Inpatient Psychiatric Facility Quality Reporting Program

Support Contractor

Inpatient Psychiatric Facility Quality Reporting IPFQR Program: Keys to Implementing and Abstracting the Tobacco Measure Set

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Katie McDonald: Hello, everyone, and welcome to today's call, *Inpatient Psychiatric Facilities Quality Reporting Program – Keys to Implementing and Abstracting the Tobacco Measure Set*.

Today's audio will be broadcasted through Internet streaming, no telephone line is required. Make sure you have your speakers or headphones plugged in and turned up.

Questions today will be handled through our "Chat with Presenter" box. You can see this down [in] the left corner of your screen. Just shoot any questions you have in there, and we will provide the answer for you.

And now I will turn this over to, I believe, Jen?

Reneé Parks: Thank you, Katie.

Hello and welcome, everyone, to the IPF Quality Reporting Program. My name is Reneé Parks, and I will be your host for today's event, as well as your ending speaker. Before we begin, however, I'd like to make a few announcements.

This program is being recorded. A transcript of the presentation, along with the questions and answers, will be posted to our website at www.qualityreportingcenter.com within two days and will be posted on www.qualitynet.org at a later date. If you registered for this event, a reminder email, as well as the slides, were sent out to your email approximately one hour ago. If you did not receive the email, you can download today's slides from our website at www.qualityreportingcenter.com.

On the next slide are the dates and topics for future presentations. The upcoming educational webinars planned for the IPF Quality Reporting Program are as follows: on March 19, we will present Follow-up After Hospitalization for Mental Illness; on April 16, we will discuss the Influenza Immunization Among Healthcare Personnel, as well as the IMM-2 measure; and, then, we'll follow that, on May 21, with the Proposed Rule.

The learning objectives are on slide five. At the conclusion of the webinar, the attendees will be able to discuss the tobacco measure set, understand keys to implementing this measure set, as well as understanding, in greater detail, for tobacco's measures 1, 2 and 2a, as well as learning about the submission of non-measure data.

On the following slide is a list of acronyms that you will see throughout this presentation. It is here for your ease of reference should you need to refer back.

And now, it is my pleasure to introduce today's guest speaker, Dr. Bruce Christiansen. He is a clinical psychologist and senior scientist at the University of Wisconsin Center for Tobacco Research and Intervention. His work focuses on tobacco dependency and treatment among people with low income, persons with mental illness, and those who are struggling with substance abuse. Dr. Christiansen was the Project Director for the U.S. Public Health Service Clinical Practice Guidelines treating tobacco use and dependence, and did the 2008 update.

And now, it is my pleasure to turn the program over to Dr. Christiansen.

Bruce Christiansen: Thank you, and I want to start by expressing my gratitude for the opportunity to speak with everybody on the phone today.

My goal with my comments is to really set the stage for what will follow, which is a detailed presentation about upcoming measurements of your patients' smoking status and the provision of – that is based tobacco dependence treatment. And so, specifically, I'm going to build a case for

why taking those measurements are so vital and important, and we'll do that through making – addressing four different topics.

I'm going to start with the burden of tobacco generally and on those with a mental illness and/or substance abuse disorder. I'm going to raise the question of how integrated your organization is by referencing some recent findings from a state-wide survey here in Wisconsin. I'll talk about why isn't there more integration when the need is so compelling, and then talk a little bit about what organizations that have integrated have learned by going through that process.

So, first, the burden of tobacco. This is a, again – this is a snapshot to summarize – tobacco remains the largest preventable source of mortality in America, far outstripping other recognized causes of death to the tune of about 480,000 deaths of Americans a year. And we estimate, of that, about 200,000 are deaths from – with people who have mental illness or substance abuse disorders and who smoke.

This is a slide that really tells a wonderfully compelling and positive public health story that simply tracks the fall in adult American prevalence since the mid-'60s, where we are at over 40 percent – about 42 percent – to 2013 where we are nationally now at 17.8 percent. But, this wonderfully positive public health story somewhat obscures an underlying challenge, and that is the challenge of tobacco disparities.

