear that you welcome all patients to your hospital, emphasizing you simply are asking tobacco users to abstain while on your properties.

> See Appendix V: News Release Template
> See Appendix W: Response to Opposition Template

APPENDIX A: 2012 Joint Commission Tobacco Use Treatment Measurement Set

The Joint Commission

Tobacco Treatment National Hospital Inpatient Quality Measures

Set Measure ID #	Measure Short Name
TOB-1	Tobacco Use Screening
TOB-2	Tobacco Use Treatment Provided or Offered
TOB-2a	Tobacco Use Treatment
TOB-3	Tobacco Use Treatment Provided or Offered at Discharge
TOB-3a	Tobacco Use Treatment at Discharge
TOB-4	Tobacco Use: Assessing Status After Discharge

Specification Manual for National Hospital Inpatient Quality Measures:
http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

APPENDIX B: Understand your Community and Facility

Your community

- What are the workplace smoking laws in your community? Americans for Non-smokers Rights maintains a database on smoke-free initiatives: *http://www.no-smoke.org/*
- What is the tobacco-use prevalence in your community? Statewide data are available at *http://apps.nccd.cdc.gov/statesystem/* Contact your county health department for county-wide data.
- How do other health care facilities in your community address tobacco issues? What about other businesses?
- How does the Tobacco Quit Line help smokers in your community? (Find out by calling 1-800-QUIT NOW or searching *http://map.naquitline.org/*)

Your workplace

- What is your workplace smoking policy? What is the history of its development? Who supported it? Who opposed it? Why?
- Do other facilities share your health system? Do you lease space to others? How can you work with these organizations in changing your tobacco use policy?
- Are tobacco-use policies or treatments addressed in any labor agreements?
- How many employees smoke or chew tobacco? Does your human resources department collect this information? Where do employees smoke? Do tobacco users want to quit?
- How much does employee tobacco use cost your organization each year? How much will this program cost?
- What tobacco-dependence treatments do your health plans or wellness programs offer? Do employees know about them? Do they use them? What are the barriers (co-payments, lifetime limits, other restrictions)? What incentives do you offer?
- How do employees feel about your tobacco-use policies? How do they feel about the benefits or services you offer to help them quit tobacco?

Your treatment center

- Have you adopted the Joint Commission measure set for tobacco use and treatment? *(See APPENDIX A.)*
- Do you ask patients admitted to your facility if they smoke? How do you record this information? Is smoking status a part of a patient's medical record?
- What protocols does your facility have for helping smokers quit? Do you provide standing orders for tobacco-cessation counseling and medications for patients who use tobacco?
- What tobacco-cessation medications are included in your formulary?
- How do you address patient tobacco use upon discharge from your facility?
- How do you follow up with patients after they are discharged from your facility?
- Do you offer a community tobacco-cessation program? Do you have a process to refer patients to community tobacco-cessation services or the tobacco quit line? 1-800-QUIT NOW

Other key facts

- How does tobacco use affect patient health outcomes (i.e. risk of liability)?
- How much will a tobacco-free initiative cost?

APPENDIX C: Sample Announcement

(Adapted from Kaiser Permanente, Northern California)

Smoke-Free Campus

Open Letter to Physicians and Staff

KAISER PERMANENTE®

To all Physicians and Staff,

All of us at Kaiser Permanente know that we are committed to improving the health of our members and staff. We also know that smoking is a health hazard. Therefore, to promote good health, and create a healthy environment for members and staff, our Kaiser Permanente campus will become smoke free on [DATE].

This new policy, known as Smoke-Free Campus, means the existing designated smoking areas will remain in place until [DATE]. After that, there will be no areas where smoking is permitted.

While physicians and staff are certainly free to continue smoking off-campus during breaks and lunch periods, those who smoke may decide this is a good time to quit. We recognize that giving up smoking is difficult – and we are committed to helping any employee or physician who needs support in their efforts to quit.

To assist those who want to quit smoking, Kaiser Permanente offers free smoking-cessation courses to all Kaiser members. The classes may include a one-day workshop, a six-session workshop and an eight-session workshop. Attendance in the classes provides members and staff with the opportunity to obtain smoking-cessation aids, like the nicotine patch or bupropion SR, for a standard co-payment. The Health Education Department has more information on these classes and other quit-smoking resources. The California Smoker's Helpline also offers telephone counseling free of charge at 1-800-QUITNOW.

Over the course of the next several months, look for more information and details about our Smoke-Free Campus in employee and member publications, as well as posters, flyers and other positive activities. If you have any questions about the Smoke-Free Campus policy, please contact _____, Human Resources, at _____.

Signatures of:

Physician-in-Chief, *Service Area Manager,*

Medical Group Administrator *Labor Management Representative*

APPENDIX D: Tobacco-Free Policy Template

(Adapted from Group Health Cooperative, Seattle, Washington)

INSERT YOUR LOGO HERE

APPROVED BY:

_____

CEO/President

_____

Chairman of the Board of Trustees

TOBACCO-FREE POLICY

Effective *DATE, ORGANIZATION* will maintain a 100% tobacco-free environment. This policy applies to employees, patients, residents, visitors, vendors and anyone who enters *ORGANIZATION*-owned property or off-campus employee worksites.

PURPOSE

As a health care provider, *ORGANIZATION* is committed to providing a healthy and safe environment for employees, patients, staff, and visitors and to promoting positive, healthy behaviors.

With this policy, we hope to:

- Eliminate secondhand smoke so everyone on our campuses can breathe clean air
- Demonstrate our commitment to improve the health of patients, employees and the community
- Increase hospital involvement in treating nicotine addiction
- Set an example that other organizations and businesses can follow

PRODUCTS COVERED BY THE POLICY

Tobacco products include, but are not limited to:

- Cigarettes
- Cigars
- Chewing tobacco
- Pipe smoking
- Dissolvable Tobacco, including strips, sticks, and orbs
- Nicotine delivery devices, including electronic cigarettes

PHYSICAL BOUNDARIES OF THE POLICY

Please refer to attached map for the boundaries of *ORGANIZATION's* campus. This policy shall apply to all indoor and outdoor spaces owned or leased by *ORGANIZATION,* including:

- Parking lots and driveways that are used by *ORGANIZATION.*
- *ORGANIZATION* vehicles
- Vehicles on property that is owned, leased or used by *ORGANIZATION*
- Adjoining sidewalks to *ORGANIZATION* owned or leased property

1. Employee Responsibilities

For purposes of this policy only, "employee" refers to employees, contract employees, volunteers and students.

All ORGANIZATION employees must observe and promote compliance with the tobacco-free policy. ORGANIZATION employees are encouraged and expected to be good neighbors and refrain from using tobacco products on the property of nearby businesses and residences.

Employees are not allowed to leave the workplace while "on the clock." Leaving campus during work time is subject to disciplinary action.

Hourly employees, who leave ORGANIZATION property for non-work matters, must clock-out upon leaving and clock-in upon returning. Unauthorized breaks are subject to corrective action.

Employees carpooling to attend training classes or work-related functions paid for by ORGANIZATION may not smoke unless all parties agree that smoking is acceptable. This applies for travel where mileage is reimbursed by ORGANIZATION.

All employees are responsible for ensuring compliance by fellow employees. Employees observing a co-worker violating the policy are requested to courteously remind the employee of the policy and ask that the tobacco product be extinguished.

Employees are encouraged to make a confidential, "good faith" report to a supervisor, manager or human resources when they observe an employee violating this policy.

If the tobacco violation involves a potential threat to health or safety, such as smoking near combustible supplies, flammable liquids, gases or oxygen, management and security staff must be contacted. If the tobacco materials are not extinguished or dispensed of or if the patient/resident repeats the activity, security will remove the tobacco materials from the room until dismissal. You may dial [PHONE NUMBER] to request security for assistance.

As outlined in the Dress Code Policy, employees are asked to pay special attention to personal hygiene. This includes not having a strong odor of smoke when working.

Employees who violate this policy are subject to disciplinary action, up to and including termination. These consequences are based on a 12-month rolling calendar:

1st VIOLATION ➤	VERBAL COACHING
2nd VIOLATION ➤	WRITTEN WARNING
3rd VIOLATION ➤	SUSPENSION
4th VIOLATION ➤	TERMINATION

Employees who smoke are encouraged to avail themselves of the tobacco cessation programs offered.

2. Visitors

Informational cards are available for staff to give visitors who are observed smoking or using tobacco on ORGANIZATION property. Staff can use the card to inform the visitor of ORGANIZATION's policy and options to relieve withdrawal symptoms or quit tobacco.

Staff is encouraged not to confront visitors, but rather to respectfully ask those who refuse to comply to please pick up their cigarette butt. Should a tobacco-use violation pose a potential safety threat to the property or to another person, employees are asked to contact security.

3. Patients and Residents

At the time of admission or registration, patients and residents will be given information regarding the tobacco-free policy. Patients will be informed that leaving the campus while admitted will not be allowed. Leaving campus while admitted is classified as leaving "against medical authorization."

Patients and residents will not be permitted to use tobacco or smoke under any circumstances. If an employee observes a patient/resident using tobacco products the employee needs to remind the tobacco user of the policy and provide an informational card. Patients' and residents' tobacco items will be placed in a secure location until dismissal.

Additional remedies are the responsibility of the management team responsible for the safety and well-being of the patient/resident. Tobacco-cessation materials will be given to the patient/resident and their physician may be contacted to request smoking-cessation products.

If the use of tobacco products continues after the first verbal reminder, management and security may be contacted for additional assistance and to reinforce the policy.

4. Security

Security is available to assist with a patient or resident who is not compliant with ORGANIZATION's tobacco-free policy. If tobacco materials are not extinguished or if the patient/resident repeats the activity, security will remove the materials from the room to be stored in a safe place until dismissal.

