Treating Tobacco Use and Dependence in Hospitalized Patients:

A Practical Guide

WISCONSIN HOSPITAL ASSOCIATION

UW-CTRI
UNIVERSITY OF WISCONSIN
Center for Tobacco Research & Intervention

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Table of Contents

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Introduction

Tobacco Dependence Treatment in the Hospital Setting

Tobacco use is the leading cause of premature disease and death in the United States and is a primary driver of hospitalizations for cancers, stroke, cardiovascular and respiratory diseases, and pregnancy and newborn complications. Tobacco use also interferes with recovery and contributes to delayed bone and wound healing, infection, and other post-operative complications.

Hospitalizations are an ideal time to assist smokers to quit. Every hospital in the United States must provide a smoke-free environment if it is to be accredited by the Joint Commission. And, hospitals both in Wisconsin and across the nation are increasingly implementing smoke-free campus policies. As a result, every hospitalized smoker is temporarily housed in a smoke-free environment. In this environment, they may be more motivated to quit than at any other time and that motivation may be enhanced because their hospitalization was caused or made worse by smoking. In addition, if a hospitalized smoker is offered and uses cessation medication to manage withdrawal symptoms and has a positive experience, s/he may be more likely to continue using that medication to permanently quit after discharge. Finally, the forced abstinence in the smoke-free hospital setting could be an important first step on the road to successful quitting.

This guide for Wisconsin hospitals is based on recommendations presented in the U.S. Department of Health and Human Services Public Health Service, *Treating Tobacco Use and Dependence Clinical Practice Guideline, 2008 Update* (The Guideline). The Guideline emphasizes that a hospitalization presents an unequaled opportunity to promote tobacco cessation. The Guideline also suggests interventions to assist hospitalized patients who smoke to quit for good. In September 2011, the *New England Journal of Medicine* published an update on treating smokers in healthcare settings. Click here to see the article.

Clinical Practice Guideline Recommendation

For every hospitalized patient, the following steps should be taken:

- Ask each patient on admission if he or she uses tobacco and document tobacco use status in the patient's medical record.
- Advise every patient who uses tobacco to stop.
- Assess the patient's willingness to make a quit attempt during the hospitalization.
- Assist patients with quitting during hospitalization by providing evidence-based counseling and medication and develop a tobacco-abstinence plan after discharge.
- Assist patients with managing withdrawal symptoms during hospitalization by providing counseling and medications.
- Arrange for follow-up to assess smoking status. Supportive contact should be provided for at least a month after discharge.

According to The Guideline, "Tobacco use presents a rare confluence of circumstances: (1) a highly significant health threat; (2) a disinclination among clinicians to intervene consistently; and (3) the presence of effective interventions…Indeed, it is difficult to identify any other condition that presents such a mix of lethality, prevalence, and neglect, despite effective and readily available interventions."

The five components of the evidence-based brief intervention are the 5A's: **ASK** about tobacco use; **ADVISE** to quit; **ASSESS** willingness to make a quit attempt; **ASSIST** in quit attempt; **ARRANGE** follow-up.

Tobacco users have higher hospitalization rates than those who do not use tobacco. However, most hospitals have not placed a priority on systematically identifying smokers, recording their smoking status, offering evidence-based assistance in quitting, and following up after discharge.

The University of Wisconsin School of Medicine and Public Health Center for Tobacco Research & Intervention (UW-CTRI), the Centers for Medicare & Medicaid Services (CMS), the Joint Commission, and other national entities have made the identification and documentation of evidence-based tobacco dependence treatment a national priority for the delivery of quality medical care. While the Joint Commission has required intervention with tobacco users for some time, the newly released (January 2012) tobacco use measure set goes much farther than anything in the past. With changes

mandated by the 2010 Federal health care reform legislation and incentives offered by Medicare and Medicaid, Wisconsin hospitals have an even greater inducement to implement a comprehensive tobacco cessation program for these patients.

Purpose of this Hospital Guide

One goal of this guide is to provide the practical tools essential for hospital leadership and practitioners to implement the 2012 tobacco cessation performance measures (Tobacco Measure Set) developed by the Joint Commission. Hospitals that select this measure set will be required to screen all patients for tobacco use, provide cessation treatment during the hospital stay and at discharge, and follow-up after discharge.

Why Hospitals Should Implement the Joint Commission Tobacco Measure Set

While the Joint Commission Tobacco Measure Set is optional, there are many important reasons to implement it:

Health of Patients
Continued tobacco use interferes with patients' recovery and overall health. Among cardiac patients, second heart attacks are more common in those who continue to smoke. Lung, head, and neck cancer patients who are successfully treated for their cancer but who continue to smoke are at elevated risk for a second cancer. Additionally, smoking both causes and exacerbates chronic obstructive pulmonary disease as well as delays bone and wound healing. Finally, tobacco use causes and exacerbates infectious diseases.

Clinical Practice Guideline Recommendation

Ask - Identify Tobacco Users

It is essential that clinicians and health care delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a health care setting.

Public Health Impact of Tobacco Use
Tobacco use imposes enormous health and financial costs on our nation — costs that are completely avoidable. Smoking is responsible for one of every five deaths in the United States, resulting in nearly half a million deaths per year. The chronic diseases caused by tobacco use, including cardiovascular, pulmonary, and oncological, lead the list of overall causes of death and disability in the United States and unnecessarily strain our health care system. The economic burden of smoking includes more than $193 billion annually in health care costs and lost productivity. In 2012, we have the tools to prevent the staggering toll that tobacco takes on individuals, families, and communities.

Health Care Reform Requirements

The federal Patient Protection and Affordable Care Act (ACA) includes tobacco coverage provisions that will ultimately affect all employer-based health insurance plans. Beginning on or after September 23, 2010, employers must offer their employees tobacco cessation benefits with no cost sharing. This applies to both insured and self-insured employers; only grandfathered employers are exempt (employers that do not make material changes to the health benefits). In addition to tobacco cessation coverage, all other United States Preventive Services Task Force (USPSTF) A and B recommendations must be covered with no cost-sharing for employees.

Commitment to Quality Care

Tobacco use is a chronic disease. Quality chronic disease care requires patient education and assistance with self-management. By providing tobacco cessation as an inpatient service combined with post-discharge follow up and communication to the out-patient primary care physician, hospitals can fill a gap in the management of this chronic disease.

Commitment to Community Wellness/Hospital Mission

Most hospital mission statements include language about improving the health of the community. Making a meaningful investment in tobacco cessation is one of the most effective ways a hospital can contribute to overall community health. Tobacco will kill approximately one of five residents in communities surrounding our hospitals.

Clinical Practice Guideline Recommendation

Tobacco Use as a Chronic, Relapsing Disease

Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.

Meaningful Use Provisions

The Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act of 2009, provides incentives to eligible professionals and hospitals that adopt certified electronic health record (EHR) technology and demonstrate that they are meaningful users of the technology. To qualify as a meaningful user, eligible professionals and hospitals must use EHRs to capture health data, track key clinical conditions, and coordinate care of those conditions. In Stage I of Meaningful Use, clinicians will have to report data on three

core quality measures in 2011 and 2012: blood-pressure level, tobacco status, and adult weight screening and follow up. For details about all stages of Meaningful Use requirements and measures, click here.

HITECH also authorized incentive payments totaling up to $27 billion over ten years through Medicare and Medicaid to clinicians and hospitals when they use EHRs privately and securely to achieve specified improvements in care delivery. The legislation ties these payments specifically to the achievement of advances in health care processes and outcomes. Participating individual hospitals can expect up to two to six million dollars in incentives annually.

CMS Endorsement
The Centers for Medicare and Medicaid Services (CMS) has included the Tobacco Measure Set in their Inpatient Prospective Payment System (IPPS) rule, at present designating the measure set "For Future Use". The IPPS rule determines Medicare reimbursement to hospitals.

The Joint Commission's Tobacco Measure Set

History
Over the past 20 years, studies have demonstrated both the clinical- and cost-effectiveness of providing tobacco treatment during a hospital stay. Despite the evidence, this intervention has not been widely adopted.

Incentives for hospitals to address tobacco use were first introduced by the Joint Commission in 1992. In 2004, the Joint Commission instituted an accreditation requirement for the delivery of evidence-based tobacco dependence interventions for patients with diagnoses of acute myocardial infarction, congestive heart failure, or pneumonia. The measures included assessment of whether smokers discharged with these diagnoses received advice or assistance to quit smoking during their hospital stay. Over time, hospitals' performance on this measure improved. But because the measure was only applied to a narrow patient group, required minimum intervention and documentation, and did not require hospitals to connect patients to post-discharge care, the intervention was not considered effective.

In 2011, aided by an external technical advisory panel of tobacco cessation experts, the Joint Commission developed a new set of performance measures to encourage the better assessment and treatment of tobacco dependence for all hospitalized patients. This new measure set enhances and broadens the scope of the existing measures and ultimately replaces the current National Hospital Quality Measures for Adult Smoking Cessation Advice/Counseling in the acute myocardial infarction (AMI-4), heart failure (HF-4), and pneumonia (PN-4) measure sets.

The new measures implemented on January 1, 2012, are much more comprehensive and are designed to encourage a greatly expanded inpatient treatment of tobacco users compared to the 2004 measures. The new tobacco use measures include:

1. Tobacco use screening;
2. Tobacco use treatment (counseling and medication) provided or offered during hospital stay;
3. Tobacco use treatment (counseling and medication) provided or offered at discharge;
4. Tobacco use assessment after discharge.

Overview of the Tobacco Measure Set

The new Joint Commission measures require acute care hospitals to identify all inpatients (excludes outpatients visiting a hospital or patients on observation status) who use tobacco, to offer them counseling and medication, and to follow-up post-discharge to maximize the benefits of in-hospital cessation interventions.

The new measures are applicable to all hospitalized patients 18-years of age and older. A detailed description of the tobacco measure set appears on the following page. To view full specifications for the tobacco measure set click here. For the Joint Commission Measure Specifications Manual, click here.

Tobacco Measure Set Specifications

TOB-1	Tobacco Use Screening **Numerator:** The number of patients who were screened for tobacco use status. **Denominator:** The number of hospitalized inpatients 18 years of age and older.
TOB-2 TOB – 2a	Tobacco Use Treatment Provided or Offered During Hospital Stay **Numerator:** The number of patients who received or refused practical counseling to quit **AND** received or refused FDA-approved cessation medications. **Denominator:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users (all products within the past 30 days). Tobacco Use Treatment During Hospital Stay **Numerator:** The number of patients who received practical counseling to quit **AND** received FDA-approved cessation medications. **Denominator:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users (all products within the past 30 days).
TOB-3 TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge **Numerator:** The number of patients who were referred to or refused evidence-based outpatient counseling **AND** received or refused a prescription for FDA-approved cessation medication at discharge. **Denominator:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users. Tobacco Use Treatment at Discharge **Numerator:** The number of patients who were referred to evidence-based outpatient counseling **AND** received a prescription for FDA-approved cessation medication at discharge. **Denominator:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.
TOB-4	Tobacco Use: Assessing Status after Discharge **Numerator:** The number of discharged patients who are contacted within 30 days after hospital discharge and follow-up information regarding tobacco use status is collected. **Denominator:** The number of discharged patients 18 years of age and older identified as current tobacco users.