Relevant to this talk, this graph is data from the *National Health Interview Survey* that simply tracks the smoking prevalence since the late '90s between those who report they have serious psychological distress and those that do not, where there's decidedly a great gap between the two populations, with those of mental stress – mental health stress – having much higher tobacco use.

So, some statistics you may find useful to know: the prevalence of tobacco use is very high amongst those with mental illness. This is simply a range of smoking prevalence by fairly typical diagnostic categories. You'll notice in there that there's quite a range in some of them. This is a compilation of a number of studies, and the range reflects mostly – it depends where you do your assessment, particularly if you're looking at inpatient populations or outpatient populations, and that's because tobacco use problems increase dramatically as a function of the severity of mental illness.

If you grant me the assumption that the number of lifetime psychiatric diagnosis is a good proxy for the severity of illness or the chronicity of illness, what this graph shows is that, as you go from "no diagnosis" to "more than four lifetime," different lifetime diagnoses, you'll see a dramatic

increase in smoking prevalence to well over 50 percent – well over half our patients. And, importantly, the proportion of those smokers who are heavy smokers also increases with the severity of the mental illness.

It's good to note and understand that this mental illness-tobacco gap is getting larger and not smaller. This is a recent article. It looks at the prevalence for those with and without mental illness from 2004 to 2011. In 2004 there was a nine percentage point gap between the two groups. This has now increased to a full two percentage points, [to] 11 percent in 2011.

We also note that – and the reason this is – the gap is getting larger, is that while the prevalence for those with mental illness is coming down, it's coming down far slowly, more slowly than the prevalence for people without mental illness. And that's just another example of the – of the commonly noted phenomena of a low-hanging fruit, that is, that people with the most resources benefit the most from our top public health efforts. And then we are at risk, therefore, [of] leaving behind certain populations. And that's where we stand today with tobacco and tobacco disparity populations.

As a result of all this, those with mental illness and substance abuse disorders consume about 40 percent of all cigarettes consumed in America. This is from the *National Surveys on Drug Use and Health*. The left-hand pie chart simply illustrates that about 25 percent of the population will have any mental illness diagnosis or substance abuse diagnosis or both and that little, that pie at 25 percent on the right grows at 40 percent when you look at the number of cigarettes consumed. And, finally, we know that people who have a mental illness die about 20 to 24 years before those who do not, and no doubt – undoubtedly, that reflects, in part, the hard tobacco prevalence.

So, how integrated is your organization? I want to share some results from a Wisconsin survey that looked at how much integration we have in our state. So, we conducted an Internet survey to all types of programs in the state. We based our survey on a document that lists a kind of a definition of what it means to be "integrated." It's a fairly short document of three or four pages that has within it a number of different standards. And if you're interested, you can get that document by going to the website noted on the slide. And this document really addresses three related but equally important aspects of integration that institutions and programs should attend to. One is having the tobacco policy for the facility and grounds. Two is treating tobacco dependence amongst patients, and, equally important, helping staff who smoke to quit. In the context of today's topic, I'll be focusing on our results regarding the second one, treating tobacco dependence.

Again, as I mentioned, this probably went out to all certified programs in Wisconsin. Amongst the responders, about half of the programs that responded treat both mental illness and substance abuse. Over a third treat primarily mental illness. Almost all the programs treated both men and women. Almost all the programs treated adults. Two-thirds also treated adolescents, and a little over half also treated children. That gives you kind of an idea of the people who responded to our survey.