5. Contractors and Vendors

All contractors and vendors will be informed of ORGANIZATION's tobacco-free policy as part of the contractual agreement. Vendors who sign-in at shipping and receiving to deliver items will be reminded of the policy. If you observe a contractor or vendor violating this policy you may inform them of ORGANIZATION's policy or contact security.

Senior leadership is responsible for monitoring compliance with this policy.

(NAME AND SIGNATURE OF PERSON IN CHARGE)

CONTACT INFORMATION

DATE

APPENDIX E: Sample Timeline

(Adapted from Kaiser Permanente, Northern California)

IMPLEMENTATION	DESCRIPTION	TIMELINE
1. Gain top-level commitment	1. Written memo to middle management signed by organization CEO or physician-in-chief and labor-management partnership representative announcing new policy and target date 2. Create Steering Advisory Committee to oversee the project	**1 year prior to target**
2. Create local implementation task force at each site	3. Recommended members: MD champion and assistant (co-chairs), coordinator, representatives from: primary care, health education, addiction medicine, personnel, security, facilities, environmental services, pharmacy, public affairs, key employee groups (union representatives, smokers) 4. Revise smoking policy and procedure 5. Adopt Joint Commission tobacco use performance measure set 6. Conduct employee focus groups 7. Develop implementation plan and timeline	**9 –10 months prior to target**
3. Facilities Planning	8. Signage location and placement 9. Eliminate ash urns	**Plans completed 8 months prior** **Signage placed 6 months prior**
4. Communication to physicians and employees	10. Send written memo from middle management announcing the new policy 11. Communicate details of phasing-out of designated areas, enforcement, stop-smoking resources and timeline	**7 months prior** **7 months prior**

IMPLEMENTATION	DESCRIPTION	TIMELINE
5. Positive promotion to members	12. Parking lot banners, lobby banners and posters 13. Employee brochure 14. Appointment card announcement 15. Newsletter articles 16. Other internal publications 17. External publications/new media 18. Train security, etc., to communicate policy 19. Begin enforcement during phase-out of designated areas/offer cessation resources (free, if possible)	**6 months prior to target "kick-off" date**
6. Going "live"	20. Kick-off celebration 21. Enforcement with employees/ members (per policy) 22. Maintain grounds 23. Prevent relapse with communication 24. Evaluate effectiveness and modify as needed	**Target date** **1 week after** **1 month after** **6 months after** **Annually**

APPENDIX F: Frequently-Asked Questions

(Derived from: Group Health Cooperative, University of Massachusetts Medical School, Centers for Disease Control & Prevention)

On DATE, ORGANIZATION *will become completely tobacco-free, both indoors and outdoors--for all properties. This includes our parking areas and the vehicles parked there. This ban covers all tobacco products, including chewing tobacco, and extends to everyone who smokes--patients, visitors, employees, students and vendors. The following should answer common questions about our Tobacco/Smoke-Free Campus policy:*

Why are we doing this?

We believe *ORGANIZATION* leads the community and nation in health promotion and staff wellness. As an institution dedicated to improving the health of our patients and community, we must "walk the talk" and show our commitment and leadership in tangible ways. Smoke-free property is the standard for many health care institutions and companies. Organizations that are already 100 percent smoke-free include Alaska Airlines, Dunkin' Donuts, Westin Hotels and thousands of businesses, hospitals and health care organizations across the region and nation.

Don't we have a right to smoke?

There is no legal right to smoke. On the other hand, this hospital has a right to create a tobacco-free environment within our buildings and grounds. This initiative is consistent with our goals of supporting good health and wellness.

How will patients, visitors and others learn of the ban?

We will announce the ban through the media and post signs around our property. We will send information to physicians and other health care providers, asking that they tell patients about our no-tobacco policy. We will tell every patient admitted to this hospital about the policy. We ask that managers begin discussing this policy with employees as soon as possible so all of us can prepare for this change.

Doesn't this policy punish smokers?

Our new policy isn't intended to punish anyone. It is designed to provide all staff with a healthy and safe workplace and to treat patients in a healthy and safe environment. Our tobacco-cessation programs and related activities show our commitment and leadership in health promotion and disease prevention for our staff, patients and communities. We hope we provide the kinds of support that staff, patients and visitors need to take steps toward health.

What about other kinds of tobacco products, like chew or pipes?

The new policy will also ban use of other forms of tobacco, including chewing tobacco, cigars, pipes and tobacco alternatives, such as clove cigarettes. Nicotine replacement therapy products (patches, gum, lozenges) are allowed.

Does this new policy comply with union contracts?

ORGANIZATION's union contracts allow us to implement general staff policies like this one. We have informed union leaders of our new policy and we will work with them as we implement this policy and other policies and changes.

How will the policy be enforced?

Our hope is that we can work together to enforce this policy through friendly interactions. All employees seen smoking or using tobacco on the premises after *DATE* will be asked to stop, reminded of the new policy and informed of tools that can ease symptoms while they are at work. If they are ready to quit, we can provide resources to help them. If you find staff who do not wish to comply with our policies, we ask that you talk with them or their supervisor to let them know you're concerned about supporting a smoke-free campus. Repeat offenders are subject to disciplinary action.

We recognize that we also will deal with visitors who may be under stress and are unfamiliar with our policies. If you see visitors smoking on our grounds, kindly inform them of the policy and request that they stop. We will provide you sample scripts and information cards. If a visitor refuses to comply, walk away. Inform security if they pose a safety threat.

What about visitors or patients who must stay on our property for lengthy periods of time?

We want to deliver a clear message to all of our patients and visitors that, 'While you are here, you and those around you have every right to breathe clean air and every opportunity to make healthy choices.' This applies to our psychiatric, chemical-dependency treatment units and long-term care as well as our tertiary care.

Experience shows that psychiatric, chemical-dependency treatment centers and long-term care facilities can implement smoke-free policies without the upheaval skeptics predict. We will provide training to our staff on treating nicotine addiction along with other psychiatric or chemical-dependency issues.

(For information and sample policies for long-term care facilities, see http://www.tcsg.org/tobacco/smokepolicies.htm)

Will staff or visitors be able to smoke on public property adjoining our property, such as a public sidewalk?

Yes, but we ask that our employees respect our neighbors and their property.

If I have to walk farther to reach public property where I can smoke, will I get more break time?

No. That would be unfair to co-workers and hurts our ability to treat patients. Failure to return from break on time will be treated as a violation of our standards of employee conduct.

Can I smoke inside my car?

If your car is parked in the *ORGANIZATION* parking lot, you cannot smoke in it because the lot is part of our tobacco-free zone. Additionally, the use of tobacco products is not allowed in any *ORGANIZATION*-owned vehicles.

Won't there be more litter around the campus because of cigarette butts?

All staff act as *ORGANIZATION* ambassadors during working hours at our campuses. As ambassadors and good neighbors, we expect that employees will treat surrounding public areas and private properties with respect. This means that staff is expected to avoid littering, including cigarette butts and other trash, on all properties adjoining our buildings.

Can an employee be disciplined for carrying cigarettes?

The tobacco-free policy is intended to cover the use of lighted cigarettes, cigars, pipes or other tobacco products on *ORGANIZATION* campuses. If you are carrying unlit cigarettes or other tobacco products in your purse or on your person going to and from a break, you will not be disciplined. You will be subject to progressive disciplinary action if you light up or smoke a lighted cigarette or other tobacco product or use chewing tobacco on *ORGANIZATION* property.

Can I use nicotine-replacement therapy products, like gum, lozenges, or patches, at work?

Yes. Some smokers may choose to use NRT products—particularly gum or lozenges—to manage their nicotine cravings during work hours. If you are still smoking or using tobacco, please be cautious if you choose to use nicotine-replacement therapy at work. Taking too much nicotine by using nicotine-replacement therapy while you still use tobacco can cause unpleasant side effects. If you want to use NRT at work, you may want to talk to your physician about appropriate dosing and use.

How do I learn more about what will happen at my work site, or otherwise get more information on our Tobacco/Smoke-Free Campus?

You can get more information from your manager or from the Tobacco/Smoke-Free Campus Web Page at _____ You can also ask questions or offer suggestions by e-mailing or calling _____.

Who enforces the no-smoking requirement for contract workers who are outside employees?

We have notified our contracted vendors of the Tobacco/Smoke-Free Campus policy and its *DATE*, effective date. All vendors and contracted employees are expected to comply with this policy.

I'm uncomfortable talking with members or visitors about smoking on campus. What am I supposed to do?

You may need to educate patients, employees and visitors about the new policy when you see someone smoking or using tobacco on campus. But managers and security staff have the primary responsibility for enforcement. This means they will talk with employees or visitors who do not wish to stop smoking or using tobacco after being educated about our policy. We anticipate that most employees, patients and visitors will comply with the policy once they know about it. We understand that conversations about personal behaviors, like smoking, can be uncomfortable. We hope you'll help *ORGANIZATION* create a healthier environment by educating people about the new policy. Gently inform them of the policy. Something like: *"Hi. I need to let you know that for the health of our patients, employees and visitors, ORGANIZATION does not allow tobacco-use on campus. Please put out your cigarette and dispose of it. Here's a card that explains our policy and offers some other options."* If the member, visitor or staff member continues smoking, walk away. If you believe the smoker poses a safety threat, report the person to security right away.

How will *ORGANIZATION* help tobacco-users who want to quit?

- *ORGANIZATION's* health plan and wellness program covers *NOTE CESSATION HELP* for employees.
- Refer tobacco-users to the national Tobacco Quit Line phone number 1-800-QUIT NOW and O*THER COMMUNITY RESOURCES.*
- Ask visitors to see what kind of assistance their health insurance may offer.

I'm a smoker. How can I get help?

We know that quitting is a process that doesn't happen the same way for everyone. Research shows that you will be most successful with a combination of support, coaching and medications.