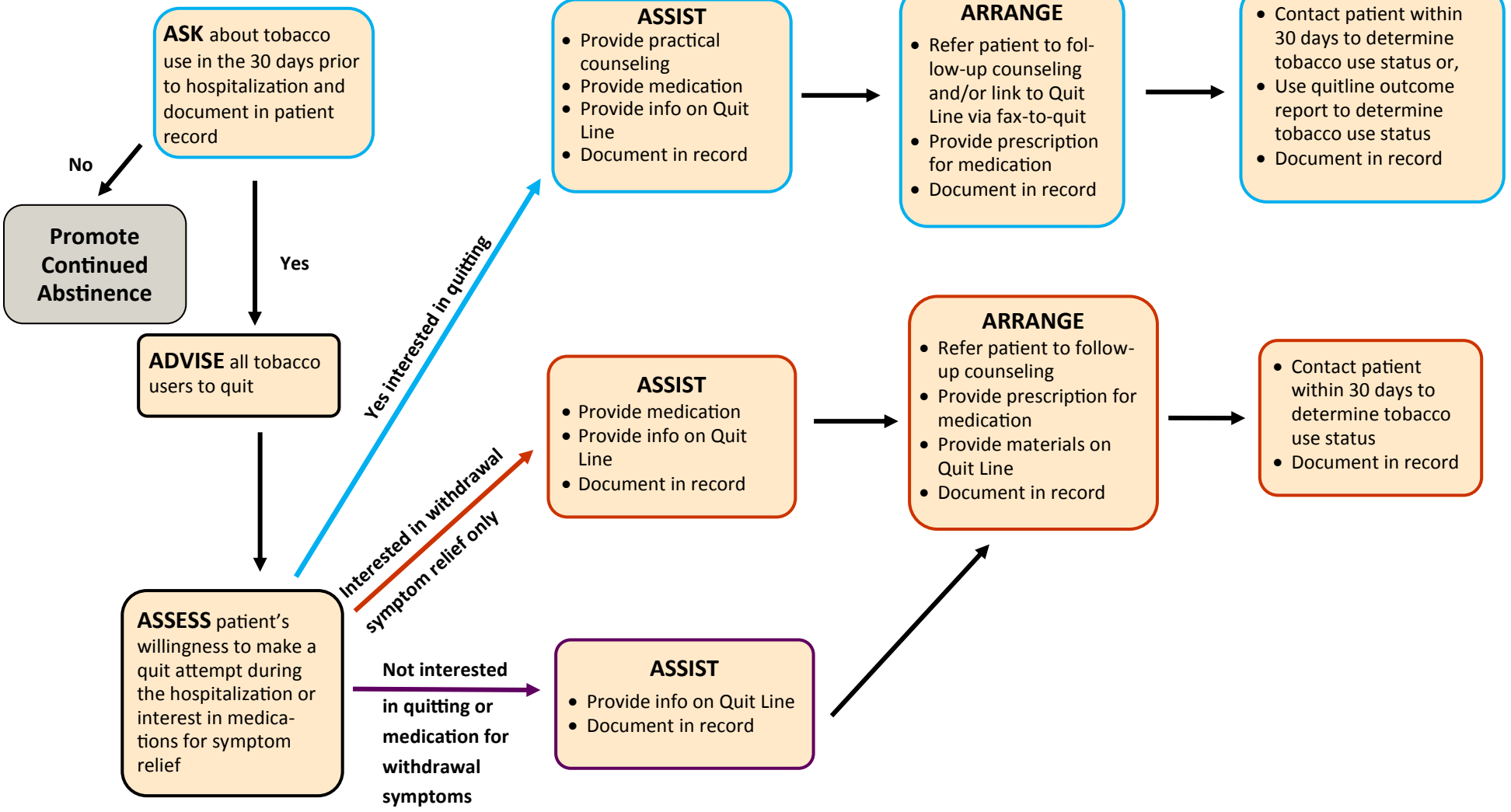
TOBACCO DEPENDENCE TREATMENT INPATIENT FLOWCHART

Admissions
Tobacco Use Screening
TOB-1

Tobacco Use Treatment
During Hospital Stay
TOB-2

Tobacco Use Treatment
At Discharge
TOB-3

Follow-up
Post-discharge



Developing a Successful Hospital-wide Tobacco Cessation Program to Meet the Joint Commission Tobacco Measure Set

Getting Started

STEP 1: *Assemble a multidisciplinary team to develop the program*

The formation of a multidisciplinary team to define the new tobacco cessation program goals, to develop an implementation plan, and to create evaluation methodologies is an important first step in launching a successful hospital tobacco cessation program that will meet the Joint Commission tobacco measure set. The effectiveness of this multidisciplinary team will be enhanced if hospital leadership endorses this effort as a key institutional priority. Start by convening a group of people from a variety of disciplines in the hospital (both inpatient and outpatient) that will help promote and champion the initiative. They might represent emergency medicine, cardiology, respiratory therapy, physical therapy, pharmacy, nursing, professional education, and quality improvement, among other hospital departments and areas. It is important to include members of the quality improvement, staff education, and information technology staff.

One of the first tasks of the multidisciplinary team is to identify a **"Physician Champion"** – a physician committed to leading the hospital-wide effort. Physician buy-in is essential to the successful integration of tobacco cessation activities within a hospital. Successful hospital-based tobacco cessation programs have found that a physician champion who promotes cessation activities hospital-wide can enhance the success of this effort.

STEP 2: *Conduct an assessment of existing hospital tobacco use treatment services*

Conduct a preliminary assessment to understand the current environment surrounding tobacco-use treatment in your hospital.

- Determine the tobacco use treatment services and activities in each area/department of the hospital, and obstacles that may prevent effective implementation of improvements developed by the multidisciplinary team. Identify departments or units within the hospital (if any) that already emphasize treating tobacco dependence and do it well. With a goal of implementing hospital-wide, consider starting with departments that are in the best position to support this initiative, such as those that already have tobacco cessation policies or processes in place. Click here for a sample program procedures and policies worksheet.

- To ensure that you have a comprehensive understanding of the evidence regarding evidence-based tobacco-use treatment strategies, click here to review the U.S. Public Health Service Clinical Practice Guideline *Treating Tobacco Use and Dependence 2008 Update.*
- To familiarize hospital staff with tobacco-use statistics for your state and community, click here to visit the Centers for Disease Control and Prevention's Office on Smoking and Health website.

STEP 3: *Set measurable tobacco cessation goals to meet Joint Commission standards*

Review the Joint Commission tobacco standards and establish quality improvement measures that meet those standards. Think about the delivery systems and providers you plan to engage; the types of support services you will offer; and the policies, processes and practices you will promote to ensure that comprehensive tobacco use treatment is implemented effectively. Use existing quality improvement/process improvement (QI/PI) teams to help develop measurable goals that help support and enhance existing programs to be in compliance with Joint Commission standards. The QI/PI team brings valuable experience in outcome measurement and goal formulation.

Most Wisconsin hospitals use rapid-cycle methodology ("Plan, Do, Check, Act" cycle) regularly in both their QI and other departmental work. The PDCA model uses information gained from data to focus attention on areas that need improvement. Consider using this model to evaluate and improve your quality improvement measures around tobacco as you work to meet the Joint Commission standards.

STEP 4: *Train staff to deliver evidence-based tobacco cessation treatment*

To the extent possible, train staff on the Clinical Practice Guideline 5A model for comprehensive tobacco cessation treatment: (1) **Ask** about tobacco use at every visit, (2) **Advise** patients to quit, (3) **Assess** readiness to quit; (4) **Assist** with quitting by providing counseling and medication; and (5) **Arrange** follow-up care. Educate hospital staff that tobacco cessation medications may be used to reduce nicotine withdrawal symptoms, even if the patient does not intend to quit at this time. On a regular basis, staff should be offered training (e.g., lectures, workshops, in-services) on tobacco dependence treatment and provided continuing education and/or other incentives for participation. Provide feedback to clinicians about their performance, drawing on data from chart audits and electronic medical record reviews.

It is not expected that a single member of the healthcare delivery team will necessarily provide all five elements of tobacco dependence treatment ("the 5As"). What is important, however, is that the hospital clearly defines who on the delivery team is

responsible for each aspect of tobacco dependence treatment delivery (the 5 As). Physicians, nurses, pulmonary and other therapists, social workers, and allied health professionals should all understand the importance of repeated, consistent messages and be part of the team that provides tobacco dependence treatment. It is important that all clinicians identified to deliver tobacco dependence treatment services receive training on how these treatments are delivered at the bedside.

Smoking Cessation Medications – Two Uses for Hospitalized Patients

- To assist with cessation
- To reduce nicotine withdrawal symptoms while in a smoke-free hospital

Some training resources include:

University of Wisconsin School of Medicine and Public Health Online Continuing Medical Education available on Medscape
http://www.ocpd.wisc.edu/tobaccocme.html

UW Center for Tobacco Research and Intervention Outreach Program
http://www.ctri.wisc.edu/providers-education.htm

US Department of Health and Human Services Guideline: Quick Reference Guide for Clinicians, Treating Tobacco Use and Dependence.
http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/quickref/index.html

Rx for Change
http://rxforchange.ucsf.edu/

Treating Smokers in the Healthcare Setting, N Engl J Med 2011; 365:1222-1231.
http://www.nejm.org/doi/full/10.1056/NEJMcp1101512

STEP 5: *Identify a tobacco cessation counselor or counseling team*

The multidisciplinary team designing the cessation program should designate a department or individuals who are responsible for bedside cessation consults and counseling each patient identified as a tobacco user. For example, Hospitalists, Physician Assistants, Nurse Practitioners, Clinical Social Workers, Respiratory Therapists, Pharmacists or other designated departments or staff may be assigned this

important task. While treatment delivered by a variety of clinician types can increase abstinence rates, assigning the responsibility of the tobacco cessation consult visit ensures uniformity in the cessation message as well as consistency with the referral process. Cessation counseling should be delivered as a bedside consult at least once during the hospitalization.

Refer to the websites below for more information on bedside tobacco cessation counseling.

American Society of Health System Pharmacists:
http://www.ashp.org/DocLibrary/BestPractices/TPSTobaccoCess.aspx

The Hospitalist - a publication of the Society of Hospital Medicine
http://www.the-hospitalist.org/details/article/234105/Smoke_Screens.html

Tobacco Free Nurses
http://www.tobaccofreenurses.org/

Surgery – An Opportunity to Intervene with Smokers

Consider using opportunities presented during pre-anesthesia or pre-surgical admission visits to focus on helping patients who use tobacco. Anesthesiologists can provide an important perspective on quitting tobacco and may play an essential role in influencing patients to quit. Talking to the patient during the pre-admission interview (for pre-planned hospitalizations) is also a good time to address tobacco cessation. Click here for information on the American Society of Anesthesiologists ASA Stop Smoking Initiative.

