Implementation of Comprehensive Inpatient Tobacco Cessation Services Following Joint Commission Recommendations: Lessons Learned and Recommendations

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Issue

Tobacco use causes adverse health outcomes in hospitalized patients which include poor wound healing, reduced pulmonary function and increased complications. Thus, the Joint Commission (JC) recommends that hospitals screen all patients for tobacco use and offer inpatient cessation support and follow up within 30 days after hospitalization. Currently, few hospitals provide these services.

Description

In 2014, MUSC implemented a tobacco cessation service modeled after the JC-recommended standard. Operationally, all tobacco users identified on admission are referred from the EMR (Epic) to a cloud based cessation software (TelASK Quit Manager). Tobacco counselors access the software on tablet devices to document patient consults at the bedside and to trigger the delivery of post-discharge interactive voice recorded (IVR) calls that assess smoking status and offer referral to tobacco cessation support services.

Overview of Tobacco Cessation Program Results (N=42,061 Hospitalized Patients)

Program Component	N	(%)
Hospitalized patients **screened** for tobacco use	42,061	(100%)
Screened patients identified as **current tobacco users**	8,423	(20%)
Current tobacco users **eligible for the program**	5,678	(67%)
Patients eligible for program who received **inpatient counseling**	1,537	(27%)
Patients eligible for program who received **30-day follow up**	2,271	(40%)
Patients eligible for program who **received counseling and/or follow up calls**	3,123	(55%)

Lessons Learned

A number of valuable lessons learned were identified:

1. The findings demonstrate the feasibility of implementing an *opt-out* tobacco cessation service for hospitalized patients that is consistent with the JC recommended standards for treating tobacco dependence.
2. It took several months to develop and test a system that would reliably identify patient records and work out logistics for downloading, transferring, and reporting patient information in a way that was usable by the bedside counselor and IVR phone follow-up system.
3. With only one full-time bedside tobacco cessation counselor and automated IVR telephone follow-up calls, the program was able to intervene either in person or by phone with 55% of eligible adult smokers.
4. Receiving a bedside tobacco cessation consult while hospitalized was associated with a greater likelihood of patients using stop smoking medications and remaining refrained from smoking after discharge from the hospital.
5. Even in those patients who did not receive a bedside consult, 5% accepted a referral to the South Carolina Tobacco Quitline to get help to stop smoking.

Future Directions

1. From a sustainability standpoint, it is helpful to identify an ongoing source of revenue to support program operations such as a per-patient preventive healthcare fee.
2. Studies are underway to investigate the impact of the service on clinical outcomes such as hospital readmission rates and cost outcomes.

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