1. **Employees can** *DEFINE BENEFITS OR SERVICES*.
2. **Talk with your doctor.**
3. **Call the Tobacco Quit Line, 1-800 QUIT NOW.** The Quit Line can offer you information and coaching *EXPLAIN QUITLINE SERVICES*.

APPENDIX G: Sample Communications Plan

(Adapted from Kaiser Permanente's Santa Rosa Medical Center's Smoke-Free Campus Communication Plan)

TARGET AUDIENCE	WHAT TOOL	HOW TO DISSEMINATE	WHO RESPONSIBLE	TARGET DATE
Employees	1. Presentation re: • Policy • Role-play on policy enforcement • Health education programs	Managers and chiefs meetings		
Employees	2. ***Card*** to be given to smokers indicating "no smoking" (may print as tear-off pads)	All managers through meetings and interoffice mail		
Employees	3. Announcements	E-mail to all employees and other appropriate distribution lists at other facilities E-mail to managers E-mail to providers		
Employees	4. "Fireside Chat"	E-mail from CEO		
Employees	5. ***Flyers***	Paychecks		
Employees	6. Policy	New-employee orientation		
Employees	7. Town Hall Meeting	Lunchtime meeting(s) for all interested employees		
Employees	8. Article and calendar section	Employee newsletter		
Unions	9. Letter	Sent to unions		
Patients and Community	10. ***Banner***	Placement in facility		
Patients and Community	11. Recorded message	On-telephone for callers on hold		
Patients and Community	12. ***Patient information***	Patient packet		
Patients and Community	13. Reminder Cards	Through scheduling		
Patients and Community	14. Press release	All media		

(***Bold italic*** items require funding.)

TARGET AUDIENCE	WHAT TOOL	HOW TO DISSEMINATE	WHO RESPONSIBLE	TARGET DATE
Patients and Community	15. Contacts with local agencies	Follow-up to press release		
Patients and Community	16. Talking points Q & A re: policy background and rationale	Task force leadership for performance improvement		
Inpatients	17. ***Pre-admit information***	Pre-admit packet		
Physicians	18. Hospital Protocol 19. Facility Policy	Chiefs meetings		
All	20. ***Flyers***	Facility information desks and waiting areas		
All	21. Health education stop-smoking programs (***Rebate*** for employees who enroll by DATE.)	Through talking points and Q & A		
All	22. ***Signs***	Through facility services		
Volunteers	23. Flyers and cards	Meet with volunteer coordinator		

(***Bold italic*** items require funding.)

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) advocates 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 Stage 1 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 Stage 1 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.

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**.

Template recommendations are on the back of this document.

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 can document secondhand smoke exposure: current, former or never, and work, home or social.

The template may include some or all of the following data points or prompts:

HISTORY

Type of tobacco:

❑ Cigarettes Packs per day/week (20 cigarettes/pack): _____

❑ Pipe Bowls per day/week: _____

❑ Cigars Number per week: _____

❑ Smokeless Cans/pouches per day/week: _____

❑ Other tobacco products (orbs, strips, sticks, hookah, etc) Amount per day/week: _____

❑ E-Cigarettes Cartridges per day/week: _____

Approx date of last quit attempt: _____

a) How long quit tha t time? _____

Longest period of time quit in past: _____

a) How long ago? _____

b) What caused relapse? _____

Medication used in previous quit attempt:

❑ Nicotine patch
❑ Nicotine gum
❑ Nicotine lozenge
❑ Nicotine nasal spray
❑ Nicotine oral inhaler
❑ Varenicline
❑ Bupropion
❑ Nortryptiline
❑ Other (i.e., herbal): _____
❑ No medication

ASSESSMENT

Readiness to Quit:

❑ Not interested in quitting

❑ Would like to quit sometime (but not within the next month)

❑ Would like to quit now or soon (within the next month)

Other smokers in household (Y / N)

PLAN

Quit date:

Counseling:

Time counseled:
❑ < 3 minutes
❑ 3 – 10 minutes
❑ > 10 minutes

Topics covered:

❑ Tobacco-proof home and car
❑ Changing daily routines
❑ Dealing with urges to smoke
❑ Getting support
❑ Anticipating/avoiding triggers
❑ Secondhand smoke
❑ Teach behavioral skills
❑ Reinforce benefits
Counseling notes: _____

PHARMACOTHERAPY

Recommended OTC:

❑ NRT Gum
❑ NRT Lozenge
❑ NRT Patch
❑ NRT Patch Plus (combination of patch plus gum or lozenge)

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 Oral Inhaler
Dosing: 6–16 cartridges/day; initially use 1 cartridge q 1–2 hours (best effects with continuous puffing for 20 minutes)

❑ Bupropion SR
Dosing: Begin 1–2 weeks prior to quit date; 150 mg po q AM x 3 days (as tolerated), 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 neuropsychiatric symptoms.

AAFP Handouts provided:

❑ Quit Smoking 'Prescription'
❑ Quitline Referral Card
❑ Steps to Help You Quit Smoking Brochure
❑ Stop Smoking Guide (Self-Help Booklet)
❑ Secondhand Smoke Brochure
❑ Familydoctor.org information
❑ Other:

FOLLOW-UP PLAN

❑ Fax referral to quitline
❑ Referred to cessation program: _____
❑ Follow-up visit in 2 weeks
❑ Staff to follow up in _____ weeks
❑ Quit date call: _____
❑ Address at next visit

APPENDIX I: Pharmalogic Product Guide

FDA-Approved Tobacco-Cessation Medications (Rx for Change)

http://www.ashp.org/Import/PRACTICEANDPOLICY/PublicHealthResourceCenters/TobaccoCessation/TobaccoCessationPharmacologicProductGuide.aspx

Pharmacologic Product Guide: FDA-Approved Medications

Rx for Change

		Nicotine Replacement Therapy (NRT) Formulations				Bupropion SR	Varenicline
		Gum	Lozenge	Transdermal Patch	Nasal Spray	Oral Inhaler	
Product		**Nicorette[1], Generic** OTC 2 mg, 4 mg original, cinnamon, fruit, mint (various), orange	**Commit[1], Generic** OTC 2 mg, 4 mg cappuccino, cherry, original (light-mint), mint	**NicoDerm CQ[1], Generic[2]** OTC (NicoDerm CQ, generic) Rx (generic) 7 mg, 14 mg, 21 mg (24-hour release)	**Nicotrol NS[3]** Rx Metered spray 0.5 mg nicotine in 50 mcL aqueous nicotine solution	**Nicotrol Inhaler[3]** Rx 10 mg cartridge delivers 4 mg inhaled nicotine vapor	**Zyban[1], Generic** Rx 150 mg sustained-release tablet	**Chantix[3]** Rx 0.5 mg, 1 mg tablet
Precautions		■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Temporomandibular joint disease ■ Pregnancy[4] and breastfeeding ■ Adolescents (<18 years)	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Pregnancy[4] and breastfeeding ■ Adolescents (<18 years)	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Pregnancy[4] (Rx formulations, category D) and breastfeeding ■ Adolescents (<18 years)	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis) ■ Severe reactive airway disease ■ Pregnancy[4] (category D) and breastfeeding ■ Adolescents (<18 years)	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Bronchospastic disease ■ Pregnancy[4] (category D) and breastfeeding ■ Adolescents (<18 years)	■ Concomitant therapy with medications or medical conditions known to lower the seizure threshold ■ Severe hepatic cirrhosis ■ Pregnancy[4] (category C) and breastfeeding ■ Adolescents (<18 years) **Contraindications:** ■ Seizure disorder ■ Concomitant bupropion (e.g., Wellbutrin) therapy ■ Current or prior diagnosis of bulimia or anorexia nervosa ■ Simultaneous abrupt discontinuation of alcohol or sedatives (including benzodiazepines) ■ MAO inhibitor therapy in previous 14 days	■ Severe renal impairment (dosage adjustment is necessary) ■ Pregnancy[4] (category C) and breastfeeding ■ Adolescents (<18 years) **Warnings:** ■ Neuropsychiatric symptoms (behavior changes, agitation, depressed mood, suicidal ideation or behavior) ■ Safety and efficacy have not been established in patients with serious psychiatric illness
Dosing		≥25 cigarettes/day: 4 mg <25 cigarettes/day: 2 mg Week 1–6: 1 piece q 1–2 hours Week 7–9: 1 piece q 2–4 hours Week 10–12: 1 piece q 4–8 hours ■ Maximum, 24 pieces/day ■ Chew each piece slowly ■ Park between cheek and gum when peppery or tingling sensation appears (~15–30 chews) ■ Resume chewing when taste or tingle fades ■ Repeat chew/park steps until most of the nicotine is gone (taste or tingle does not return; generally 30 min) ■ Park in different areas of mouth ■ No food or beverages 15 min before or during use ■ Duration: up to 12 weeks	1st cigarette ≤30 minutes after waking: 4 mg 1st cigarette >30 minutes after waking: 2 mg Week 1–6: 1 lozenge q 1–2 hours Week 7–9: 1 lozenge q 2–4 hours Week 10–12: 1 lozenge q 4–8 hours ■ Maximum, 20 lozenges/day ■ Allow to dissolve slowly (20–30 minutes) ■ Nicotine release may cause a warm, tingling sensation ■ Do not chew or swallow ■ Occasionally rotate to different areas of the mouth ■ No food or beverages 15 minutes before or during use ■ Duration: up to 12 weeks	≥10 cigarettes/day: 21 mg/day x 4 weeks (generic) 6 weeks (NicoDerm CQ) 14 mg/day x 2 weeks 7 mg/day x 2 weeks <10 cigarettes/day: 14 mg/day x 6 weeks 7 mg/day x 2 weeks ■ May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) ■ Duration: 8–10 weeks	1–2 doses/hour (8–40 doses/day) One dose = 2 sprays (one in **each** nostril); each spray delivers 0.5 mg of nicotine to the nasal mucosa ■ Maximum – 5 doses/hour – 40 doses/day ■ For best results, initially use at least 8 doses/day ■ Patients should not sniff, swallow, or inhale through the nose as the spray is being administered ■ Duration: 3–6 months	6–16 cartridges/day Individualize dosing; initially use 1 cartridge q 1–2 hours ■ Best effects with continuous puffing for 20 minutes ■ Initially use at least 6 cartridges/day ■ Nicotine in cartridge is depleted after 20 minutes of active puffing ■ Patient should inhale into back of throat or puff in short breaths ■ Do NOT inhale into the lungs (like a cigarette) but "puff" as if lighting a pipe ■ Open cartridge retains potency for 24 hours ■ Duration: 3–6 months	150 mg po q AM x 3 days, then 150 mg po bid ■ Do not exceed 300 mg/day ■ Patients should begin therapy 1–2 weeks **prior** to quit date ■ Allow at least 8 hours between doses ■ Avoid bedtime dosing to minimize insomnia ■ Dose tapering is not necessary ■ Can be used safely with NRT ■ Duration: 7–12 weeks, with maintenance up to 6 months in selected patients	Days 1–3: 0.5 mg po q AM Days 4–7: 0.5 mg po bid Weeks 2–12: 1 mg po bid ■ Patients should begin therapy 1 week **prior** to quit date ■ Take dose after eating with a full glass of water ■ Dose tapering is not necessary ■ Nausea and insomnia are side effects that are usually temporary ■ Duration: 12 weeks; an additional 12 week course may be used in selected patients