STEP 6: *Assess the current hospital medical record system and modify as needed to effectively document tobacco use status and cessation interventions.*

A variety of hospital medical record systems exist and they vary as to the specific data elements that can be captured to effectively track tobacco use and cessation treatment. Electronic health record (EHR) systems can be customized to offer features that assist in consistently identifying, facilitating, and documenting tobacco cessation efforts. For instance, making certain EHR fields relating to tobacco use and cessation interventions mandatory before moving to the next screen, automating prompts when a tobacco user is identified, developing drop-down lists to provide additional information regarding brief and effective cessation messages, and preparing order sets for cessation medication and follow-up prompts, are all EHR measures designed to enhance cessation efforts.

Implementation: Joint Commission Tobacco Measures

TOB-1: Tobacco Use Screening

Purpose: The purpose of TOB-1 is to ensure that tobacco use status is queried and documented for every patient admitted to a hospital for every hospitalization.

Description: To fulfill TOB-1, hospitals must document that all admitted patients (18 years of age or older) were screened during the hospital stay for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the 30 days prior to their hospitalization.

Tobacco use screening is the essential first step in the intervention process. Although it is important to determine tobacco use status for all patients, the Joint Commission measures require documentation only for patients 18 years of age or older that are admitted to the hospital. The reason this measure is limited to those 18 and older is that the evidence for tobacco cessation treatments is strongest for this age group. The tobacco use screen should identify the type of tobacco used, the volume used, and the timeframe of use.

To meet this Joint Commission measure, hospitals must implement a hospital-wide system that ensures that, for EVERY patient who is admitted, tobacco use status is queried and documented. This often takes place during the admission process at the same time that vital signs are recorded, either in the admitting office or by the admitting clinician during the history and physical. Click here for sample tobacco use admission questions.

TOB-1 Considerations

- Use pre-admission hospital visits as an opportunity to prepare the patient for being smoke-free while hospitalized. Encourage her/him to consider a quit attempt prior to hospitalization.
- Use the admission process to 'set the stage' for a successful quit attempt while hospitalized.
- During the admission process:
  - Inform and prepare the patient for being smoke-free while in the hospital.
  - Pave the way for a follow-up inpatient consultation by informing tobacco users.

Documentation for TOB-1:

For hospitals using *paper medical records*, the most common and consistent place for documenting tobacco use status is on the nursing admission history form and is usually reviewed or completed by a nurse upon admission. *Electronic medical record* systems

offer many more features that assist in consistently identifying and documenting tobacco use status during the initial screening process for TOB-1.

Clinical Practice Guideline Recommendation

Applying the Guideline's "Ask, Advise, and Assess" to the Hospital Admission Process
Tobacco users should be identified and documented irrespective of the means by which the patient is admitted, including admissions that occur via the emergency room or the admitting office. During the admission intake, all patients should be **ASKED** about their tobacco use, **ADVISED** to quit, and **ASSESSED** regarding their interest in making a quit attempt during the hospitalization. Hospitals that have successfully integrated tobacco cessation into the hospital admission process have used the following methods:

- Include a question about tobacco use, a statement advising the patient to quit and a question on willingness to make a quit attempt during the hospitalization in the **preadmission form** completed by the patient prior to admission. When using this method, it is important that a designated clinician review the answers to the questions with the patient, and that the clinician strongly **ADVISES** the patient to quit. For example, the admitting physician may review the information when completing the preadmission review and discuss the patient responses to these questions.

Clinician Role: Asking, Advising and Assessing
Clinicians admitting patients should **ASK** about tobacco use, **ADVISE** the patient to quit and **ASSESS** willingness to quit. This should be documented in the patient record.

ASK every patient if they use tobacco and document in the patient health record.

Once tobacco use status has been identified and documented, **ADVISE** all tobacco users to quit. The Guideline evidence shows that even brief advice to quit results in higher quit rates. Advice should be clear, strong, and personalized**.** "As your health care provider, I must tell you that the most important thing you can do to improve your health is to stop tobacco use."

ASSESS whether the patient is willing to quit tobacco use during the hospitalization with exploratory language: "What are your thoughts about quitting tobacco?" If the patient is willing to make a quit attempt, cessation counseling should be immediately provided or arranged via a smoking cessation consultation. If the patient is unwilling to make a quit attempt, he or she should receive brief motivating information, offered pharmacotherapy for relief of nicotine withdrawal symptoms and provided information on accessing the telephone quitline, 800-QUIT-NOW. (In Wisconsin, the Wisconsin Tobacco Quit Line)

TOB-2: Tobacco Use Treatment Provided or Offered during the hospital stay

Purpose: The purpose of TOB-2 is to ensure that every hospitalized patient who uses tobacco is provided evidence-based counseling and medication to manage withdrawal symptoms in-hospital and to encourage long-term tobacco cessation.

Description: To fulfill TOB-2, hospitals must document that hospitalized patients identified through the screening process as having used tobacco products (cigarettes, smokeless tobacco, pipe, and cigars) within the past 30 days received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the hospital stay.

Once a tobacco user has been identified, advised to quit and assessed for willingness to make a quit attempt, a systematic method must be in place to provide counseling and medication for cessation or for relief of nicotine withdrawal symptoms.

ASSIST During the Hospitalization

TOB-2 – The delivery of counseling and medication – corresponds to the "Assist" recommendation of the 2008 U.S. Public Health Service Clinical Practice Guideline. That Guideline documented that patients who have counseling and medication for tobacco cessation are more likely to successfully quit than those who have either counseling or medication individually or no intervention at all.

The components of the TOB-2 hospital *Assist intervention* will differ slightly depending on the patient and generally fall into one of three categories:

1. Not interested in quitting and declining medication and counseling.
   Patients not willing to make a quit attempt nor wishing to receive pharmacotherapy for relief of nicotine withdrawal symptoms should receive information on the Tobacco Quit Line, 800-QUIT-NOW.
2. Interested in withdrawal symptom relief medication only.
3. Interested in making a quit attempt.

Records indicating patients willing to make a quit attempt or wishing relief of withdrawal symptoms during hospitalization should prompt the completion of a **'Standing Order'** for delivery of tobacco cessation counseling and medication.

Tobacco Use Standing Orders

For those patients willing to make a quit attempt and those patients interested in relief of withdrawal symptoms, the attending physician should complete the **Tobacco Use Standing Order Form**, tailoring it to the individual needs of the patient. The standing order form should include:

- A request for smoking cessation counseling for all patients willing to make a quit attempt during hospitalization. This is typically provided during a bedside cessation consult.
- Pharmacotherapy options for cessation medication, depending on whether the patient will attempt cessation or use medication for withdrawal symptom relief.

Tobacco use standing orders work best when they are attached to the new patient admission orders and the patient record is created. This should lead the admitting physician to complete and sign the orders, including calling for a tobacco cessation consult and initiating medication for tobacco cessation or managing withdrawal symptoms during the hospitalization. For examples of standing orders for tobacco use, click here or click here.

Counseling Patients to Quit for TOB-2

Counseling patients to quit should include assisting the patient in developing problem-solving skills, providing the patient with cessation support and encouragement during the hospitalization, and assisting the patient to find additional cessation assistance after s/he leaves the hospital. **In order to meet the requirements of TOB-2, an appropriately trained member of the hospital staff must interact with the patient and provide him/her with the following components of practical counseling: recognizing danger situations that put him/her at risk of relapsing to tobacco use, developing coping skills to deal with urges, and providing basic information about quitting**.

Additional counseling components of the tobacco cessation consult consistent with TOB-2 include:

- Assist the patient to get ready to quit. Discuss past quit attempts - what worked and what did not. Help the patient set-up a quit plan. Use the pneumonic STAR to develop elements of the quit plan.
  - **S**et a quit date. Ideally, the quit date should be within 2 weeks.
  - **T**ell family, friends, and coworkers about quitting and request understanding and support.
  - **A**nticipate challenges to the upcoming quit attempt, particularly during the critical first weeks. These include withdrawal symptoms.
  - **R**emove tobacco products from your environment. Prior to quitting, avoid tobacco use in places where you spend a lot of time (e.g. work, home, car). Make your home tobacco free. Clean your home and car to remove ashtrays and the smell of tobacco.

Clinical Practice Guideline Recommendation

Evidence-Based Counseling Components – Practical Counseling

Practical counseling treatment components	Examples
Recognize danger situations – identify events, internal states, or activities that increase the risk of tobacco use or relapse.	• Negative moods and/or stress. • Being around other tobacco users. • Drinking alcohol. • Experiencing urges. • Tobacco cues and availability.
Develop coping skills – identify and practice coping or problem-solving skills. Typically these skills are intended to cope with danger situations.	• Learning to anticipate and avoid temptation and trigger situations. • Learning cognitive strategies that will reduce negative moods. • Accomplishing lifestyle changes that reduce stress, improve quality of life, and reduce exposure to tobacco cues. • Learning cognitive and behavioral activities to cope with smoking urges (e.g. distracting attention, changing routines).
Provide basic information – provide basic information about tobacco and successful quitting.	• The fact that any tobacco use (even a single puff or chew) increases the likelihood of a full relapse. • Withdrawal symptoms typically peak within 1-2 weeks after quitting but may persist for months. These symptoms include negative mood, urges, and difficulty concentrating. • The addictive nature of tobacco.

- Provide encouragement and support. Encourage the patient to discuss their quit attempt with family and friends, talk to health care providers, seek support from local resources, and/or call the Tobacco Quit Line at 1-800-QUIT-NOW.

Clinical Practice Guideline Recommendation

Additional Evidence-Based Counseling Components - Support

Supportive Treatment Component	Examples
Encourage the patient in the quit attempt	• Note that effective tobacco dependence treatments are now available. • Note that one-half of all people who have ever smoked have now quit. • Communicate belief in patient's ability to quit. Self-efficacy is one of the best predictors of success.
Communicate caring and concern	• Ask how patient feels about quitting. • Directly express concern and willingness to help. • Ask about the patient's fears and ambivalence regarding quitting.
Encourage the patient to talk about the quitting process	Ask about: • Reasons the patient wants to quit. • Concerns or worries about quitting. • Success the patient has achieved with past quit attempts. • Difficulties encountered while quitting.

The **"You Can Quit Smoking"** tear sheet prepared by the United States Public Health Service can guide the clinician through cessation counseling and help personalize the brief tobacco cessation counseling intervention. This personalized plan can be given to the patient as a take away. The front of the plan includes motivational messages and specific advice on how to quit successfully. The back of the plan offers five key steps that embody the key recommendations from the PHS Guideline.

You Can Quit Smoking tear sheets can be downloaded or ordered from the Agency for Healthcare Research and Quality (AHRQ) website at click here. They can also be downloaded from the University of Wisconsin School of Medicine and Public Health Center for Tobacco Research and Intervention (UW-CTRI) website at click here.

Medication for TOB-2

A recommendation to use one of the seven (7) FDA-approved medications should be made for every patient (except when contraindicated or with specific populations*) interested in quitting or interested in withdrawal symptom relief while hospitalized. Discuss with the patient which medication will work best for him/her. Some of the criteria that can be used to select among the seven FDA-approved medications include: past medication use (was it helpful), clinician familiarity with the medication, patient preference, side effect profiles, and contraindications. By using the pharmacotherapies found to be effective in the PHS Guideline, a clinician can double or triple a patient's chances of abstinence. Discussion should include continuation of medication after discharge. As previously noted, cessation medication options should be listed in the standing orders. Click here for the UW-CTRI ***Quit Tobacco Series: Medication Chart*** for details of the seven (7) FDA-approved tobacco cessation medications.