So, selected results in our state – level of integration suggests an 89 percent record smoking status, but only 18 percent actually record that as the diagnosis. Over half the programs assess interest in quitting amongst those patients who are smoking. About 40 percent provide a motivational intervention for those smokers who don't want to quit. Seventy percent provide support to those who want to quit, and 62 percent provide cessation medications or explain, on an individual patient basis, why medications are not provided. And about 60 percent make referrals to our telephone quit line, the Wisconsin Tobacco Quit Line. About a third inform users about outside resources at time of discharge. Twenty-eight percent provide a relapse prevention plan. But, in some of the areas that you would expect to support an effective treatment program, there's less compliance. Fully 83 percent doesn't provide specific training on treating tobacco to their staff, and amongst those programs that do a formal QA process, such as chart reviews, only one in five checks for the presence of a tobacco dependence treatment plan.

So, there's a compelling need. Integration has [a] ways to go yet. So, why isn't there more integration? In here I want to address briefly three myth barriers that we've run across in Wisconsin, from talking to programs and providers, as well as documenting the literature. One is that people with mental illness *don't want* to quit. Here's results of a fairly informal survey we did with people with severe, persistent disabling mental illness. Fully we found that a third definitely "want" to quit, and another 40 to 50 percent are "maybe" or "pass" want to quit. Furthermore, 83 percent of smokers have tried to quit. Obviously, not always successful. But, this population are trying to quit and, despite where they were at that moment of the survey, have said that [it] was a good time to try for them to quit.

Myth number two is that people with a mental illness *can't* quit. So, in our survey, the left-handed red bar, we found that amongst our respondents, fully, almost 25 percent were ex-smokers, that is, they had quit. That doesn't compare too dissimilar to this median state results from the Behavioral Risk Factor Surveillance System, about 25 percent. So, this population has plenty of role models of people who have quit. In fact, in our survey, 63 percent knew patients like themselves who had quit.

The third myth is that trying to quit is bad for or will, in some way, hurt those with a mental illness. And this barrier comes out in several different themes – it will increase the symptoms and destabilize my patient; it will undo the progress I've made and will lead to relapse; it will erode their confidence; smoking is one of my patients very few coping mechanisms; now is not a really good time, we'll do it later when the patient's more stable; smoking is one of the few enjoyments they have left; smoking is one of the few things they control; tobacco addiction is simply not as important as what I'm treating. Those beliefs are contradicted by the evidence.

I'm going to just present two examples of that, one for substance abuse disorders and one for mental illness. So, a recent meta-analysis of 19 studies found out that when one co-treats smoking tobacco dependence as part of an addiction program, there is a 25-percent greater likelihood of long-term abstinence from the alcohol or the drugs. So, contrary to concerns, treating smoking cessation actually adds to the outcome. I should note that the abstinence from smoking was far – was far more modest in these studies.

I think it's fairly logical to think why that is. For many, many, many people, smoking and drinking, for example, co-occur so that each is really providing the setting for relapse with the other so that if you are having somebody who is in recovery but continues to smoke, they are forever priming the pump for relapse regarding their drinking.

As an example for mental illness, meta-analysis out last year found that compared to those that did not quit, those that did experienced significant improvements in depression and anxiety and significant reduction in stress. This is typically measured about a year later. And, interestingly, the amount of reduction in anxiety and depression was equal to or bigger than what one would have expected had one used medications to treat the anxiety and depression. So, the outcomes are better for people with mental illness if they quit smoking. I should note that this not to say that, in the short run, going through nicotine withdrawal doesn't produce anxiety, mood swings, sleep disruption. For some smokers, that will appear as if the psychiatric symptomatology has increased. But, this just underscores the need to support and provide treatment and help the person quitting rather than expecting someone with a mental illness to go through withdrawal alone by themselves.

There are other barriers to integration that you'll hear: "I'll lose business." "My treatment program will get disrupted." "My staff won't accept this." "My staff doesn't know how to treat tobacco dependence." "I don't know how to get paid." "You can't make people quit if they don't want to." "It's unethical

to force patients to quit." And I might add the concerns that managers have about their staff who themselves smoke.