	Nicotine Replacement Therapy (NRT) Formulations					Bupropion SR	Varenicline
	Gum	Lozenge	Transdermal Patch	Nasal Spray	Oral Inhaler		
Adverse Effects	▪ Mouth/jaw soreness ▪ Hiccups ▪ Dyspepsia ▪ Hypersalivation ▪ Effects associated with incorrect chewing technique: – Lightheadedness – Nausea/vomiting – Throat and mouth irritation	▪ Nausea ▪ Hiccups ▪ Cough ▪ Heartburn ▪ Headache ▪ Flatulence ▪ Insomnia	▪ Local skin reactions (erythema, pruritus, burning) ▪ Headache ▪ Sleep disturbances (insomnia, abnormal/vivid dreams); associated with nocturnal nicotine absorption	▪ Nasal and/or throat irritation (hot, peppery, or burning sensation) ▪ Rhinitis ▪ Tearing ▪ Sneezing ▪ Cough ▪ Headache	▪ Mouth and/or throat irritation ▪ Cough ▪ Headache ▪ Rhinitis ▪ Dyspepsia ▪ Hiccups	▪ Insomnia ▪ Dry mouth ▪ Nervousness/difficulty concentrating ▪ Rash ▪ Constipation ▪ Seizures (risk is 1/1,000 [0.1%])	▪ Nausea ▪ Sleep disturbances (insomnia, abnormal/vivid dreams) ▪ Constipation ▪ Flatulence ▪ Vomiting ▪ Neuropsychiatric symptoms (see Precautions, above)
Advantages	▪ Might satisfy oral cravings ▪ Might delay weight gain ▪ Patients can titrate therapy to manage withdrawal symptoms ▪ Variety of flavors are available	▪ Might satisfy oral cravings ▪ Might delay weight gain ▪ Easy to use and conceal ▪ Patients can titrate therapy to manage withdrawal symptoms ▪ Variety of flavors are available	▪ Provides consistent nicotine levels over 24 hours ▪ Easy to use and conceal ▪ Once daily dosing associated with fewer compliance problems	▪ Patients can titrate therapy to rapidly manage withdrawal symptoms	▪ Patients can titrate therapy to manage withdrawal symptoms ▪ Mimics hand-to-mouth ritual of smoking (could also be perceived as a disadvantage)	▪ Easy to use; oral formulation might be associated with fewer compliance problems ▪ Can be used with NRT ▪ Might be beneficial in patients with depression	▪ Easy to use; oral formulation might be associated with fewer compliance problems ▪ Offers a new mechanism of action for patients who have failed other agents
Disadvantages	▪ Need for frequent dosing can compromise compliance ▪ Might be problematic for patients with significant dental work ▪ Patients must use proper chewing technique to minimize adverse effects ▪ Gum chewing may not be socially acceptable	▪ Need for frequent dosing can compromise compliance ▪ Gastrointestinal side effects (nausea, hiccups, heartburn) might be bothersome	▪ Patients cannot titrate the dose to acutely manage withdrawal symptoms ▪ Allergic reactions to adhesive might occur ▪ Patients with dermatologic conditions should not use the patch	▪ Need for frequent dosing can compromise compliance ▪ Nasal/throat irritation may be bothersome ▪ Patients must wait 5 minutes before driving or operating heavy machinery ▪ Patients with chronic nasal disorders or severe reactive airway disease should not use the spray	▪ Need for frequent dosing can compromise compliance ▪ Initial throat or mouth irritation can be bothersome ▪ Cartridges should not be stored in very warm conditions or used in very cold conditions ▪ Patients with underlying bronchospastic disease must use the inhaler with caution	▪ Seizure risk is increased ▪ Several contraindications and precautions preclude use in some patients (see Precautions, above)	▪ May induce nausea in up to one third of patients ▪ Post-marketing surveillance data indicate potential for neuropsychiatric symptoms (see Precautions, above)
Cost/Day[5]	2 mg: $3.28–$6.58 (9 pieces) 4 mg: $4.31–$6.58 (9 pieces)	2 mg: $3.66–$5.26 (9 pieces) 4 mg: $3.66–$5.26 (9 pieces)	$1.90–$3.89 (1 patch)	$4.10 (8 doses)	$7.32 (6 cartridges)	$3.62–$7.78 (2 tablets)	$4.90–$5.18 (2 tablets)

[1] Marketed by GlaxoSmithKline.
[2] Transdermal patch formulation previously marketed as Habitrol.
[3] Marketed by Pfizer.
[4] The U.S. Clinical Practice Guideline states that pregnant smokers should be encouraged to quit without medication based on insufficient evidence of effectiveness and hypothetical concerns with safety. Pregnant smokers should be offered cessation counseling interventions that exceed minimal advice to quit.
[5] Average wholesale price from Medi-Span Electronic Drug File. Indianapolis, IN: Wolters Kluwer Health, April 2009.

Abbreviations: Hx, history; MAO, monoamine oxidase; NRT, nicotine replacement therapy; OTC, (over-the-counter) non-prescription product; Rx, prescription product.

For complete prescribing information, please refer to the manufacturers' package inserts.

Updated April 17, 2009.

APPENDIX J: Sample Standing Orders to Initiate Tobacco-Cessation Treatment

UMASS MEMORIAL MEDICAL CENTER

PHYSICIAN'S ORDERS

NICOTINE DEPENDENCE TREATMENT

NAME:

ADDRESS:

BIRTHDATE/AGE: SEX:

MEDICAL RECORD NUMBER:

PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

3

Height Inches _____ Cm. _____	**Weight** Lbs. _____ Kg. _____
ALLERGIES: ☐ YES (LIST BELOW) OR ☐ LISTED PREVIOUSLY ☐ NONE KNOWN	

PROVIDER TO SIGN AND PLACE PAGER NUMBER LEGIBLY UNDER EACH ORDER SET
INDICATE CHOICE OF ORDER OPTIONS BY USING X IN CHECK BOXES ☒

Admit to/Change Attending To: _____ **Pager:** _____
(First) (Last)

Resident: _____ **Pager:** _____ **Overnight coverage:** _____ **Pager:** _____

Intern/NP (First Call): _____ **Pager:** _____ **House Staff Coverage:** ☐ **Yes** ☐ **No (uncovered)**

ALL OTHER ORDERS	DATE	TIME	MEDICATION ORDERS ONLY
☐ Consult Tobacco Consultation Service (ext 44372)			**Note: Please refer to Adult Nicotine Withdrawal Clinical**
☐ Pt. declines consultation with Tobacco Consultation Service.			**Practice Guideline for additional information.**
			☐ Nicotine Patch _____mg. Remove old patch and apply new
DOSING GUIDELINES:			patch daily.
☐ Nicotine Patch:			
<10 cigarettes a day - 7mg patch			☐ Nicotine Gum _____mg. Chew and "park" in cheek for 15-30
10-19 cigarettes a day or < 1 can/pouch smokeless per week -			minutes every 1 hour prn (dosage range 9-24 pieces/day) to
14 mg patch			avoid withdrawal.
20-30 cigarettes a day or 1 can/pouch smokeless tobacco per			
week - 21 mg patch			☐ Nicotine Lozenge _____mg. Use 1 lozenge every 1 hour PRN
For heavy users (over 30 cigarettes a day or over 1 can/pouch			(max dose 5 lozenges in 6 hrs or 20 lozenges in 24 hrs) to
per week consider adding a prn gum or lozenge to avoid with-			avoid withdrawal symptoms
drawal symptoms			
31-40 cigarettes / day or 2 cans/pouches /week use 21mg			☐ Bupropion SR 150 mg PO daily for 3 days, then increase to
plus 14mg patch			150mg PO twice daily. (May use in conjunction with NRT)
Over 40 cigarettes / day or over 3 cans/pouches per week -			Do not use if your patient has a history of a seizure disorder,
two 21 mg patches (total 42mg)			or increased risk of seizures, h/o anorexia/bulemia, or is tak-
			ing an MAO inhibitor
☐ Nicotine Gum:			
<24 cigarettes /day - 2mg gum			☐ Varenicline (Chantix) 0.5 mg PO daily on days 1-3, then 0.5
≥ 24 cigarettes / day - 4mg gum			mg PO twice daily on days 4-7, then 1 mg PO twice daily
			starting on day 8 (dosage adjustment necessary with severe
☐ Nicotine Lozenge:			renal impairment) May use in conjunction with NRT (avoid
<24 cigarettes / day - 2mg lozenge			nicotine patch due to high risk of nausea.) during first week of
≥ 24 cigarettes / day - 4mg lozenge			treatment.
			☐ Other

Signature of MD/DO/NP/PA:_____ Printed Name:_____ Pager:_____

Signature of RN: _____ Printed Name: _____ Date: _____ Time: _____

Prohibited Abbreviations: U, qd, qod, IU, .1 (write 0.1), 1.0 (write 1), MS, MSO4, MgSO4, µg, AS, AD, AU, OS, OD, OU, tiw

NS ORDER 0536 Rev 5/08

3

APPENDIX K: Enforcement Scripts

Be friendly and respectful when informing employees, patients, or visitors about the tobacco-free policy. Remember, tobacco-use is an addiction, which can be triggered by stress. Our tobacco-free policy is designed to provide a safe and healthy environment and model healthy behaviors. As you enforce the policy, provide as much help as possible: First educate people about the policy. Then, as appropriate, offer symptom relief for tobacco-users during their stay, encourage tobacco-users to quit when they are ready, or direct visitors to places where they are allowed to smoke. Keep discussions about the tobacco-use policy brief and non-confrontational.