***There is insufficient evidence to recommend medication for pregnant women, adolescents, smokeless tobacco users, and light smokers (<10 cigarettes/day).**

Documentation for TOB-2

It is vital that counseling and medication cessation services (whether delivered or declined by the patient) are well documented in the medical record. Depending on where the interventions take place, who administers the intervention, and whether or not an electronic record is used, there is a wide range of documentation possibilities. Typically, cessation interventions are documented in one or more of the following components of the health record:

- Respiratory therapy notes.
- Nursing notes.
- Medication administration record (MAR).
- Physician progress notes.
- Physician orders.
- Consultation notes.
- History and physical.
- Anesthesia record.
- Electronic care notes or patient education forms.

Note: If appropriate, clearly document the reason for not administering medication during the hospital stay. This includes: patient refuses medication, allergies, drug interactions, or other reasons documented by a physician, nurse practitioner, physician assistant, or pharmacist.

TOB-3: Tobacco Use Treatment Provided or Offered at Discharge

Purpose: The purpose of TOB-3 is to ensure that every hospitalized patient who uses tobacco is provided a referral to evidence-based, effective counseling and cessation medication(s) upon discharge.

Description: Hospitalized patients identified through the screening process as having used tobacco products (cigarettes, smokeless tobacco, pipe, and cigars) within the 30 days prior to hospitalization who were referred to or refused evidence-based out-patient counseling AND received or refused a prescription for FDA-approved cessation medication(s) at discharge.

It is important that all tobacco users (even those who refused in-patient counseling and medication) are offered both counseling and medication for tobacco cessation at discharge. A hospitalization (even a brief hospitalization) represents a change in a person's daily routine and the recovery period post-hospitalization provides a unique opportunity to establish new and healthier lifestyle patterns.

ARRANGE

TOB-3 – the delivery of discharge counseling and medication – corresponds to the "Arrange Follow-up" recommendation of the 2008 U.S. Public Health Service Clinical Practice Guideline. That Guideline documented that patients who have follow-up counseling and medication for tobacco cessation are more likely to successfully quit than those who don't.

Evidence-Based Out-Patient Counseling for TOB-3

Follow-up counseling can be arranged during the initial consult visit or subsequent inpatient cessation visits. Additionally, hospital discharge planners can assist in arranging follow-up cessation services even for patients who refused inpatient counseling. Discharge planners should have knowledge of resources available in the community to assist patients in maintaining abstinence. Outpatient cessation counseling may include proactive telephone, individual or group counseling, as well as e-health and internet interventions. A cessation counseling referral may be defined as an appointment made by an attending provider or hospital staff through phone contact, fax, or email.

Patients should also be provided with helpful discharge cessation resources such as quitline materials, community resources, self-help materials, and information about medication use. Discharge instructions should highlight suggestions for maintaining abstinence after hospitalization. Click here to see a sample discharge form.

There are a variety of options for systematic cessation follow-up counseling that meet the TOB-3 requirements:

- A scheduled follow-up cessation counseling session with the attending physician or another clinician. This visit should be scheduled to take place within one to two weeks after hospital discharge.
- Follow-up telephone call by designated hospital staff.
- Referral to group, community, or health plan cessation counseling. Local tobacco cessation programs often maintain contact information on the Wisconsin Tobacco Quit Line's internet site found here. *The Wisconsin Tobacco Quit Line is not responsible for the listing accuracy of local tobacco cessation programs nor is it responsible for efficacy claims by any tobacco cessation program listed on its website.*
- Referral to the Wisconsin Tobacco Quit Line at 1-800-QUIT NOW (784-8669). For quit line referrals, the provider or hospital can either assist the patient in directly calling the quit line prior to discharge or use Fax-to-Quit for direct referral for the patient from the hospital to the Quit Line. Click here to see a sample Fax-to-Quit form.

Fax-to-Quit

Fax- to-Quit is a program to directly refer your patients to the Wisconsin Tobacco Quit Line. It is a convenient way to have the Quit Line proactively call your patient to provide evidence-based counseling. Fax-to-Quit assists hospitals in meeting Joint Commission TOB-3 measure for tobacco use treatment at discharge. More information and how to implement Fax-to-Quit at your facility can be found by **clicking here**.

Medication for TOB-3

In addition to a referral for counseling at discharge, to meet the TOB-3 requirements, every tobacco user should receive a prescription for one (or more as needed) of the seven (7) FDA-approved medications. Discuss with the patient any issues concerning medications used during the hospital stay and continue that medication or another after discharge. Discharge is a great opportunity to promote continued abstinence. The patient may have a renewed interest in staying quit after successfully being in a tobacco-free hospital environment. If patients have positive experiences with the alleviation of their withdrawal symptoms by using cessation medication, they may be more likely to use this medication or other treatments in a future quit attempt or as part of an effort to maintain their abstinence post-hospitalization. If the patient declines cessation medication at discharge, this should be documented as well.

Documentation for TOB-3

Clearly document both referral for out-patient counseling and prescription for medication in the medical record. Documentation can be done in any of the following:

- Discharge summary/plan.
- Transfer sheet.
- Discharge Instructions.
- Medication Reconciliation Form (MAR).
- Nursing Discharge Summary.
- Physician Discharge Orders.

If the patient has been referred to the Quit Line using Fax-to-Quit, keep the patient Fax-to-Quit consent form in the medical record to document a referral for out-patient counseling.

Clinical Practice Guideline Recommendation

Use Both Counseling and Medication

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit.

Note: If the clinician and patient decide to continue or recommend a discharge cessation medication that does not require a prescription (e.g. over the counter NRT) or medication that will be provided through outpatient counseling such as the Quit Line, this should be documented in the record. Such documentation is sufficient for meeting the requirements of the TOB-3 measure. Finally, if you want to notify the patient's primary care provider about the inpatient tobacco dependence treatment intervention, we have provided a sample letter that you can view by clicking here.

TOB-4: Tobacco Use: Assessing Status after Discharge

Purpose: The purpose of TOB-4 is to assess the rate at which hospitalized patients who use tobacco and were recently discharged, quit tobacco use post-hospitalization.

Description: Discharged patients who are identified through the screening process as having used tobacco products within the 30 days prior to admission, should be contacted within 30 days after hospital discharge to assess and document tobacco use status.

As with other chronic diseases addressed during a hospitalization, the treatment of tobacco use and dependence is most effective when the in-hospital interventions are continued upon discharge.

Post-discharge contact with the patient may be made using a variety of methods including via phone calls, via in-person discussion at follow-up clinic visits, or by mailings (either electronic or hard copy mail), as long as information about tobacco use post discharge is received and catalogued by the hospital.

Models for follow-up contact to ensure compliance with TOB-4 include:

- Phone calls from hospital staff are standard practice after outpatient surgery or giving birth. A similar process can be instituted to address tobacco cessation follow-up, or additional questions and data gathering can be added to existing calls.
- Interactive Voice Response (IVR) is a telephone technology that allows a computer to place automated calls to patients, inquiring about their smoking status after discharge. The IVR system recognizes patients' verbal responses to prerecorded questions and records the responses in a database. Staff can review the results of IVR calls and respond appropriately to particular patient needs or requests. An IVR system can automate the substantial effort required to contact patients.
- If the patient returns for an in-person follow-up visit, hospitals must inquire about and document their post-discharge smoking status in order to meet TOB-4 requirements.

Utilizing a telephone quitline service

- Referring patients to the Wisconsin Tobacco Quit Line via the Fax-to-Quit option described above is an effective option for fulfilling TOB-4 follow up after discharge. If your hospital is a registered***** Fax-to-Quit site, the Wisconsin Tobacco Quit Line will fax a *Participant Outcome Report* to your office, describing the type of service the patient received through the Quit Line. Information provided includes:
  - Patient information.
  - Contact date.
  - Enrollment status.
  - Quit date (if applicable).
  - Medication dispensed (if applicable).
  - Counseling provided (if applicable).

  To see a sample participant outcome report from the Wisconsin Tobacco Quit Line click here.

***Only registered Fax-to-Quit sites will receive a Participant Outcome Report. Click here to find out how to become a registered hospital site.**

Clinical Practice Guideline Recommendation

Arrange for Follow-Up Cessation Treatment

Arrange for follow-up contact, either in-person or via telephone

- Timing: Follow-up contact should begin soon after the quit date, preferably during the first week. A second follow-up contact is recommended within the first month. Schedule additional follow-up contacts as appropriate.
- Actions during follow-up contact: For all patients, identify problems with quitting already encountered and anticipate challenges in the immediate future. Assess medication use and problems. Remind patients of quitline support (1-800-QUIT-NOW). Address tobacco use at next clinical visit (treat tobacco use as a chronic disease).
- For patients who are abstinent, congratulate them on their success.
- If tobacco use has occurred, review circumstances surrounding the lapse/relapse and elicit a recommitment to total abstinence.
- Timing and content for post-hospitalization cessation follow-up can be adjusted to make it consistent with TOB-4.

Documentation for TOB-4

Documentation in the health record for TOB-4 should include the date of follow-up contact and the patient's post-discharge tobacco use status. Phone calls can be logged in call logs. If contact is made through email or letter, use the date of receipt of the patient's response regarding post-discharge tobacco use status, not the date the letter or email was sent. The Fax-to-Quit *Participant Outcome Report* can also be used to document the patient's tobacco use status.

Other Considerations When Treating Tobacco Dependence in Hospitals

Coding/Billing/Reimbursement

ICD-10 Diagnosis Codes

An effective way to highlight the importance of treating the chronic disease of tobacco dependence is to list it as one of the admission and discharge diagnoses.

The ICD-9 code for tobacco dependence (305.1), changed to ICD-10 code **F17 nicotine dependence, with multiple subsections to define tobacco type and current or former use status**. For complete ICD-10 information click here.

CPT and HCPCS Codes

Commercial health plans: The Current Procedural Terminology (CPT) codes for tobacco use treatment are **99406** and **99407**. Time devoted to delivering the tobacco dependence treatment service along with appropriate documentation in the medical record should determine which of these two CPT codes are selected. These codes are for face-to-face counseling by a physician or other qualified health care professional, using "standardized, evidence-based screening instruments and tools with reliable documentation and appropriate sensitivity."

- **99406 should be used for intermediate visit of between 3 and 10 minutes.**
- **99407 should be used for an intensive visit lasting longer than 10 minutes.**

Some private health plans cover tobacco dependence counseling and/or medications, while others explicitly exclude tobacco addiction treatment services from coverage. Your billing department should inquire directly with each private plan to see whether tobacco treatment services are covered. Additionally, some patients may be willing to pay out of pocket for cessation medications that are not covered because tobacco cessation treatments are eligible expenses under many **flexible spending account plans**. These may enable patients to use pretax dollars to pay for these health care expenses not covered by insurance.

Medicare: Medicare covers counseling services for patients who use tobacco. Billing is for intermediate (3 – 10 minutes) and intensive (greater than 10 minutes) service levels. Coverage for up to three minutes of counseling is considered by Medicare to be included in reimbursement for the standard evaluation and management (E/M) visit. See the chart below and click here for more information on Medicare tobacco cessation benefits.

