UCSF Smoking Cessation Leadership Center | National Center of Excellence for Tobacco-Free Recovery

"Improving Tobacco Cessation with Adult Inpatient Psychiatric Clients"
on Wednesday, May 19, 2021, at 2:00 pm EDT

Speakers:

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

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1. **How did you select which facilities to include (in the survey of staff needs and organizational barriers related to tobacco cessation)?**

Facilities included in the survey were classified as state-operated facilities and were enrolled in the NRI's Behavioral Healthcare Performance Measurement System (BHPMS) at the time of the survey.
Enrolled facilities submit monthly data to the BHPMS to participate in quality measures of care.
The survey was sent to 165 persons identified in the BHPMS as facility contacts.
The facility contacts were instructed to forward the email to the clinical person(s) responsible for providing tobacco use cessation treatment and referral at discharge.
108 facility respondents answered the survey from 70 facilities.
91% of facilities staff that responded to the survey participate in the CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) program.

2. **With all the barriers in place, how can one receive treatment?**

NRI Survey results indicated that facility staff want access to evidence-based training, funds for resource building and medication options, and time for training and protocol delivery to improve delivery of tobacco cessation treatment including use of Tobacco Cessation specialty staff as part of the general treatment team for in-patient psychiatric hospitals.
NRI developed 2 infographics loaded with all free resources so that each hospital can determine their need gap and quickly locate resources they could integrate into the policy through service delivery to improve treatment approaches, integration, and referral at discharge for tobacco use.
For more information and access to the infographics, visit https://www.nri-inc.org/focus-areas/performance-measurement/clinical-oversight/tobacco-cessation/

3. **CMS is proposing removing required reporting for some of these measures discussed - if that passes how could you see that affecting systems change motivation?**

When CMS removes measures because a measure has "topped out" with performance at the 95%, the measure practice is expected to continue as standardized practice.
TOB 1, screening for tobacco use within the first day of admission to an inpatient psychiatric facility, was removed in 2018 for this reason, but screening for use is an expected standardized practice that should

remain in the clinical assessment for patients, and appropriate treatment should then be delivered as a result of the screening during the patient stay.
However, CMS data indicates that there is a disparity between state operated facilities and other psychiatric hospitals in TOB data outcomes.
NRI engaged in this Tobacco Cessation Project to provide technical assistance to increase motivation for BHPMS client hospitals to target this clinical disparity throughout the treatment experience for clients from screening to discharge with actionable options for policy, education, staffing, and resource inclusion to facilitate measure outcome improvements through practice change.

4. **What should be the focus of training patients how to use medications after discharge?**

Staff and patients benefit from information regarding the interaction between tobacco use and medications prescribed for patients. Tobacco use may decrease the effectiveness of psychotropic medications.
Patient education while in hospital should routinely include the effects of tobacco use with these medications as well as how to appropriately access and utilize tobacco cessation medications while in-patient and after hospital discharge.
Guidance may be found here for professionals on the mechanisms of interaction:
https://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/drug-interactions.pdf

5. **What elements are used to score compliance? I wonder if our staff are doing things that might not be reflected in a way that is counting toward compliance.**

This is an excellent question. The TOB measures have clear definitions and protocols for reporting IPFQR chart abstracted outcomes per the Joint Commission requirements which were adopted by CMS for these measures.
NRI recommends facilities conduct review of the clinical to data flow (the Golden Thread) against the following process: measure definitions, screening tools used for determination of tobacco use, documentation of "practical counseling" as defined, multiple offers for medication and treatment while in the hospital, treatment plan review for inclusion of tobacco use as a focus for care, embedding of Tobacco Cessation concepts and skill training within existing wellness and recovery management protocols, skill-building of staff in tobacco cessation engagement and recovery supports at multiple levels (including prescribers and peer providers), electronic health record data abstraction review for accuracy, chart abstraction rule guidance reviews for coding reliability, access to tobacco cessation medications during active treatment and at the point of discharge, smooth transitions to tobacco cessation treatment in the community after discharge, and Quality Assurance efforts which target and support improvements for tobacco outcomes.
NRI provides an implementation manual, general education, and individualized technical assistance to our member clients for all Joint Commission, CMS, and additional measures to improve the client experience of care and outcomes from a psychiatric hospital admission.
Contact us for more information on how we could help you: LSchacht@nri-inc.org.
For summary of the TOB measures and chart abstraction requirements: http://www.nri-inc.org/media/1672/tobacco-use-core-measures-set-summary9_16_2020.pdf

6. **Missy. . . Any comments on diagnosing Tobacco use, mild, moderate, severe. . . DSM5 criteria?**

This is potentially a much longer training question, but here are some broad strokes of commentary within the context of the Tobacco Measures described in the webinar today.