Schedulers, registration and physician offices to patients:

"I'd like to let you know that for the health of patients, employees and visitors, ORGANIZATION does not allow tobacco-use on campus. That includes all property, grounds and parking area. Under our policy, a patient cannot leave the hospital to smoke. However, if you are interested, we can provide nicotine-replacement therapy to relieve your symptoms. We also can provide nicotine gum for family members and visitors who request it."

Employees to patients, visitors, contractors, paramedics, police officers, firefighters, tenants, vendors, or volunteers:

Scenario: Someone lights up on campus:

"Hi. I need to let you know that for the health of our patients, employees and visitors, ORGANIZATION does not allow tobacco-use on campus. Please put out your cigarette and dispose of it. Here's a card that explains our policy and offers some other options."

Scenario: Someone is smoking in a car, truck or other vehicle in the parking lot.

"Hello. I just wanted to let you know that this parking lot is part of our smoke-free campus. Here is an information card that explains our policy and gives you some other options."

Employee to employee:

Scenario: Employee says, "If I can't smoke on campus, I'll just leave when I need a smoke."

"That's probably something you need to talk about with your supervisor."

Employee to patient:

Scenario: Patient says, "If I can't smoke on campus, I'll just leave your campus."

"I'm sorry, but for your safety, patients are asked not to leave ORGANIZATION's property. If you'd like, we can assist you with other options for your nicotine cravings."

Scenario: Patient has been told, "If you cooperate with this procedure, I'll let you smoke."

"I'm sorry you got that information. ORGANIZATION now has a tobacco-free campus. We can see about providing you with a patch or some gum to help you with your cravings."

Potential challenges with employees, patients, or visitors

Scenario: Smoker becomes irate and out of control, saying, "I need a cigarette."

"It sounds like things are tough for you right now. We don't make exceptions to our policy, for the health and safety of everyone. I can offer you nicotine gum or lozenges that will make it easier for you not to smoke. Or, if you prefer, I can show you the quickest way off our smoke-free area. Is there anything else I can do?

(Have nicotine gum and lozenges available for staff members, families and visitors on each nursing unit or at another designated site.)

Scenario: Smoker, reminded of the policy, declares: "I'm going to smoke here anyway!"

"Sorry you're having a rough time. (If smoker seems agitated): *Could you please pick up your cigarette butt when you're done. Here is an information card that explains our policy and gives you some other options." Then walk away.*

Scenario: Smoker responds: "Then where am I supposed to smoke?"

"In order to provide a healthier environment, ORGANIZATION no longer permits smoking anywhere on the campus. I can show you where you can get some free nicotine lozenges, but if you wish to smoke, you will need to leave the campus. I can show you the quickest way off our smoke-free area if you like. Here is an information card that explains our decision and gives you some other options."

Scenario: Tobacco-user rants about the tobacco-free policy.

"Perhaps you should tell a manager how you feel about this policy. I suggest you call NAME OF MANAGER IN CHARGE.

Scenario: Smoker says, "If I can't smoke here, I'll go to another hospital."

"I'd hate to see you leave. Our policy is designed to protect the health of patients, employees and visitors and (depending upon the locale…) *is similar to other hospitals in this area. While you're here, we can make it easier for you not to smoke by giving you nicotine gum or lozenges. Here is an information card that explains our policy and gives you some options."*

APPENDIX L: How Much Will it Cost?

CATEGORY	OPTIONS	QUANTITY	PRICE	TOTAL
Communications Campaign	Banners: Posters with tear-offs: Flyers: Brochures: Buttons: Video:			
Website Development	For employee program			
Copying, duplication	Training handouts			
Tobacco-Free Signs	Metal signs Removal of ashtrays			
Meetings and Celebration	Food and drink for meetings Celebration of new policy			
Quitting help for employees	Nicotine patches and lozenges for employees wanting to quit Cessation counseling			
Support packs for visitors				
Total				

APPENDIX M: Sample Patient Release Form

(INSERT LOGO)

Leaving the Unit for Smoking Form
RELEASE

I have been informed that (ORGANIZATION) Medical Center has a smoke-free policy.

It is my desire to leave the unit to smoke.

I understand that my physician has been notified, and that certain medications and/or treatments will be discontinued until my return to the floor.

I understand that leaving to smoke is against medical advice.

I assume all risk of injury that may occur to me, the patient, while smoking. I assume all risk of delayed treatments that may occur due to my absence to smoke.

I understand and accept the risks and/or any complications that may arise as the result of leaving the unit to smoke.

I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE (ORGANIZATION), its agents, employees, and physicians from any and all liability, claims, demands or injury, including death, that may be sustained by me in leaving the unit to smoke.

_____

(Patient Name) (Date and Time)

_____

(MD/RN Signature) (Date and Time)

☐ ***Patient has been informed of hospital policy and refuses to sign form.***

ORGANIZATION

ADDRESS

PHONE NUMBER

FAX

E-MAIL OF PERSON RESPONSIBLE

APPENDIX N: Sample Clinical Practice Guideline

From UMass Memorial Medical Center

UMass Memorial Medical Center

Clinical Practice Guideline

Guideline Name: Adult Nicotine Withdrawal Guideline **Effective Date: 5/27/08**

I. OWNER: TOBACCO CONSULTATION SERVICE SUBGROUP OF THE TOBACCO-FREE INITIATIVE WOPRKGROUP

BACKGROUND & AIM:

The Tobacco Free Initiative mandates that, as of May 27, 2008, all UMMMC facilities and grounds will be smoke free. In keeping with this mandate, all inpatients will be screened by the admitting physician/LIP for nicotine dependence. If nicotine dependence therapy is warranted, it will be ordered using the Nicotine Dependence Treatment Order Sheet. The goal of this policy to assist all patients in a quit attempt while keeping them free of uncomfortable withdrawal symptoms during their hospitalization.

Medication usage in treating nicotine dependence parallels other addictions in treating acute withdrawal (detoxification), protracted withdrawal, and maintenance. Primary medications are Nicotine Replacement Therapy (NRT); patch, gum, spray, inhaler, and lozenge as well as Bupropion and Varenicline (Chantix). Utilizing these treatments to help manage required abstinence periods and as part of nicotine dependence treatment is routine standard of care[1].

II. CLINICAL PRACTICE GUIDELINE:

RESPONSIBILITY:

Physician/Licensed Independent Practitioner (MD/LIP)

a. Identifies and documents tobacco use (cigarettes, cigars, pipe, smokeless tobacco) as part of the admitting History & Physical
b. Uses the Nicotine Dependence Treatment Order form to order the appropriate pharmacologic therapy for inpatient tobacco cessation.
c. Based upon the importance of the policy and the message that it conveys to our patients, orders may no longer be written allowing patients to use tobacco while on the grounds of any UMMMC facility.

Registered Nurse (RN)

a. Counsels the patient that UMMMC and its grounds are Tobacco Free and the use of tobacco on hospital property is prohibited.
b. Encourages patient and family to send home all tobacco and tobacco-related products as to have them in their possession would be a trigger to use.
c. Administers ordered medications per hospital policy.
d. Notifies physician/LIP of inadequate relief of nicotine withdrawal symptoms.
e. Implements patient education on the health risks of smoking/smokeless tobacco and the benefits of quitting.
f. Continues to offer a referral to Quitworks per protocol.

PROCEDURE:

1. Physician/LIP will screen for nicotine dependence as part of the Admission History & Physical. Document findings, including nicotine delivery system (cigarettes, cigars, pipe, smokeless tobacco, etc. or combination), and number of cigarettes smoked/smokeless tobacco chewed per day.
2. Complete Nicotine Dependence Treatment Order Sheet, specifying pharmacologic agent of choice and need for Tobacco Consultation Liaison Service.
3. Document success with pharmacologic agent of choice in Discharge Summary. Include instructions for continuation of pharmacologic agent and prescriptions at discharge. NRT should be prescribed for at least 3 months (not greater than a year).