Following is a coding guideline for tobacco use prevention and cessation counseling Medicare benefits.

Health Status	Symptomatic Patient	Asymptomatic Patient
Qualifying Medical Patient	A patient who: 1. Uses tobacco and a. Has been diagnosed with a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use; or b. Is taking a therapeutic agent for which the metabolism or dosing is affected by tobacco use (based on U.S. Food and Drug Administration [FDA]-approved information); and 2. Is competent and alert at the time that counseling is provided; and 3. Receives counseling from a qualified physician or other Medicare-recognized health care professional	A patient who: 1. Uses tobacco but does not have symptoms of tobacco-related disease: 2. Is competent and alert at the time that counseling is provided; and 3. Receives counseling from a qualified physician or other Medicare-recognized health care professional
CPT Codes	99406: Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes, up to 10 minutes 99407: Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes	G0436: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes G0437: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes
ICD-10 Diagnosis Codes	F17.XX (multiple subsections). For full ICD-10 tobacco diagnostic codes click here.	F17.XX (multiple subsections). For full ICD-10 tobacco diagnostic codes click here.
Patient's Out-of-Pocket Cost	Eligible beneficiaries are covered under Medicare Part B. Both the coinsurance and deductible apply.	Eligible beneficiaries are covered under Medicare Part B. Both the coinsurance and deductible apply
Frequency	2 cessation attempts per 12-month period; maximum of 4 intermediate or intensive sessions per attempt (i.e., up to 8 sessions per 12-month period)	2 cessation attempts per 12-month period; maximum of 4 intermediate or intensive sessions per attempt (i.e., up to 8 sessions per 12-month period)

Adapted from: http://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/medicare-tobacco-cessation-counseling.pdf

***Medicaid**:* The 2010 Patient Protection and Affordable Care Act made some changes that increase state Medicaid coverage of tobacco cessation treatments. As of October 1, 2010, all Medicaid programs are required to cover comprehensive tobacco cessation benefits for pregnant Medicaid members. The legislation also removes tobacco cessation medications from the list of excludable medications, meaning that Medicaid programs may no longer explicitly exclude these treatments from coverage. And states that cover all preventive services given an 'A' or 'B' by the U.S. Preventive Services Task Force (including tobacco cessation) with no cost-sharing will begin receiving a one percentage point increase in the federal Medicaid matching rate for those services starting in 2014.

In 2011, Wisconsin Medicaid, BadgerCare & SeniorCare programs covered the following FDA-approved medications:

- Bupropion SR: Zyban, Wellbutrin or generic.
- Nicotine inhaler: Nicotrol.
- Nicotine nasal spray: Nicotrol.
- Nicotine patch: Over-the-counter, or prescribed as "legend" (SeniorCare covers only prescription "legend" patches).
- Nicotine gum: Over-the-counter (SeniorCare does not cover nicotine gum).
- Varenicline: Chantix.

Click here for more detailed information about tobacco dependence treatment benefits for Wisconsin Medicaid, BadgerCare and SeniorCare members.

Tobacco Users Who Are Unwilling to Quit

While most tobacco users have made at least one attempt to quit tobacco in their lives, some may be resistant to making a quit attempt during their hospitalization. The "5 Rs," *Relevance*, *Risks*, *Rewards*, *Roadblocks*, and *Repetition*, are designed to motivate smokers who are unwilling to quit at this time to consider quitting in the future. Smokers may be unwilling to quit due to misinformation, concern about the effects of quitting (e.g. withdrawal symptoms), or demoralization because of previous unsuccessful quit attempts. Therefore, after asking about tobacco use, advising the smoker to quit, and assessing the willingness of the smoker to quit, it is important to provide the "5 R" motivational intervention to smokers who say they are unwilling to make a quit attempt at this time. Click here to see a sample form to use with tobacco users who are not ready to quit.

The 5Rs for Tobacco Users Unwilling to Make a Quit Attempt at This Time

Relevance

Encourage the patient to indicate why quitting is personally *relevant*, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

Risks

The clinician should ask the patient to identify potential negative consequences (*risks*) of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks.

Examples of risks from tobacco use are:

- Acute risks: Shortness of breath, exacerbation of asthma, harm to pregnancy, infections, impotence, infertility, and increased serum carbon monoxide.
- Long-term risks: Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability, and need for extended care.
- Environmental risks: Increased risk of lung cancer and heart disease in spouses; higher rates of smoking in children of tobacco users; increased risk for low birth weight, sudden infant death syndrome (SIDS), asthma, middle ear disease, and respiratory infections in children of smokers.

Rewards
The clinician should ask the patient to identify potential *rewards* of stopping tobacco use and should highlight those that seem most relevant to the patient.

Examples of rewards resulting from quitting include:

- Improved health.
- Food will taste better.
- Improved sense of smell.
- Save money.
- Feel better about yourself.
- Home, car, clothing, breath will smell better.
- Can stop worrying about quitting.
- Set a good example for children.
- Have healthier babies and children.
- Not worry about exposing others to smoke.
- Feel better physically.
- Perform better in physical activities.
- Reduced wrinkling/aging of skin.

Roadblocks
The clinician should ask the patient to identify barriers or impediments to making a quit attempt and note elements of treatment (problem solving, pharmacotherapy) that could address *roadblocks*.

Typical barriers to making a quit attempt include:

- Withdrawal symptoms.
- Fear of failure.
- Weight gain.
- Lack of support.
- Depression.
- Enjoyment of tobacco.

Repetition
The motivational intervention should be *repeated* every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be reminded that most people make repeated quit attempts before they are successful.

Obstetrics/Maternity Units

Smoking during pregnancy and after giving birth can be detrimental to both the mother's and the infant's health. Infants exposed to smoke are more likely to suffer from sudden infant death syndrome (SIDS), bronchitis, pneumonia, asthma, and ear infections. Approximately 20% of women smoke in the months immediately prior to pregnancy, with one third to one half spontaneously suspending or quitting smoking during pregnancy. Unfortunately, about 50% relapse by 6 months postpartum, and up to 80% relapse within 12 months of childbirth.

With such high relapse rates among postpartum women and the serious health effects of secondhand smoke on infants, it is important to encourage and support women in their efforts to quit during pregnancy and/or remain quit after delivery. The post-delivery hospital stay is an important opportunity for clinicians to implement post-partum interventions designed to prevent relapse. In addition to the counseling strategies described above, discuss the following relapse prevention topics with this population:

- Risks of second-hand smoke exposure.
- Health benefits of quitting for mother and baby.
- Potential or underlying issues such as postpartum depression and stress management.
- Friends and other family members who smoke in or around the home.
- Resuming activities that might trigger cravings (consumption of alcohol, return to work outside the home, social activities that put her around other smokers, full load of household or other chores).
- Coping with weight gain. Most people gain some weight when they quit smoking. However, after having a baby, it may be difficult to separate the weight gained from the pregnancy versus the weight gained from quitting smoking. Many women are eager to lose weight after having a baby, so it is important to emphasize that they not turn to tobacco as a way to regulate their weight. Instead, they should be urged to use healthier ways to manage weight. Click here to see a fact sheet on managing weight gain after quitting.

For examples of assessment/intervention forms for documenting postpartum interventions with women who use tobacco while pregnant or quit during their pregnancy click here, click here, and click here. Refer to the National Partnership for Smoke-free Families website for more information and resources by clicking here.

First Breath is a program that helps pregnant and postpartum women in Wisconsin quit smoking. For more information, click here.

Patient Education

The University of Wisconsin Center for Tobacco Research & Intervention and the Wisconsin Tobacco Quit Line (800-QUIT-NOW) have resources for your patients.

Facts About the Wisconsin Tobacco Quit Line - Details the process of telephone counseling and free, over-the-counter tobacco cessation medication delivery:
http://www.ctri.wisc.edu/page-factsheets.htm

Quit Line Web Coach - Outlines how Wisconsin Tobacco Quit Line callers can receive free and unlimited online support and interaction during their quit attempt:
http://www.ctri.wisc.edu/factsheetwebcoach.htm

Menu of Tobacco Cessation FDA-approved Medications - Describes how to use each of the seven (7) FDA-approved medications, including their contraindications and dosages:
http://www.ctri.wisc.edu/smokers-meds.htm

Prepare to Quit – Tips for patients on how to prepare themselves for their quit date:
http://www.ctri.wisc.edu/factsheet1.htm

What Happens When You Quit – Details about how quickly the human body begins to repair itself after quitting smoking or using smokeless tobacco:
http://www.ctri.wisc.edu/documents/7.whathappensuw.pdf

Getting Through the First Week After You Quit – Practical ideas on how to navigate the first week as a non-tobacco-user:
http://www.ctri.wisc.edu/factsheet6.htm

Chewing Tobacco Quit Guide – Tips on becoming a non-smokeless-tobacco-user:
http://www.ctri.wisc.edu/factsheet9.htm

Managing Weight After Quitting – Tips for managing weight after quitting:
http://www.ctri.wisc.edu/factsheet15.htm

Treatment Resources and Videos

University of Wisconsin Center for Tobacco Research and Intervention: www.ctri.wisc.edu

Quit Tobacco Materials for Providers
http://www.ctri.wisc.edu/page-factsheets.htm

- ✓ Medications Chart
- ✓ Interactive Quit Plan - Type It In and Print It Out
- ✓ Tobacco Treatment Chart with the 5 A's-Fact Sheet #2
- ✓ Wisconsin Medicaid, Badger Care & Senior Care Cover Treatments to Quit Tobacco-Fact Sheet #3
- ✓ Medicare Covers Medication & Counseling For Tobacco Cessation-Fact Sheet #4
- ✓ Locate a UW-CTRI Outreach Professional-Fact Sheet #8
- ✓ Quit Chewing Tobacco-Fact Sheet #9
- ✓ Outreach Programs Overview-Fact Sheet #10
- ✓ Varenicline Fact Sheet-Fact Sheet #11
- ✓ Smoking Cessation Billing and Diagnostic Counseling Codes-Fact Sheet #14
- ✓ Weight Management after Quitting Tobacco Use-Fact Sheet #15

Inpatient Tobacco Dependence Treatment Videos for the Clinician
http://www.ctri.wisc.edu/video-hospitals.htm

- ✓ Patient with cardiovascular disease
- ✓ Patient with pulmonary disease
- ✓ Patient being discharged

Wisconsin Tobacco Quit Line Resources
http://www.ctri.wisc.edu/page-factsheets.htm

- ✓ Quit Line Fact Sheet
- ✓ Quit Line Web Coach
- ✓ Fax To Quit FAQ

Additional Online Treatment Resources

The websites listed here are intended to assist readers in finding additional information regarding the treatment of tobacco dependence and does not constitute a UW-CTRI endorsement of the contents of any particular site.