1. Screening for tobacco use is the first step in determining if further assessment is required for diagnosis and treatment assistance with a client.
2. Screening outcomes are different beginning in 2021 for tobacco use due to new definitions and reporting rubric for Tob 2. For example, "heavy" and "mild" use are no longer response basis to the measure. "Practical Counseling" is a specific brief intervention along with cessation medication prescribed for "heavy" users prior to 2021 and for "daily" users effective 2021. These are the minimal components of effective intervention and treatment for an adult client presenting with these attributes. However, individuals who may not be "current" tobacco users only because they have been in confined environments need assessment and treatments offered to effect behavior change and recovery and may meet criteria for diagnosis for Tobacco Use Disorder even if upon admission they had not used tobacco for the past 30 days.
3. DSM5 diagnosis uses a 12-month span to assess for the presence of the disorder.
4. An individual experiencing tobacco withdrawal meets criteria for TUD (withdrawal and tolerance, 2 of 11 elements)
5. An individual admitted on nicotine replacement therapy meets criteria for TUD.
6. Clinicians should thoughtfully differentiate between severity of TUD following assessment with the client.
7. Effective screening and assessment will include review of type, frequency, duration, circumstances for preferred use of tobacco, history of quit attempts including outcomes, pros and cons elicited from the client for tobacco cessation, discussion of reluctance and barriers for a "quit attempt", encouragement for "trying again" with staff support and behavioral reinforcement as part of the treatment plan.
8. Appropriate diagnosis for TUD includes severity of mild, moderate, severe and modifiers for Maintenance Therapy and In A Controlled Environment. Being in a controlled environment with no access to tobacco is not the same as "quit attempt/ status".
9. Tobacco Withdrawal or Tobacco-induced sleep disorder may be an appropriate diagnosis early after treatment admission which hopefully resolves and consideration for TUD should then occur at diagnosis revision/ review.
10. If clinicians/ facility/ documentation/ abstraction has not been updated to TOB 2021 requirements, systematic review is needed now for measure and clinical guidance alignment.

7. **At times, it's very challenging to get patients on-board with tobacco cessation, but it is even more difficult to get staff to take tobacco cessation seriously, especially when they themselves use tobacco products. Lack of staffing support also includes the attending Psychiatrists. Do you have any recommendations on how to get others to take it seriously?**

There has been a trajectory of learning in the alcohol and drug field that has taught us the higher likelihood of co-occurring disorders in the mental health AND substance use disorder clients from which we continue to be taught as helpers.

There has been a history of "single issue" treatment focus that has changes with research and training to include "multi-issue" needs presented by clients in the behavioral health systems. Providers continue to apply research to practice improvements for co-occurring disorders which often require multiple exposures, shorter treatment bursts, longer period of time for tracking change, wrap-around supports

for change establishment for persons living with Serious Mental Illness, those primarily served by state operated psychiatric hospitals for longer lengths of stay.
We must acknowledge that we ourselves as providers and by policy have added to the difficulties for engagement for tobacco use change by use of access to tobacco as a reward/ reinforcement in behavioral health and substance use disorder settings for decades.
Staff and providers are influenced by the training they have received and delivered in behavioral healthcare settings as to "what works" at an intuitive as well as research-informed level. Behavioral healthcare is a combination of science (still emerging) and art. Updating training to reflect what we continue to learn from the science is ethical practice for providers, which can put staff and clients into a dilemma of potential conflict.
The human freedom to choose, even when the choice has known risks/ benefits, remains a high value. For example, I know driving too fast puts me and others at risk for injury and death, but sometimes I drive over the posted speed limit.
Clients have the right to choose to decline medications, referrals, even supported housing or employment which has documented efficacy to enable recovery. They also have the right to return later and make a different choice.
Training all staff in the process of tobacco use risks, the value of quit attempts, providing access to medication and treatment, creating a positive recovery Tobacco Free culture takes time and benefits from the usual components necessary for behavior change:

1. Family/ organizational champions for change
2. Access to education, services, options for change
3. Exploration for motivation for change, and responses that are aligned with that stage of change
4. Motivational incentives (by policy, word, and tangible reinforcers)
5. Prevention strategies
6. Relapse prevention strategies
7. Relapse recovery support to try again
8. Tobacco Free campus policies that apply to clients and staff
9. Education for clients and staff about triggers for tobacco use, including the smell on hair, clothes, vehicles, breath of colleagues and staff interacting with clients
10. Celebrations for incremental changes
11. Tolerance for risk reduction approaches as well as for abstinence approaches for TUD
12. Keep going: all change takes time and repeated efforts.

8. **If a patient has been hospitalized for several years, is there a recommendation/limitation for using NRT's? In other words, is there more damage being done by re-activating the nicotine receptor cites? Wouldn't it be more prudent to work on relapse prevention strategies?**

This question falls outside the scope of our project and internal expertise. I would refer this question to SCLC. My only comment is that yes, strategies and skillbuilding is essential, but you may want to consider ST prescription at discharge in case there is relapse because the individual may not have approached the time in hospital as an actual "quit attempt" and we know there is high risk for return to use of drugs, alcohol, and tobacco especially right after hospital discharge.
Someone with pharmacology background needs to field this and point to research for this very specific question.

https://pubmed.ncbi.nlm.nih.gov/31018852/ 2019 Critical steps in the path to using cessation pharmacotherapy following hospital-initiated tobacco treatment. **Not IPF specific**

https://pubmed.ncbi.nlm.nih.gov/22121242/ **2012 Nicotine replacement therapy use at home after use during a hospitalization.** Not IPF specific.

https://pubmed.ncbi.nlm.nih.gov/29481616/ **2019 Tobacco Use Prevalence and Smoking Cessation Pharmacotherapy Prescription Patterns Among Hospitalized Patients by Medical Specialty**. Includes psychiatry and notes racial differences.