So, let me talk briefly about what other organizations have learned that have integrated the treatment of tobacco. And I'm going to mention here that, obviously, it takes some resources, some efforts to integrate the treatment of tobacco dependence into withdrawal programs. Conceptually, the integration is quite straightforward, and what makes it particularly straightforward is that most clinicians have the requisite skills, at least at a general level, to treat tobacco. They just need to be redirected to this fight, and that's a far easier objective than trying to create skills where none exist.

I'm going to suggest a simple conceptual model to follow that's based on the public health services tobacco – human tobacco guidelines known as the five As, which is what we use typically for healthcare providers. And, I think you'll see that this mirrors quite nicely the measurement indexes that you'll be developing and tracking. So, the integration would suggest that every smoking patient should be *asked* if they use tobacco, and they should be recorded in the electronic health record. Every patient who does use should be *advised* to quit, hopefully, in a way that's personalized to the needs of the smoker. Every smoker should get an *assessment* about the motivation to quit, essentially, "Would you like to make a quit attempt at this time?" And then, historically, the guidelines before 2008 said that there is an obligation to provide *assistance* to those who want to quit. We know that the best treatment, the most effective treatment, is a combination of using cessation medications and coaching or counseling to the degree that that's tolerated by the smoker. And then, post 2008, the assist was also addressing those who did not want to quit.

We now know there are specific strategies that will improve the motivation to quit. Motivational interviewing comes to mind. The guidelines themselves present the five Rs, talking about their *relevance*, *risks*, *rewards*, *road blocks*, and *repeating* that message to smokers. And, here I would stress that these are the areas that your clinician staff already excel at, that is, unlike most healthcare providers, most clinicians are very well-versed and trained to motivate for behavioral change.

The last A is to *arrange* for follow-up. And this context, you know, includes whatever follow-up is included in the facility. It include a follow-up for the tobacco, discharge with a lapse prevention and relapse recovery plan in place, and provide outside resources, especially telephone quit line information. The telephone quit line can be an invaluable extension to the clinical staff.

Lessons we've learned from working with programs in Wisconsin: it's important to cultivate a champion within an organization; it helps to establish an implementation committee; one does have to allow for a very specific preparation period that includes time to build the case amongst the staff of why this is important to do and, then, throughout the – before and throughout the process, providing training and support to all aspects of the organization that has a role to play in implementation.

I'm going to end by showing a video of some work we've done in Wisconsin. This video was produced by the Wisconsin Nicotine Treatment Integration Project (WiNTiP). You will find – see that signage in the video. WiNTiP is funded by the Tobacco Prevention and Control Program of Wisconsin, and its mission is to work with programs to integrate the tobacco dependence in the behavioral healthcare system. And what you'll see in this nine-minute video is simply a variety of programs, staff and patients talking about their experiences of integration – telling their story. These programs represent a broad range of inpatient, outpatient, residential, mental illness treatment, substance abuse treatment – the whole gamut. And as you listen to it, I would challenge you to listen with an ear toward identifying barriers that the staff and patients repudiate, that is, the barriers that – "I'll lose business." "This will disrupt my treatment milieu." "It won't be accepted by staff." "It will harm my patients." "Patients will never choose or wouldn't appreciate this."

So, with that, I'll have the video play.

Reneé Parks: No audio. This is not good. We have no audio for our video. Yes.

Female: The audio portion is playing through their computer speakers.

Reneé Parks: I want to – hello, everyone. I want to thank you for staying with us and watching the video. We hope that you learned a few valuable pearls as you took the time to watch the video.

And I want to thank Dr. Christiansen for sharing his insight into the history of the tobacco measures, as well as providing guidance and resources on how inpatient psychiatric facilities can implement these measures.