Agency for Health Care Research and Quality (AHRQ) - *Treating Tobacco Use and Dependence*: Quick Reference Guide for Clinicians:
http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/quickref/index.html

Agency for Health Care Research and Quality (AHRQ) - hospital patient handout in English and Spanish:
http://ahrqpubs.ahrq.gov/OA_HTML/ibeCCtpItmDspRte.jsp?section=10170&item=18552

American Academy of Family Physicians Ask and Act Tobacco Cessation Program:
www.askandact.org

American Lung Association: (maintains profiles of state tobacco control activities):
http://www.lungusa.org/stop-smoking/

Association for the Treatment of Tobacco Use and Dependence: www.attud.org

Campaign for Tobacco-Free Kids: www.tobaccofreekids.org

Joint Commission: http://manual.jointcommission.org/
A description of the tobacco measure development process and the four components that constitute the Joint Commission tobacco cessation performance measure set:
http://www.ctri.wisc.edu/documents/joint.pdf

National Cancer Institute: www.nci.nih.gov

National Partnership for Smoke-free Families:
http://www.smokefreefamilies.tobacco-cessation.org

Office on Smoking and Health at the Centers for Disease Control and Prevention:
www.cdc.gov/tobacco

Office of the Surgeon General:
http://www.surgeongeneral.gov/index.html

Office of the Surgeon General: The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014
http://www.surgeongeneral.gov/library/reports/50-years-of-progress/index.html
http://www.surgeongeneral.gov/library/reports/50-years-of-progress/consumer-guide.pdf

Partnership for Prevention – Working with Healthcare Delivery Systems to Improve the Delivery of Tobacco-Use Treatment to Patients:
www.prevent.org/data/files/initiatives/tobaccousetreatment.pdf

Society for Research on Nicotine and Tobacco: www.srnt.org

Tobacco Free Nurses: www.tobaccofreenurses.org

Smokeless Tobacco Education and Treatment Resources

Centers for Disease Control smokeless tobacco information and factsheets:
http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/

Fact sheets with information and statistics regarding spit tobacco:
http://www.tobaccofreekids.org/research/factsheets/pdf/0003.pdf

My Last Dip, a web-based smokeless tobacco cessation project offers two unique programs to help chewing tobacco users quit: http://mylastdip.com/

National Cancer Institute's smokeless tobacco fact sheet: http://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco/smokeless-fact-sheet

National Institutes of Health funded this site to help people quit their use of chewing tobacco or snuff; teen friendly: http://chewfree.com/

Robert Wood Johnson Foundation national smokeless tobacco education program:
http://www.rwjf.org/pr/product.jsp?id=34370

The National Institute of Dental and Craniofacial Research guide for quitting smokeless tobacco:
http://www.nidcr.nih.gov/OralHealth/Topics/SpitTobacco/SpitTobaccoAGuideforQuitting.htm

UW-CTRI information and cessation methods for smokeless tobacco users:
http://www.ctri.wisc.edu/smokers-smokeless.htm

Programs/Training

UW-CTRI Tobacco Use and Dependence: An Updated Review of Treatments CME/CE
Free, online course describes evidence-based, effective interventions for tobacco use:
http://www.ocpd.wisc.edu/tobaccocme.html

Association for the Treatment of Tobacco Use and Dependence (ATTUD)
ATTUD is an organization dedicated to the promotion of and increased access to evidence-based tobacco treatment:
Accredited programs: http://attud.org/
Training program information: http://www.attud.org/ttstrainprogcreds.php

Mayo Clinic Nicotine Education Program Distance Educational Offerings
Nicotine Education Program **1-800-344-5984** or:
http://mayoresearch.mayo.edu/mayo/research/ndc_education/webed_sess.cfm

Annual Mayo Clinic Nicotine Dependence Conference
https://ce.mayo.edu/

Smoking Cessation Leadership Center (SCLC)
See links to courses and trainings:
http://smokingcessationleadership.ucsf.edu/Resources.htm#Courses

University of Massachusetts
Distance learning opportunities offered by the University of Massachusetts Medical School Center for Tobacco Treatment Research and Training:
http://www.umassmed.edu/tobacco/training/CE.aspx

West Virginia University's Tobacco Research Intensive Lecture Series (TRILS)
Tobacco and Co-Occurring Health Risks and Disparities live Webcasts offer continuing education credits: http://www.hsc.wvu.edu/mbrcc/trils/

Hospital References

The following articles are free online through PubMed:
http://www.ncbi.nlm.nih.gov/pubmed

Duffy SA, Karvonen-Gutierrez CA, Ewing LA, Smith PM. Implementation of the Tobacco Tactics program in the Department of Veterans Affairs. *Journal of General Internal Medicine.* Jan 2010;25 Suppl 1:3-10.

Faseru B, Turner M, Casey G, et al. Evaluation of a hospital-based tobacco treatment service: outcomes and lessons learned. *Journal of hospital medicine : an official publication of the Society of Hospital Medicine.* Apr 2011;6(4):211-218.

Faseru B, Yeh HW, Ellerbeck EE, Befort C, Richter KP. Prevalence and predictors of tobacco treatment in an academic medical center. *Jt Comm J Qual Patient Saf.* Nov 2009;35(11):551-557.

Jones R, Nyawo B, Jamieson S, Clark S. Current smoking predicts increased operative mortality and morbidity after cardiac surgery in the elderly. *Interactive Cardiovascular and Thoracic Surgery.* Mar 2011;12(3):449-453.

Mazza R, Lina M, Boffi R, Invernizzi G, De Marco C, Pierotti M. Taking care of smoker cancer patients: a review and some recommendations. *Annals of Oncology* 2010;21(7):1404-1409.

Mohiuddin SM, Mooss AN, Hunter CB, Grollmes TL, Cloutier DA, Hilleman DE. Intensive smoking cessation intervention reduces mortality in high-risk smokers with cardiovascular disease. *Chest.* 2007;131(2):446-452.

Shi Y, Warner DO. Brief preoperative smoking abstinence: Is there a dilemma? *Anesth Analg* 2011;113(6):1348-1351.

Tonnesen H, Faurschou P, Ralov H, Molgaard-Nielsen D, Thomas G, Backer V. Risk reduction before surgery. The role of the primary care provider in preoperative smoking and alcohol cessation. *BMC Health Services Research.* 2010;10:121.

Warner DO. Preoperative smoking cessation: how long is long enough? *Anesthesiology.* 2005;102(5):883-884.

The following article is free and available through AHRQ:

Agency for Healthcare Research and Quality. Nurse-led program increases provision of cessation counseling to inpatients who smoke. 2009. https://innovations.ahrq.gov/profiles/nurse-led-program-increases-provision-cessation-counseling-inpatients-who-smoke

There is a charge for online access for the following articles, so we have provided the abstract for each.

Myers K, Hajek P, Hinds C, McRobbie H. Stopping smoking shortly before surgery and postoperative complications: A systematic review and meta-analysis. *Archives of Internal Medicine.* 2011;171(11):983-989.

OBJECTIVE: To examine existing smoking studies that compare surgical patients who have recently quit smoking with those who continue to smoke to provide an evidence-based recommendation for front-line staff. Concerns have been expressed that stopping smoking within 8 weeks before surgery may be detrimental to postoperative outcomes. This has generated considerable uncertainty even in health care systems that consider smoking cessation advice in the hospital setting an important priority. Smokers who stop smoking shortly before surgery (recent quitters) have been reported to have worse surgical outcomes than early quitters, but this may indicate only that recent quitting is less beneficial than early quitting, not that it is risky.
DESIGN: Systematic review with meta-analysis.
STUDY SELECTION: Studies were included that allow a comparison of postoperative complications in patients undergoing any type of surgery who stopped smoking within 8 weeks prior to surgery and those who continued to smoke.
RESULTS: Nine studies met the inclusion criteria. One found a beneficial effect of recent quitting compared with continuing smoking, and none identified any detrimental effects. In meta-analyses, quitting smoking within 8 weeks before surgery was not associated with an increase or decrease in overall postoperative complications for all available studies (relative risk [RR], 0.78; 95% confidence interval [CI], 0.57-1.07), for a group of 3 studies with high-quality scores (RR, 0.57; 95% CI, 0.16-2.01), or for a group of 4 studies that specifically evaluated pulmonary complications (RR, 1.18; 95% CI, 0.95-1.46).
CONCLUSIONS: Existing data indicate that the concern that stopping smoking only a few weeks prior to surgery might worsen clinical outcomes is unfounded. Further larger studies would be useful to arrive at a more robust conclusion. Patients should be advised to stop smoking as early as possible, but there is no evidence to suggest that health professionals should not be advising smokers to quit at any time prior to surgery.

NOTE: Comments on the Myers, et al. article above are found at:

Chow CK, Devereaux PJ. The optimal timing of smoking cessation before surgery: comment on "smoking cessation shortly before surgery and postoperative complications". Comment. *Archives of Internal Medicine.* 2011;171(11):989-990.

Shi Y, Warner DO. Brief preoperative smoking abstinence: Is there a dilemma? *Anesth Analg* 2011;113(6):1348-1351.

Kisuule F, Necochea A, Howe EE, Wright S. Utilizing audit and feedback to improve hospitalists' performance in tobacco dependence counseling. *Nicotine & Tobacco Research: official journal of the Society for Research on Nicotine and Tobacco.* Aug 2010;12(8):797-800.

INTRODUCTION: Hospitalized smokers benefit from smoking cessation counseling and nicotine replacement therapy (NRT). However, inpatient providers who care for hospitalized patients carry out these preventive measures inconsistently.
METHODS: We designed a peer-led audit and feedback intervention to improve (a) the frequency of smoking cessation counseling and (b) the appropriateness of the prescribing of NRT by hospitalist practitioners in our hospital. Documentation of tobacco cessation counseling in progress notes and discharge summaries and the ordering and dosing of NRT were assessed for 30 hospitalists before and after an intervention. This intervention included specific feedback on their counseling and prescribing practices as well as education and was delivered as part of a one-on-one academic detailing session.
RESULTS: Five hundred and forty five and 1,119 patient-days were considered for this analysis in the pre- and postperiods, respectively. Documentation of tobacco dependence counseling in progress notes increased from 36% to 44% ($p = .002$) and from 7.5% to 46.8% in discharge summaries ($p < .0001$) following the intervention. The appropriateness of NRT dosing increased from 26% (before) to 64% (after) the intervention ($p < .0001$).
DISCUSSION: A peer-led audit and feedback intervention for hospitalists significantly increases the frequency of smoking cessation counseling and the adequacy of NRT prescribing for hospitalized smokers.

Ladapo JA, Jaffer FA, Weinstein MC, Froelicher ES. Projected cost-effectiveness of smoking cessation interventions in patients hospitalized with myocardial infarction. *Archives of Internal Medicine.* Jan 10 2011;171(1):39-45.