AVAILABLE THEURAPEUTIC OPTIONS:

NICOTINE REPLACEMENT THERAPY (NRT):

Indications and Contraindications for NRT:

Pregnant and Lactating Smokers: Patches are not recommended for lactating women. For Pregnant women intermittent dosing products may be preferable as these provide a lower daily dose of nicotine than patches. However, a patch is preferred if the woman is suffering from nausea. Patches should not be used during night-time sleep. [2]

Cardiovascular Patients: NRT is safer than smoking in dependent smokers, even in those patients who are acutely ill. However, until cautions regarding Cardiovascular disease (CVD) are removed from NRT labeling, the following recommendations should be followed: In patients who have experienced a serious cardiovascular event, or

hospitalization for a cardiovascular complaint in the previous 4 weeks or where they suffer with uncontrolled hypertension, care should be used in prescribing NRT.[3] Use of NRT in cardiovascular patients in general does not appear to be associated with an increased risk of MI.[4]

Nicotine replacement therapy can be administered to Acute Coronary Syndrome (ACS) patients as soon as it can be determined that the patient is:

- Clinically stable,
- Exhibits little risk of cardiac ischemia
- Has been successfully revascularized.

NOTE: Withhold in patients with unstable arrhythmia, vasospastic conditions, uncontrolled CHF or unstable angina.

Patients with a history of multiple quit attempts should be offered a combination of a patch and gum.

EXCLUSIVITY CRITERIA:
Known Allergy to Nicotine Product: (specify which) _____

Active Peptic Ulcer Disease: Both nicotine gum and transdermal patches should be used in caution in patients with active peptic ulcer disease.

Severe Dermatologic Conditions: Nicotine transdermal patches should not be used in patients with severe dermatologic conditions.

RECOMMENDED DOSAGE:

Suggested NRT Dosing for ACS Patients[5]

For Patients who smoke:	Dose
<5 cigarettes/day	None
5-10 cigarettes/day	14 mg / day
11-20 cigarettes/day	21 mg / day
21-40 cigarettes/day	21 mg / day

Suggested NRT Dosing for GENERAL POPULATION[6]

DAILY CIGARETTE USE	PIPE /SPIT/SMOKELESS TOBACCO	PATCH DOSE PER DAY
< 10 cigarettes		7mg patch
10 – 19 cigarettes	<1 can / pouch per week	14 mg patch
20 – 30 cigarettes	1 can / pouch per week	21 mg patch

For Heavy Tobacco Users (>30 cigarettes a day or > 1 can/pouch per week), consider adding a prn gum or lozenge.

Nicotine Gum: Nicotine gum 2 mg can be used in conjunction with other nicotine replacement therapies. 1 piece every 1-2 hours not to exceed 24 pieces a day[7].

If necessary, may use multiple patches:

DAILY CIGARETTE USE	PIPE/SPIT/SMOKELESS TOBACCO	PATCH DOSE PER DAY
31 – 40 cigarettes	2 cans/ pouches per week	21mg patch plus 14 mg patch (total 35 mg)
> 40 cigarettes	> 3 cans/ pouches per week	TWO 21 mg patches (total 42 mg)

Note: There is only a small marginal benefit in quit rates when using multiple patches to equal >21 mg/day.

May treat with Hydrocortisone 1% cream if itching, redness, or burning occurs.

GUM

☐ **Nicotine gum _____mg: Chew and "park" in cheek for 15-30 minutes every 1 hour PRN (dosage range 9-24 pieces/day).**
< 24 cigarettes per day - 2 mg
≥24 cigarettes per day - 4 mg

LOZENGES

☐ **Nicotine lozenge _____ mg: Use 1 lozenge every 1 hour PRN (max dose 5 lozenges in 6 hours or 20 lozenges in 24 hours).**
< 24 cigarettes per day - 2 mg
≥ 24 cigarettes per day - 4 mg (use if patient normally smokes within 30 minutes after waking)

NASAL SPRAY

☐ **Nicotine Nasal Spray (Nicotrol NS) 10mg/ml: Initial Dose: 1-2 doses per hour. One dose = 2 sprays (one in each nostril). Maximum dose is 5 doses per hour or 40 doses per day.**

INHALER

☐ **Nicotine Inhaler (Nicotrol Inhaler) 10mg/cartridge: Initial Dose: 6-16 cartridges per day, initially using 1 cartridge every 1-2 hours. Each cartridge is effective for 20 minutes of active puffing. Maximum dose is 16 cartridges per day.**

Other Smoking Cessation Treatments:

BUPROPION SR: Bupropion SR may be used to alleviate symptoms of nicotine withdrawal. Dosing should be 150 mg/day p.o. for 3 days, then 150 mg p.o. bid for 7 to 12 weeks. If insomnia is experienced the order should be written as 150mg p.o. in the morning and give the second dose earlier in the evening at 5pm. This drug does not attain therapeutic blood levels for 1 to 2 weeks so this should be started as soon as possible[8]. **May use in conjunction with Nicotine replacement therapy.**

Do not use Bupropion SR if any of the following apply:

- **History of seizure disorder or increased risk of seizures**
- **History of anorexia or bulimia**
- **Patient is taking an MAO inhibitor**

VARENICLINE (CHANTIX)[9]: The most successful use of Varenicline (Chantix) is for the patient to set a quit date and then dosing should start one week before this date. Patients should be treated for 12 weeks and an additional 12 weeks of treatment can be added for patients who successfully have stopped smoking and need additional support.

Contraindications and Cautions:

Renal Impairment:
Dosage adjustment necessary with severe renal impairment (see dosing recommendations).

Age:
Varenicline is not recommended for patients under the age of 18.

Combining with other Therapeutic Options:
Using Varenicline with Bupropion and other smoking cessation therapies has not been studied, so this is not recommended.
May use in conjunction with Nicotine replacement therapy during first week of treatment. Avoid Nicotine patch due to higher risk of nausea.

Pregnancy:
This is a Pregnancy Category C drug. It is not recommended for nursing mothers. There are no adequate and well controlled studies in pregnant women. Varenicline should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Usual Dosing:

Treatment Duration	Dosing
Days 1 – 3:	0.5 mg once daily
Days 4 – 7:	0.5 mg twice daily
Day 8 – End of Treatment	1 mg twice daily

Dosing for Patients with Impaired Renal Function:

Impairment	Dosing
Mild to moderate	Use usual dosing – no adjustment needed
Severe	Starting dose: 0.5 mg once daily. Then Titrate as needed to: Min dose of 0.5 mg twice a day.
End-Stage Renal Disease (hemodialysis)	Max dose of 0.5 mg once daily if tolerated well.

ASSOCIATED TOOLS:

Nicotine Dependence Treatment Order Form

REFERENCES:

[1] Ziedonis, D., Zammarelli, L., Seward, G., Oliver, K., Guydish, J., Hobart, M., & Meltzer, B. Addressing Tobacco through Organizational Change: A Case Study of an Addiction Treatment Organization. Journal of Psychoactive Drugs, Vol 39 (4) 451-459.

[2] Action on Smoking and Health (ASH), UK, Guidelines for Healthcare Professionals on using Nicotine Replacement Therapy for smokers not yet ready to stop smoking, February 2007.

[3] Nicotine replacement therapy in patients with cardiovascular disease: guidelines for health professionals; Hayden McRobbie & Peter Hajek; Addition (2001) 96, 1547-1551

[4] Risk of Acute First Myocardial Infarction and Use of Nicotine Patches in a General Population; Kimmel, Berlin, Miles, Jaskowiak, Carson, Strom; Journal of the American College of Cardiology, Vol. 37, No 5, 2001.

[5] Cardiovascular Center Pocket Guide, University of Michigan Board of Regents

[6] Nicotine Replacement Therapy Physician Orders, Riverside Methodist Hospital

[7] http://www.quitsolutions.org/quit-solutions_HCR_Nicotine-Replacement-Therpay.asp

[8] Cardiovascular Center Pocket Guide, Guidelines for the Use of Nicotine Replacement Therapy (NRT) and Bupropion Hydrochloride (Wellbutrin SR, Zyban) with Acute Coronary Syndrome (ACS) Patients – University of Michigan Board of Regents, 2005

[9] Chantix Product Information Sheet, Pfizer Labs, 2006

APPENDIX O: Discharge Plan Form Template

Adapted from Treating Tobacco-use and Dependence in Hospitalized Smoker,
University of Wisconsin Center for Tobacco Research and Intervention

Patient: _____

ID number: _____

Referred by: _____

Discharge plan:

Quit date: _____

Consult visit date: _____

Comments: _____

_____

_____

_____

_____

Medications prescribed:

_____

_____

_____

_____

Follow-up plan:

_____

_____

_____

Call from hospital within 15 to 30 days to discuss counseling, medications, quitting status and questions or concerns.

Convenient telephone-based services to help you quit or sustain your efforts are available through a tobacco quitline, 1-800-QUIT NOW

Nicotine Anonymous offers 12-Step groups, similar and compatible with Alcoholics Anonymous, which also may be helpful. Check *http://www.nicotine-anonymous.org/*

Signature: _____

Date: _____

HCPCS, CPT, & ICD-9 Codes
Related to Tobacco Cessation Counseling

MEDICARE SMOKING CESSATION BENEFIT

For an explanation of benefits, see the document titled "Tobacco Cessation Counseling – 2011 Medicare Benefits."