And as you can see with this slide, we are pleased to share with you the latest program resources now available. The IPF Quality Reporting Program Manual provides an overview of the program from start to finish on how to participate, with a step-by-step guidance on *QualityNet Secure Portal* registration, measure information, data submission using the Web-based measure application, and how to preview the publicly-reported facility data. Also available are the paper tools. These are available for all

measures and designed as an optional informal mechanism to assist IPFs in the collection of major data, HBIPS-2 and -3, HBIPS-4 through 7, IMM-2, SUB-1, TOB-1, 2 and 2a, as well as frequently-asked questions. And they can be found on the website www.qualityreportingcenter.com under resources for IPF. These documents are also available on *QualityNet* as they were recently uploaded last evening.

And, now, for the last portion of today's program, we will build on what Dr. Christiansen shared, as he shared the insights into why these tobacco measures are important to the community and especially in the psychiatric population with relevant statistics along with the keys of how to successfully integrate this measure set into your facility's processes.

Over the next few slides, we will focus on the details of the measures. As this measure sets for tobacco assesses activities demonstrated to produce positive results in tobacco – in tobacco use reduction, strong and consistent evidence demonstrate that timely tobacco dependence intervention for patients using tobacco can significantly reduce the risk of suffering from tobacco-related diseases, as well as provide improved health outcomes for those already suffering from a tobacco-related disease. Effective tobacco cessation support across the care continuum can be provided with only minimal additional effort and without harm to the mental health recovery process.

And, with that, let's take a closer look at our first measure, Tobacco-1 or the Tobacco Use Screening Measure. This is a chart-abstracted measure, and the description for the measure, as found in your Specifications Manual, is "hospitalized patients who are screened within the first three days of admission for tobacco use." That means cigarettes, smokeless tobacco, pipes, cigars – any of that used within the past 30 days.

The numerator for this measure is the number of patients who were screened within the first three days of admission, and the denominator is for all of those admissions that were 18 years of age and older. The excluded populations for this measure are patients less than 18 years of age, patients who are cognitively impaired, patients who have a duration of stay that are equal to three days or greater than 120, and patients with comfort measures only, and that must be documented.

The data element for *comfort measures only* – the data element, *comfort measures only*, refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for the dying patient, as well as the patient's family.

Comfort measures only is commonly referred to as comfort care by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as a do not resuscitate or DNR. *Comfort measures only* allowable value – these are the values that if you use a vendor that will be in the algorithm or if you elect to utilize one of the paper tool resources spoken of earlier. As you can see, for the first allowable value, it is day zero to and, then, number two is for day two or after. Number three would be where timing is unclear or, four, you cannot determine and it is not documented.

As we move on to the next slide, 46, if you were following along from a printed version, *comfort measures only* – these are notes for the abstractor. Per the data element, only accepted terms identified in the list of inclusions. There are – no other terminology will be accepted. And this must be documented, as mentioned, and provided by the physician and advanced practice nurse or a physician assistant, depending on your hospital's protocol. *Comfort measures only* order for consultation or an evaluation by hospice – and you can see the others as determined on this slide. You would determine the earliest day *comfort measures only* was documented by the healthcare staff, and if any inclusion terms are documented, then you would select your values accordingly.

Now, let's take a look at the primary data element for this measure, *tobacco use status*. The definition is "documentation of adult patient's tobacco use status within the past 30 days prior to the day of hospital admission." Tobacco use includes all forms of tobacco including cigarettes, smokeless tobacco products, pipes and cigars. A tobacco use screen should identify the type of tobacco product used, the volume used, as well as the timeframe that it's used in.

Now, as we look further at this data element and the allowable value – as you can see there are six allowable values. And to include – the tobacco use includes all forms of tobacco, again, including: cigarettes, smokeless tobacco, pipes, and cigars. A tobacco use screen should identify, again, the type of product that is used, the volume of that tobacco used, and the timeframe over which they utilize their tobacco product.

Now, as we move into slide 49, primary data element for tobacco use status – this shows you the inclusions and the exclusions. Remember, this is for tobacco and not nicotine, which is currently found in your e-cigarettes, hookah pipes, or illegal drug use such as marijuana. So, again, those are the exclusions. The inclusion list is quite specific, as well, with Snus, as well as smokeless tobacco products, and there is a milieu of those, as well as the Snus and the Twist.