BACKGROUND: As many as 70% of smokers with acute myocardial infarction (AMI) continue to smoke after hospital discharge despite high rates of inpatient smoking cessation counseling. Supportive contact after discharge improves quit rates but is rarely used.
METHODS: Using data from a meta-analysis of randomized trials of smoking cessation interventions and other published sources, we developed a Monte Carlo model to project health and economic outcomes for a hypothetical US cohort of 327,600 smokers hospitalized with AMI. We compared routine care, consisting of advice to quit smoking, with counseling with supportive follow-up, consisting of

routine care and follow-up telephone calls from a nurse after discharge. Primary outcomes were number of smokers, AMIs, and deaths averted; health care and productivity costs; cost per quitter; and cost per quality-adjusted life-year.
RESULTS: Implementation of smoking cessation counseling with follow-up contact for the 2010 cohort of hospitalized smokers would create 50,230 new quitters, cost $27.3 million in nurse wages and materials, and prevent 1380 nonfatal AMIs and 7860 deaths. During a 10-year period, it would save $22.1 million in reduced hospitalizations but increase health care costs by $166.4 million, primarily through increased longevity. Productivity costs from premature death would fall by $1.99 billion and nonmedical expenditures would increase by $928 million, for a net positive value to society of $894 million. The program would cost $540 per quitter considering only intervention costs. Cost-effectiveness would be $5050 per quality-adjusted life-year. Results were sensitive to the utility and incidence of nonfatal AMI and the potential effect of pharmacotherapies.
CONCLUSION: Smoking cessation counseling with supportive contact after discharge is potentially cost-effective and may reduce the incidence of smoking and its associated adverse health events and social costs.

Rigotti N, Munafo M, Stead L. Interventions for smoking cessation in hospitalised patients. *Cochrane Database Syst Rev.* 2007(3):CD001837.

BACKGROUND: A hospital admission provides an opportunity to help people stop smoking. Providing smoking cessation advice, counseling, or medication is now a quality-of-care measure for US hospitals. We assessed the effectiveness of smoking cessation interventions initiated during a hospital stay.
METHODS: We searched the Cochrane Tobacco Addiction Review Group's register for randomized and quasirandomized controlled trials of smoking cessation interventions (behavioral counseling and/or pharmacotherapy) that began during hospitalization and had a minimum of 6 months of follow-up. Two authors independently extracted data from each article, with disagreements resolved by consensus.
RESULTS: Thirty-three trials met inclusion criteria. Smoking counseling that began during hospitalization and included supportive contacts for more than 1 month after discharge increased smoking cessation rates at 6 to 12 months (pooled odds ratio [OR], 1.65; 95% confidence interval [CI], 1.44-1.90). No benefit was found for interventions with less postdischarge contact. Counseling was effective when offered to all hospitalized smokers and to the subset admitted for cardiovascular disease. Adding nicotine replacement therapy to counseling produced a trend toward efficacy over counseling alone (OR, 1.47; 95% CI, 0.92-2.35). One study added bupropion hydrochloride to counseling, which had a nonsignificant result (OR, 1.56; 95% CI, 0.79-3.06).

CONCLUSIONS: Offering smoking cessation counseling to all hospitalized smokers is effective as long as supportive contacts continue for more than 1 month after discharge. Adding nicotine replacement therapy to counseling may further increase smoking cessation rates and should be offered when clinically indicated, especially to hospitalized smokers with nicotine withdrawal symptoms

Thomsen T, Villebro N, Moller AM. Interventions for preoperative smoking cessation. *Cochrane Database of Systematic Reviews.* 2010(7):CD002294.

BACKGROUND: Smokers have a substantially increased risk of postoperative complications. Preoperative smoking intervention may be effective in decreasing this incidence, and surgery may constitute a unique opportunity for smoking cessation interventions.
OBJECTIVES: The objective of this review was to assess the effect of preoperative smoking intervention on smoking cessation at the time of surgery and 12 months postoperatively and on the incidence of postoperative complications.
SELECTION CRITERIA: Randomized controlled trials that recruited people who smoked prior to surgery, offered a smoking cessation intervention, and measured preoperative and long-term abstinence from smoking and/or the incidence of postoperative complications.
AUTHORS' CONCLUSIONS: There is evidence that preoperative smoking interventions including NRT increase short-term smoking cessation and may reduce postoperative morbidity. The optimal preoperative intervention intensity remains unknown. Based on indirect comparisons and evidence from two small trials, interventions that begin four to eight weeks before surgery, include weekly counseling, and use NRT are more likely to have an impact on complications and on long-term smoking cessation.

Hospital Assessment of Tobacco Use
Procedures and Policies Worksheet

Department/Unit_____

Contact Person, Title_____

Ext. _____ **Date** _____

1. Does department/unit have a dedicated staff member, cessation champion, or team to provide tobacco dependence treatment? _____ yes _____ no

If yes, who (names and positions) _____

_____

2. Does clinic dept/hospital unit have a system for identifying and documenting tobacco users? (i.e. vital signs or stamp) _____ yes _____ no

Describe system: _____

_____

3. Are patients being asked about their tobacco use status at EVERY visit? _____ yes _____ no

Who initially identifies tobacco status (name and position) _____

_____

4. Is tobacco use status (not use) documented each time? _____ yes _____ no

How is status documented? _____

_____

5. Who will initially counsel patient regarding cessation? _____

---

6. If not the physician, how will the physician receive cue to reinforce counseling message? (How would nurse relate to physician if patient wanted a prescription medication such as bupropion?)

---

7. Does clinic dept/hospital unit have a tool for creating an “action plan” to cessation? (Patient handout)

_____ yes _____ no If yes, please attach copy.

8. What is the process, who will provide, and what is time line for patient follow-up?

---

9. How will champion ensure standard of care is being implemented?

_____

_____

10. Who will be responsible for tracking inventory? _____

---

11. Where will program materials be stored? _____

---

12. Is staff aware of cessation pharmacotherapy? _____ yes _____ no

13. Is staff aware of cessation pharmacotherapy insurance coverage? _____ yes _____ no

14. Are cessation medications offered to patients regardless of insurance coverage?
_____ yes _____ no

ADDRESS:

BIRTHDATE/AGE: SEX:

MEDICAL RECORD NUMBER:

PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

UMASS MEMORIAL MEDICAL CENTER

PHYSICIAN'S ORDERS
NICOTINE DEPENDENCE TREATMENT

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

MR

NAME

DOB SEX

University of Wisconsin Hospital and Clinics
600 Highland Avenue - Madison, Wisconsin 53792

Tobacco Abstinence - Adult - Supplemental Order Set

Date of Service_____

Date	Time	Initials		
			Patient Care Orders	
			Non-Categorized Patient Care Orders	
			[ ] Tobacco Cessation Counseling	ONCE, For 1 Occurrence, For patients motivated to make a quit attempt.
			[ ] Education based on patient's stage of readiness ("Tobacco Use Assessment")	ONCE, For 1 Occurrence
			Medication - Tobacco Abstinence	
			Regimen #1 - Nicotine Gum **NOTE: Order alone or in addition to any other regimen**	
			[ ] nicotine polacrilex (NICORETTE) gum	4 mg, Oral, EVERY 1 HOUR PRN, nicotine replacement Chew and park. Maximum 24 pieces/day.
			Regimen #2 - Nicotine Patch for Patients Smoking Less Than 10 Cigarettes/Day **NOTE: Order all if ordering from this group**	
			[ ] nicotine (NICOTROL) 24hr patch	14 mg, Transdermal, EVERY 24 HOURS For 28 Days Apply to upper body or upper outer arm for nicotine replacement
			[ ] nicotine (NICOTROL) 24hr patch	7 mg, Transdermal, EVERY 24 HOURS Starting 28 Days After Initial Dose For 28 Days Apply to upper body or upper outer arm for nicotine replacement
			Regimen #3 - Nicotine Patch for Patients Smoking 10 or More Cigarettes/Day **NOTE: Order all if ordering from this group**	
			[ ] nicotine (NICOTROL) 24hr patch	21 mg, Transdermal, EVERY 24 HOURS For 28 Days Apply to upper body or upper outer arm for nicotine replacement
			[ ] nicotine (NICOTROL) 24hr patch	14 mg, Transdermal, EVERY 24 HOURS Starting 28 Days After Initial Dose For 14 Days Apply to upper body or upper outer arm for nicotine replacement
			[ ] nicotine (NICOTROL) 24hr patch	7 mg, Transdermal, EVERY 24 HOURS Starting 42 Days After Initial Dose For 14 Days Apply to upper body or upper outer arm for nicotine replacement

MR

NAME

DOB SEX

University of Wisconsin Hospital and Clinics
600 Highland Avenue - Madison, Wisconsin 53792

Tobacco Abstinence - Adult - Supplemental Order Set

Date of Service_____

Date	Time	Initials		
			Regimen #4 - Non-Nicotine Agent - Varenicline **NOTE: Order all if ordering from this group**	
			[ ] varenicline (CHANTIX) tab	0.5 mg, Oral, 1 X DAILY For 3 Days
			[ ] varenicline (CHANTIX) tab	0.5 mg, Oral, 2 X DAILY (AT MEALTIME) Starting 3 Days After Initial Dose For 4 Days
			[ ] varenicline (CHANTIX) tab	1 mg, Oral, 2 X DAILY (AT MEALTIME) Starting 7 Days After Initial Dose For 77 Days
			Regimen #5 - Non-Nicotine Agent - Bupropion **NOTE: Order all if ordering from this group**	
			[ ] bupropion (WELLBUTRIN SR) 12hr ER tab	150 mg, Oral, 1 X DAILY For 3 Days
			[ ] bupropion (WELLBUTRIN SR) 12hr ER tab	150 mg, Oral, 2 X DAILY (AT MEALTIME) Starting 3 Days After Initial Dose For 81 Days
			Consults	
			[ ] Consult Learning Center (Inpatient)	ONCE, For 1 Occurrence Type of Education: Tobacco Cessation Reason for Consult: Tobacco Dependence
			[ ] Consult Cardiac Rehab/Preventive Cardiology (Inpatient)	ONCE, For 1 Occurrence Reason for consult: Smoking cessation counseling

MD Signature:_____ Date:_____ Time:_____ Pager#:_____

Transcriber Key

Initials	**Signature**

Respiratory Therapy Referral
Tobacco Cessation Intervention and Education

To be completed by RN with Admission History:

Admitting RN to ask the following questions of patient:

1. Do you use any type of tobacco product?
   _____Yes _____No

2. How long have you used tobacco products?
   _____

3. How much and how often?
   _____per day (packs or individual tobacco items)
   _____dips or chews per day

4. Have you used any tobacco product within the past 12 months?
   _____Yes _____No

5. Do any household members use tobacco products or smoke?
   _____Yes _____No

If answer "Yes" to any question, admitting RN to give form to Unit Clerk to put "order" in for Respiratory Therapy "Tobacco Cessation Education consult".

Affix patient label here

Referred by: (RN Signature) _____

Date: _____ **Time:** _____

Place form under RT tab in patients chart.