ICD-9 diagnosis codes (All codes with .x or .xx require fourth and fifth digits. See the ICD-9 manual for complete descriptions.):

Report 305.1 Tobacco use disorder **and** related condition or interference with the effectiveness of medications*:

140.x	Malignant neoplasm, lip
141.x	Malignant neoplasm, tongue
143.x	Malignant neoplasm, gum
144.x	Malignant neoplasm, floor of mouth
145.x	Malignant neoplasm, other parts mouth
146.x	Malignant neoplasm, oropharynx
147.x	Malignant neoplasm, nasopharynx
148.x	Malignant neoplasm, hypopharynx
149.x	Malignant neoplasm, other and ill-defined sites within the lip, oral cavity, and pharynx
150.x	Malignant neoplasm, esophagus
151.x	Malignant neoplasm, stomach
157.x	Malignant neoplasm, pancreas
161.x	Malignant neoplasm, larynx
162.x	Malignant neoplasm, trachea, bronchus and lung
180.x	Malignant neoplasm, cervix uteri
188.x	Malignant neoplasm, bladder
189.0	Malignant neoplasm, kidney except pelvis
205.xx	Acute myeloid leukemia
231.x	Carcinoma in situ respiratory system
250.xx	Diabetes mellitus
296.xx	Episodic mood disorders
300.4	Dysthymic disorder
311	Depressive disorder, not elsewhere classified
366.xx	Cataract
401.x	Essential hypertension
402.xx	Hypertensive heart disease
403.xx	Hypertensive chronic kidney disease
404.xx	Hypertensive chronic heart and kidney disease
405.xx	Secondary hypertension
410.xx	Acute myocardial infarction
411.xx	Other acute and subacute ischemic heart disease
412	Old myocardial infarction
413.x	Angina pectoris
414.0x	Coronary atherosclerosis
415.0	Acute cor pulmonale

415.1x	Pulmonary embolism and infarction
416.x	Chronic pulmonary heart disease
420.xx	Acute pericarditis
421.x	Acute and subacute endocarditis
422.xx	Acute myocarditis
423.x	Other diseases of the pericardium
424.xx	Other diseases of the endocardium
425.x	Cardiomyopathy
426.xx	Conduction disorders
427.xx	Cardiac dysrhythmias
428.xx[1]	Heart failure
429.xx	Other ill-defined heart disease
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432.x	Other and unspecified intracranial bleeding
433.xx	Occlusion and stenosis of precerebral arteries
434.xx	Occlusion of cerebral arteries
435.x	Transient cerebral ischemia
436	Acute, but ill-defined, cerebrovascular disease
437.x	Other and ill-defined cerebrovascular disease
438.xx	Late effects of cerebrovascular disease
440.xx	Atherosclerosis
441.xx	Aortic aneurysm and dissection
442.xx	Other aneurysm
443.xx	Other peripheral vascular disease
444.xx	Arterial embolism and thrombosis
445.xx	Atheroembolism
461.x	Acute sinusitis
462	Acute pharyngitis
463	Acute tonsillitis
464.xx	Acute laryngitis and tracheitis
465.x	Acute upper respiratory infections of multiple or unspecified sites
466.xx	Acute bronchitis and bronchiolitis
472.x	Chronic pharyngitis and nasopharyngitis
473.x	Chronic sinusitis
474.xx	Chronic disease of tonsils and adenoids
476.x	Chronic laryngitis and laryngotracheitis
477.x	Allergic rhinitis
478.xx	Other diseases of upper respiratory tract
480.x	Viral pneumonia
481	Pneumococcal pneumonia
482.xx	Other bacterial pneumonia
483.x	Pneumonia due to other specified organism
484.x	Pneumonia in infectious diseases classified elsewhere
485	Bronchopneumonia, organism unspecified
486	Pneumonia, organism unspecified
487.0	Influenza with pneumonia
490	Bronchitis, not specified as acute or chronic
491.xx	Chronic bronchitis

[1] If heart failure is due to hypertension, code first 402.0-402.9 with fifth digit 1 or code 404.0-404.9 with fifth digit 1 or 3.

415.1x	Pulmonary embolism and infarction
416.x	Chronic pulmonary heart disease
420.xx	Acute pericarditis
421.x	Acute and subacute endocarditis
422.xx	Acute myocarditis
423.x	Other diseases of the pericardium
424.xx	Other diseases of the endocardium
425.x	Cardiomyopathy
426.xx	Conduction disorders
427.xx	Cardiac dysrhythmias
428.xx[1]	Heart failure
429.xx	Other ill-defined heart disease
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432.x	Other and unspecified intracranial bleeding
433.xx	Occlusion and stenosis of precerebral arteries
434.xx	Occlusion of cerebral arteries
435.x	Transient cerebral ischemia
436	Acute, but ill-defined, cerebrovascular disease
437.x	Other and ill-defined cerebrovascular disease
438.xx	Late effects of cerebrovascular disease
440.xx	Atherosclerosis
441.xx	Aortic aneurysm and dissection
442.xx	Other aneurysm
443.xx	Other peripheral vascular disease
444.xx	Arterial embolism and thrombosis
445.xx	Atheroembolism
461.x	Acute sinusitis
462	Acute pharyngitis
463	Acute tonsillitis
464.xx	Acute laryngitis and tracheitis
465.x	Acute upper respiratory infections of multiple or unspecified sites
466.xx	Acute bronchitis and bronchiolitis
472.x	Chronic pharyngitis and nasopharyngitis
473.x	Chronic sinusitis
474.xx	Chronic disease of tonsils and adenoids
476.x	Chronic laryngitis and laryngotracheitis
477.x	Allergic rhinitis
478.xx	Other diseases of upper respiratory tract
480.x	Viral pneumonia
481	Pneumococcal pneumonia
482.xx	Other bacterial pneumonia
483.x	Pneumonia due to other specified organism
484.x	Pneumonia in infectious diseases classified elsewhere
485	Bronchopneumonia, organism unspecified
486	Pneumonia, organism unspecified
487.0	Influenza with pneumonia
490	Bronchitis, not specified as acute or chronic
491.xx	Chronic bronchitis

[1] If heart failure is due to hypertension, code first 402.0-402.9 with fifth digit 1 or code 404.0-404.9 with fifth digit 1 or 3.

APPENDIX Q: Tobacco-Treatment Trainings

Rx for Change: Clinician-Assisted Tobacco Cessation is a free, comprehensive, turn-key, tobacco treatment training program that equips health professionals, students and licensed clinicians with knowledge and skills for assisting patients with quitting. Trainings can be live or on-line and can range from one to 12 hours. *http://rxforchange.ucsf.edu/about.php*

The University of Massachusetts Medical School offers a self-paced on-line basic skills course with continuing education credits for nurses, social workers, health educators, respiratory therapists and certified substance abuse counselors. It also periodically offers a five-day, live intensive tobacco treatment course for health care workers. *http://www.umassmed.edu/tobacco/training/index.aspx*

Mayo Clinic periodically offers four-day trainings for a Tobacco Treatment Specialist Certification and has a distance-learning option as well. *http://mayoresearch.mayo.edu/mayo/research/ndc_education/tts_certification.cfm*

The American Society of Hospital Pharmacists maintains a website with patient materials, articles and trainings at *http://www.ashp.org/DocLibrary/Policy/Tobacco/Educational-Kit.aspx*

The University of Wisconsin's Center for Tobacco Research and Investigation offers on-line continuing education courses for doctors, nurses and pharmacists. The website has videos modeling doctors talking with patients about tobacco use, case studies and materials. *http://www.ctri.wisc.edu/HC.Providers/healthcare_education.htm*

The Alliance for the Prevention and Treatment of Nicotine Addiction (APTNA) lists trainings, resources and links on its website: *http://www.aptna.org/*

The University of Medicine & Dentistry of New Jersey periodically offers a five-day course for health care professionals wanting a certificate in tobacco dependence treatment. *http://www.tobaccoprogram.org/tobspeciatrain.htm*

APPENDIX R: Letter to Neighbor Template

DATE

NAME
TITLE
ADDRESS
CITY, STATE ZIP CODE

Dear *NAME*:

Effective *DATE,* will take a proactive step to implement a tobacco-free policy on all of our campuses. The tobacco ban will apply to all patients, visitors, medical staff members, vendors and employees. This means as of DATE, no tobacco use of any kind will be permitted inside hospital buildings and on parking lots or grounds.

We have talked with employees about possible neighborhood concerns and are confident that most will exercise consideration of you and your property. Though we do not endorse it, we are concerned that some employees may leave the hospital to use tobacco products. If any staff behaviors, whether related to smoking or not, becomes a problem for you *(CHOOSE: OR YOUR EMPLOYEES or THOSE WITH WHOM YOU LIVE),* please contact me at the number below.

As a health care institute, *ORGANIZATION's* primary mission is to protect the health of those in our community, while promoting a culture of healthier living. We are not asking employees to stop using tobacco. However, we are requiring them to refrain from tobacco use during work hours. *ORGANIZATION* is developing programs for employees who choose to quit using tobacco products altogether as well as programs to help get them through their designated shifts. Our patients are our first priority. Thus we are working with our physicians as we develop coping and nicotine treatment strategies.

We appreciate your help and support as we head toward *DATE.*

Sincerely,

NAME OF ADMINISTRATIVE CHAMPION, TITLE
NAME OF FACILITY
TELEPHONE NUMBER OF FACILITY

APPENDIX S: Letter to Physicians Template

Adapted from "Moving Toward a Tobacco-Free Future," Nebraska Hospital Association, Nebraska C.A.R.E.S., and Tobacco-Free Nebraska, 2007. http://www.nhanet.org/publications/tobaccofree.htm

Send on hospital letterhead.

Date

Physician Name
Address
City, State, Zip

Dear Dr. _____

Effective *DATE, NAME OF HOSPITAL* will take a proactive step to implement a tobacco-free policy on all of our campuses. The tobacco ban will apply to all patients, visitors, medical staff members, vendors, and employees. This means as of *DATE*, no tobacco-use of any kind will be permitted inside hospital buildings and on parking lots or grounds.

Please inform patients scheduled for a procedure at our facility that we do not allow tobacco-use by patients or visitors at our hospital or on hospital properties. If you wish, you can provide patients with a flyer that explains our policy or display the flyers in your office. You also are welcome to adapt the attached patient letter.

Research shows that continued tobacco-use can cause problems for hospitalized patients: Smoking retards wound healing, increases infection rates in surgeries and is the most common cause of poor birth outcomes. We hope your conversation with your patient about our policy can lead to a discussion about why, both in the short-term and the long-term, now is a good time for your patient to quit tobacco.

Our patient-treatment protocols will include tobacco-dependence treatment. Whether you assist the patient in quitting or refer him or her to the tobacco quit line, 1-800 QUIT NOW, we will provide relief from nicotine withdrawal during the hospital stay. If the patient chooses, we will assist with quitting. As a partner in health and a skilled professional, we know you will follow-up and provide additional support your patient may need.