INTEGRIS Health

10028264

NOT Ready to Quit

Tobacco Assessment & Education Form

Nicotine History: ____age began using tobacco ____quit attempts
____how many years ____how long abstinent
____how many packs/chews/cigars per day
relapse problems: _____
household members who smoke: _____
household members willingness to support: _____

Primary Physician:_____

1. If not ready to quit at this time, promote motivation to quit:
a. Relevance - encourage the patient to indicate why quitting is personally relevant
____ children ____ health problem____ social stigma ____other

b. Risks - ask the patient to identify potential negative consequences to tobacco use
____energy level____ second hand smoke____ heart disease____ cancer
____other

c. Rewards - ask the patient to identify potential benefits of stopping tobacco use
____money saved____ increased health benefits____ no worrying about quitting
____ no social stigma____ increased energy____ increased recovery____ other

d. Roadblocks - ask the patient to identify barriers to quitting
____specific triggers_____
____family smokers____ environmental factors (work)____
failed attempts_____what you like about using tobacco_____
____ other

a. tobacco users who have failed in previous attempts should be told that most people make repeated quit attempts before they are successful

2. Workbook given and reviewed with patient. ____ complete

3. Discuss phone and/or letter follow -up:
a. will be within one month of discharge
b. where/when can you be reached?_____
c. phone # _____

4. Date of discharge _____
Interviewer Signature_____ Date_____

5. Notes:
FAX AT TIME OF DISCHARGE TO NURSE OF FOLLOW-UP PHYSICIAN

PRENATAL FIVE As TOBACCO CESSATION INTERVENTION RECORD

Client Name: _____ **Date of Birth:** / /

ASK client to choose the statement that best describes her smoking status

Write the letter in the box

A. I have **NEVER** smoked or have smoked less than 100 cigarettes in my lifetime.

B. I stopped smoking **BEFORE** I found out I was pregnant and am not smoking now.

C. I stopped smoking **AFTER** I found out I was pregnant, and I am not smoking now.

D. I am still smoking now.

ADVISE - Clear, strong, personalized advice to quit - Note benefits for woman & whole family – 1st Visit

Advised client to quit ☐

ASSESS - Assess willingness to quit in next 30 days - check boxes and enter dates where appropriate			
Enter date of visit	**1st visit** / /	**2nd visit** / /	**3rd visit** / /
NOT READY TO QUIT (If checked **CONTINUE to ARRANGE**)	☐	☐	☐
READY TO QUIT (DATE)	/ /	/ /	/ /
Quit since last visit (DATE)		/ /	/ /
Still smoking		☐	☐
Relapsed		☐	☐
Stayed Quit		☐	☐

ASSIST - For those who are ready to quit, provide pregnancy-specific counseling and information			
Used a problem-solving method (i.e. identify triggers/support systems)	☐	☐	☐
Assessed social environment (with whom/where do they smoke?)	☐	☐	☐
Provided pregnancy-specific materials	☐	☐	☐
Referred to Quit Line **(check box, fill out referral form and fax)**	☐	☐	☐

ARRANGE - Inform client you will talk further about cessation/staying quit at next visit			
Arranged (check box when complete)	☐	☐	☐

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support of The Robert Wood Johnson Foundation

POST-NATAL FIVE As TOBACCO CESSATION INTERVENTION RECORD

Client Name: _____ **Date of Birth:** / /

ASK client to choose the statement that best describes her smoking status

Write the letter in the box

A. I have **NEVER** smoked or have smoked less than 100 cigarettes in my lifetime.
B. I stopped smoking **BEFORE** I found out I was pregnant and am not smoking now.
C. I stopped smoking **AFTER** I found out I was pregnant, and I am not smoking now.
D. I stopped smoking during pregnancy, but I am smoking now.
E. I smoked during pregnancy, and I am smoking now

ASK client about second hand smoke

	CIRCLE
Mother	
a. Does the child's mother currently smoke in the **home**?	**Y N**
b. Does the child's mother currently smoke in the **car**?	**Y N**
Father	
a. Does the child's father smoke?	**Y N**
b. Does the child's father currently smoke in the **home**?	**Y N**
c. Does the child's father currently smoke in the **car**?	**Y N**
Others	
a. Is the child exposed to tobacco smoke on a regular basis (any exposure at least 1 time per week) from anyone other than the parents?	**Y N**

ADVISE - Clear, strong, personalized advice to quit - Note benefits for woman & whole family – 1st Visit

Advised client to quit ☐

ASSESS - Assess willingness to quit in next 30 days - check boxes and enter dates where appropriate

Enter date of visit	1st visit / /	2nd visit / /	3rd visit / /
NOT READY TO QUIT (If checked **CONTINUE to ARRANGE**)	☐	☐	☐
READY TO QUIT (DATE)	/ /	/ /	/ /
Quit since last visit (DATE)		/ /	/ /
Still smoking		☐	☐
Relapsed		☐	☐
Stayed Quit		☐	☐

ASSIST - For those who are ready to quit, provide parenting-specific counseling and information

Used a problem-solving method (i.e. identify triggers/support systems)	☐	☐	☐
Assessed social environment (with whom/where do they smoke?)	☐	☐	☐
Provided parent-specific materials	☐	☐	☐
Referred to Quit Line **(check box, fill out referral form and fax)**	☐	☐	☐

ARRANGE - Inform client you will talk further about cessation/staying quit at next visit

Arranged (check box when complete)	☐	☐	☐

Developed by Smoke-Free Families with the support of The Robert Wood Johnson Foundation

SMOKE-FREE FAMILIES POSTPARTUM ASSESSMENT FORM
(Page 1 of 1)

ID #: _____ Date: _____/_____/_____
(mo) (day) (yr)

1. Have you smoked a cigarette, even a puff, WITHIN THE LAST 30 DAYS? (*Circle one*)

1. Yes **2.** No

2. Have you smoked a cigarette, even a puff, WITHIN THE LAST 7 DAYS? (*Circle one*)

1. Yes **2.** No

3. **DURING** THE PAST 7 DAYS, how many cigarettes did you usually smoke each day?
(*If none, your answer should be "0."*)

_____ cigarettes

4. How much do you think that cigarette smoking can harm your infant's health? (*Circle one*)

1	**2**	**3**	**4**
not at all	a little	some	a lot

5. How is cigarette smoking handled in your home? (*Circle one*)

1. No one is allowed to smoke in my home

2. Only special guests are allowed to smoke in my home

3. People are allowed to smoke only in certain areas in my home

4. People are allowed to smoke anywhere in my home

6. Has your baby's doctor or nurse ever talked with you about the importance of not smoking around your baby? (*Circle one*)

1. Yes **2**. No

7. During the past month, how much of the time have you felt downhearted and blue? (*Circle one*)

1	**2**	**3**	**4**
never	some	a lot	all

8. When was your baby born? Date (month, day, year): _____

9. How much did your baby weigh at birth? _____ pounds, _____ ounces

WISCONSIN TOBACCO QuitLine 800-QUIT-NOW

When complete, please fax to: 1-800-xxx-xxxx

Wisconsin Tobacco Quit Line Fax to Quit Consent Form

Fax to Quit is for patients who are **ready to quit in the next 30 days** AND **ready to accept a call from the Quit Line**. If neither of these conditions is met, Fax to Quit is not appropriate at this time. Instead, provide patient with Quit Line or other tobacco resource information.

Provider Information:

Fax Sent Date: ___ / ___ / ___

Facility Name: _____

HIPAA-Covered Entity (Please check one): ☐ Yes ☐ No ☐ I don't know

Healthcare Provider: _____

Address: _____

City: _____ **Zip:** _____ **County:** _____

Contact Name: _____

Fax: (_____) _____ - _____ **Phone:** (_____) _____ - _____

Email: _____

Comments: *(e.g. Patient has COPD, diabetes, any information that might be helpful to the Quit Line)*

Patient Information: *(please print)*

Pregnant? ☐ Yes ☐ No

Patient Name: _____ **DOB:** ___/___/____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: (_____) _____ - _____ **Alternate Phone Number:** (_____) _____ - _____

Language Preference (check one): ☐ English ☐ Other - _____

Tobacco Type (check primary use): ☐ Cigarettes ☐ Chew / Spit ☐ Cigar ☐ Pipe

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

The Wisconsin Tobacco Quit Line will call you. The call will come from *"Free & Clear,"* area code *"206"*. Please check the best times for them to reach you in the next 72 HOURS. The Quit Line is open 7 days a week:

☐ 7am - 11am ☐ 11am - 2pm ☐ 2pm - 5pm ☐ 5pm - 8pm ☐ 8pm - 11pm

Comments: *(e.g. I'm not available weekends, prefer Tues or Thurs, after 9pm, etc.)*

Patient Signature: _____ **Date:** ____/____/____

Wisconsin Tobacco Quit Line Fax to Quit Treatment Outcome Sample Form

Your Clinic recently referred a patient via the Wisconsin Quit Line Fax Referral Program. This form describes the type of service the patient received through the Wisconsin Quit Line. Please place this in the patient's files.

Clinic Information

Clinic Name:

Clinic Phone Number:

Clinic Fax Number:

Patient Information

Participants Name:

Participants Address:

Participants Primary Phone Number:

Participants Date of Birth:

Outcomes

Disposition:

Contact Date if Contacted:

Planned Quit Date (If accepted services):

Stage (If accepted services):

NOTE:
Status
Accepted Services: Participant was reached and accepted service.
Declined Services: Participant was reached and declined service.
Unreachable: Attempts were made to contact the participant during their best time, but the quitline was unable to reach the participant.

Disposition
General Questions: Participant asked general questions and the quitline and its services, but did not opt for an intervention or materials.
Materials Only: Participant requested quit guides only.
One-Call: Participant received a single call intervention with a Quit Coach.
Multi Call: Participant received an intervention with a Quit Coach and accepted additional proactive calls from the quitline.
Nicotine Patch – Participant met screening criteria for nicotine patch.
Nicotine Gum – Participant met screening criteria for nicotine gum.
Nicotine Lozenge – Participant met screening criteria for nicotine lozenge.

Tobacco Cessation
Discharge Plan

Patient: _____

ID number: _____

Referred by: _____

Discharge plan:

Quit date: _____

Consult visit date: _____

Comments: _____

_____

_____

Medications prescribed:
_____

_____

_____

_____

Follow-up plan:
_____

_____

_____

Convenient telephone-based services to help you quit or sustain your efforts are available through the Wisconsin Tobacco Quit Line (1-800-QUIT NOW)

Signature: _____

Date: _____

Sample Letter to Primary Care Provider Regarding a Hospital Tobacco Cessation Intervention

Sample Letter to Primary Care Provider

Hospital Address
Hospital Address
Hospital Phone

Date

(Primary Care Provider Name)
(Primary Care Provider Address)
(City, State, Zip)

Re Patient Name: _____ Patient Identification No:_____

Dear Healthcare Provider:

Your patient was recently admitted to the [HOSPITAL NAME] While here, she/he was identified as a current tobacco user and received tobacco treatment counseling on [DATE].

Your patient was assessed for her/his readiness to quit tobacco. The following is the result of that intervention and recommendations for your involvement to assist her/his quitting tobacco. **Your participation in this patient's quit attempt or movement toward a quit attempt is very important.**

Patient's readiness to quit:

__Not contemplating smoking cessation
__Wanting to quit in the next 6 months but still ambivalent
__Taking steps to quit within the next month (e.g., cut back number of cigarettes)
__Has currently quit tobacco Quit date:_____
__Has quit tobacco and is in maintenance phase

Recommended medications:
__Patches Dosage: __21mg __14mg __7mg
__Nicotine Gum Dosage: __4mg __2mg
__Nicotine Inhaler
__Nicotine Spray
__Buproprion/Zyban/Wellbutrin SR
__Varenicline

A brief word from you regarding her/his tobacco use is invaluable. A suggested statement is:
"Congratulations on thinking about quitting in the next month. Are you ready to set a quit date? Would you like to learn more about quit smoking medication, or referral to the tobacco quitline? We can take care of that today."

Sincerely,

(Name)

Source: Tobacco Consultation Service, University of Michigan Health System