ORGANIZATION is not asking patients to stop using tobacco products, but we require them to refrain from its use while in our facility. Patients who insist on leaving the campus to use tobacco must check out of the hospital against medical advice (AMA). They can be re-admitted through *ORGANIZATION's* standard admitting process.

As a healthcare organization, our mission is to protect the health of those in our community while promoting and supporting a culture of healthy living. We appreciate your support as we implement this program. Please call me with any questions, phone number.

Sincerely,

XXX, President and CEO
NAME OF HOSPITAL

APPENDIX T: Letter to Patients Template

Send on medical practice letterhead.

To Our Patients:

Beginning on *DATE, NAME OF HOSPITAL* will adopt a campus-wide, tobacco-free policy. This policy means that patients, visitors, employees and physicians are prohibited from using tobacco products anywhere inside or outside *ORGANIZATION*.

ORGANIZATION has joined hospitals across the nation that have become tobacco-free. This policy has been endorsed by numerous health advocacy groups, including *NAMES OF SUPPORTING ORGANIZATIONS*. It is intended to help *ORGANIZATION* maintain the healthiest possible environment for patients, employees and visitors.

Upon your admission to *ORGANIZATION*, please notify the admissions staff if you use tobacco. This information will be forwarded to clinicians who can help you quit, provide tobacco-abatement products, or discuss alternative resources for you.

Thank you for your cooperation with this *ORGANIZATION* policy and for helping maintain a healthier environment for everyone.

If you choose to quit or cut back on tobacco-use, I am always happy to talk with you about it. You may also consider calling the tobacco quit line, 1-800-QUIT NOW, where trained coaches can help you through the quitting process.

Sincerely,

NAME OF PHYSICIAN

APPENDIX U: Sample Fax Referral Form

WASHINGTON TOBACCO QUIT LINE

FAX REFERRAL FORM Fax Number: 1-800-483-3078

Provider Information: Date: ___/____/____

Health Care Provider Name: _____

Clinic Name: _____

Contact Name (nurse, med. asst., etc.): _____ _____

Fax: (____) _____ - _____ Phone (____) _____ - _____

MD back line: (____) _____ - _____

Provider Authorization and Signature (required for pregnant patients only):
I understand that the FDA has not approved the use of over-the-counter nicotine replacement products for treatment of tobacco-dependence in pregnant women. I have read the enclosed information (reverse side of this page) regarding smoking risks and benefits of treatment during pregnancy, have discussed this with my patient, and authorize the WAQL (F&C) to supply NRT (patch, gum or lozenge) along with telephone counseling for the pregnant patient identified below, if patient is eligible and such treatment is indicated.

Signed _____ Date_____

Patient Information:

Gender: Male _____ Female_____ Pregnant? Y ☐ N ☐

Patient Name: _____

DOB: _____ / _____ / _____

Address: _____ City: _____Zip: _____

Home #: (____) _____ - _____ Work #: (____) _____-_____

Cell #: (____) _____ - _____

☐ I am ready to quit tobacco and request the **Washington Tobacco Quit Line** contact me to help me with my quit plans. (Initial)

☐ I agree to have the **Washington Tobacco Quit Line** tell my health care provider(s) that I enrolled in Quit Line services and (Initial) provide them with the results of my participation.

Congratulations on taking this important step! Telephone support from a Tobacco-Treatment Specialist will greatly increase your chance of success.

Patient Signature: _____ Date: _____/_____/_____

The Washington Tobacco Quit Line will call you. Please check the best times for them to reach you. The Quit Line is open 7 days a week:

☐ 6am – 9am ☐ 9am – 12pm ☐ 12pm – 3pm ☐ 3pm – 6pm ☐ 6pm – 9pm

Within this 3-hour time frame, please contact me at (check one): ☐ Home ☐ Work ☐ Cell

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FOR WASHINGTON TOBACCO QUIT LINE USE ONLY:

FAX REFERRAL OUTCOME:

☐ Letter and materials sent (after 3 attempts); Date: _____

☐ WA QL Intervention completed, refused F&C, materials sent; Date: _____

☐ WA QL Intervention completed, with enrollment into F&C, materials sent; Date:_____

☐ Dosed for NRT; Date:_____

☐ Refused services

TREATING TOBACCO-DEPENDENCE DURING PREGNANCY

Smoking during pregnancy is the primary modifiable risk factor for perinatal complications leading to infant morbidity and mortality in the US today, and is known to cause premature births, low birthweight babies and SIDS. Quitting smoking at any time during pregnancy decreases the risk of birth complications, newborn illnesses and neonatal deaths, but fewer than half of pregnant women who smoke are able to quit.

The FDA has not approved the use of over-the-counter nicotine medications (NRT patch, gum and lozenges) for pregnant women who smoke; however, there is accumulating evidence from European countries (where NRT has been approved for use in pregnancy since 1997) that use of NRT reduces smoking among pregnant women and decreases the risk of adverse smoking-related outcomes.

While quitting without the use of NRT would be preferred, ***using NRT is clearly safer for maternal-child health than continuing to smoke,*** as ingredients in tobacco smoke other than nicotine are the primary causes of the conditions leading to adverse pregnancy outcomes. Benowitz and colleagues, while recognizing that animal studies have shown risk of neuro-developmental defects with high doses of nicotine, have determined that ***there is low to minimal risk to the human fetus associated with judicious NRT use during pregnancy*** and recommend that such treatment be considered for women who are otherwise unable to quit. Additionally, they advise that ***NRT can be used without restriction postpartum, as only trace amounts of nicotine are absorbed by breast-fed infants.***

The WA State Quitline, in conjunction with the Free & Clear program, offers direct mail order (DMO) NRT patch, gum and/or lozenge for eligible callers, along with our standard counseling program. However, we are unable to provide NRT to pregnant women without the approval of their physician (or other licensed healthcare provider). Therefore, ***if you would like your patient to receive NRT as part of her treatment for quitting tobacco, please discuss this with her and sign the authorization on the front of this form.*** Then, when it is faxed to the WAQL, we will assess your patient's need for NRT and deliver up to eight weeks of nicotine medication to augment our counseling program and help your patient quit, if NRT is indicated and your patient is eligible.

If you have any questions, would prefer to prescribe NRT directly to your patient, or would like additional information, please call one of our medical staff physicians, Tim McAfee or Abigail Halperin at 206-876-2100.

Thank you,

Free & Clear Medical Team

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APPENDIX V: News Release Template

For Immediate Release: *DATE*

ORGANIZATION Announces New Tobacco-Free Policies

(CITY) – *ORGANIZATION* today announced plans to implement a new tobacco-free policy at all facilities, effective *DATE.*

Hospital leaders say the new policy reflects the health system's mission: "We are eliminating tobacco-use on our properties to provide a healthy and safe environment for employees, patients and visitors and to promote positive health behaviors," said *NAME,* chief executive officer at *ORGANIZATION.*

The new policy bans the use of all tobacco products, including cigarettes, cigars, pipes and smokeless tobacco, within all properties owned, leased, or occupied by *ORGANIZATION.* This includes parking lots, hospital vehicles, and employees' personal vehicles parked on the premises. Employees are prohibited from using tobacco products during working hours.

The US Surgeon General's Office in 1964 declared that smoking is hazardous to health. Yet smoking remains the number one cause of preventable death and disability, according to the Centers for Disease Control & Prevention.

ORGANIZATION views tobacco-use as a quality concern: "We can no longer turn a blind eye to on-campus smoking when we know that continued tobacco-use can cause problems for a patient," said chief medical officer, *NAME.* "Smoking retards wound healing, increases infection rates in surgeries, and is the most common cause of poor birth outcomes."

Furthermore, three-fourths of all tobacco-users say they want to quit. But the *ORGANIZATIO*N medical director recognizes the challenges of breaking the addiction to nicotine and respects an individual's quitting process. "We are not telling anyone, 'you must quit smoking.'" said *NAME OF MEDICAL DIRECTOR*. "We are saying, 'Don't use tobacco at our hospital.' While you are a patient or visitor at this hospital, we can suggest ways to ease nicotine withdrawal symptoms. And if you are ready to quit, we have trained professionals and community partners who can help you."

ORGANIZATION hopes hospital employees will help inform visitors and patients about the new policy, said *NAME OF CEO.* "This will not be easy," he said, "but it's central to our continuing efforts to make an excellent place to work and to receive health care." In implementing the new tobacco ban, the hospital plans to offer symptom relief or tobacco-cessation treatment to interested staff, visitors and patients.

APPENDIX W: Response to Opposition TemplateAdapted from letter created by the Kansas Hospital Association:

http://www.kha-net.org/CriticalIssues/TobaccoFree/default.aspx

Letter in Response to Opposition to your Tobacco-Free Policy
To be printed on hospital letterhead

Date

Name
Title
Business Name
Address
City, State, Zip

Dear (personalize with name),

In response to your recent comment about our tobacco-free policy, our mission calls us to improve the health of not only those we serve and their families, but also those who work with us. Tobacco use is the number one cause of preventable disease worldwide and is responsible for approximately one in five deaths in the United States. Tobacco use in and around our hospital poses health and safety risks for patients, employees and visitors.

As a health care provider, we feel it is necessary to take a stand to stop this public health epidemic. ORGANIZATION joins hundreds of hospitals across the nation that have become tobacco-free. Our tobacco-free policy is intended to create a healthy environment for everyone who comes to ORGANIZATION to receive care, visit a patient or work. Legally, tobacco use is not a right; it is a privilege that can be restricted when it is detrimental to others. We hope that you will understand and support our tobacco-free initiative.

Sincerely,

NAME
Director of Quality Management
ORGANIZATION

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