Notes for abstraction of the screening – these are derived from frequently asked questions. So, please note the following: there is no specific tool required or recommended, and any healthcare provider can complete the screening for tobacco use in the initial counseling; the patient does not need to sign the form as long as the nurse documents that they were provided and a face-to-face interaction did occur.

As we further look at the notes for abstraction in the documentation for the screening tool, it's that there was definitive documentation and that the appropriate allowable value was selected, regardless of whether or not there is conflicting documentation. You would utilize a history and physical. Now, that might be from an EHR. It could be in the form of a handwritten note, or it could be in the progress notes or a dictation that has been added to a paper chart. Remember, it must be – it can be labeled as the history and physical, and this is a source that can be utilized. A nursing assessment can also be utilized, as long as it is documented as so and that the assessment includes a medical-surgical history with a list of current meds, allergies, and then the physical assessment, and that it must be reviewed and signed by a nurse. So, you would disregard any type of documentation of tobacco use history if the current tobacco use status or that timeframe for that patient when they quit is not identified. And the example we utilize is such as a 20-pack-a-year smoking history.

Tobacco documentation, again, notes for abstraction – Do not include documentation of smoking history where it's referenced as a risk factor for tobacco or risk factor for smoking or being a smoker where current tobacco use status is indeterminable. When there is conflicting information in the record with regard to the volume – for instance, one document has indicated that the patient may be a light smoker of less than two cigarettes a day and another may indicate that the patient is a greater-than-lighter smoker and – you would indicate, in that instance, the greater or the heaviest use of tobacco usage. If the medical record indicates that the patient smokes and the volume is unable to be determined or is unknown, assume smoking at the heaviest level and select a value of one – allowable value one.

The tobacco status use screening timeframe must have occurred within the first three days of admission. Remember, the day after admission is the defined as the first day.

Now, let's take a look at cognitive impairment. The data element for cognitive impairment, remember, with 2015, is not as a – listed as a data element. The cognition refers to the mental activities associated with thinking, learning and memory. And cognitive impairment, for the purposes

of this measure, is related to documentation that the patient can't be screened for tobacco use due to an impairment: whether they are obtunded, confused, or they have memory loss, or they may have disorientation due to drug utilization. In the 2015 specifications change, the data element for tobacco use status in the note for abstraction states that cognitive impairment must be documented at all times during the first three days of hospitalization in order to select your number six value. If there is documentation in the medical record that a patient is cognitively impaired and there is no additional documentation that the patient's mental status was normal – within normal limits or alert and oriented to time and place during the first three days of the hospitalization, the abstractor can select value six. Again, this is – this slide relates to cognitive impairment. If there is documentation that the patient had a temporary cognition impairment due to acute substance use, an overdose or acute intoxication, value six cannot be selected. And examples of that are listed below on this slide. And the list of examples comes from the tobacco use status data element section from The Joint Commission's Specifications Manual.

Now, let's look at – that was all fine and well about screening for tobacco use. Now, let's take a look at the tobacco patients who do state that they have a tobacco – they do come up positive in the screening for tobacco use. So, this is where your tobacco measures 2 and 2a come into play. They're both chart-abstracted, again, and both are reported as an overall rate that includes patients who, again, use tobacco products, and that they are offered and refused; or a subset of that first tobacco screening that were positive – for 2a, they were offered and received medication to assist with their tobacco discontinuation or the tobacco use treatment. So, for Tobacco-2 the description, again, that they've been identified is utilizers of tobacco products and they have smoked within the last 30 days and they have received or refused practical counseling to quit, and they received or refused the FDA-approved cessation medications during the first three days. So, again, for Tobacco-2, they – in order to get into the Tobacco-2, they must have been positive for utilization of tobacco products and they must have received counseling. And they can either receive or refuse the medications for TOB-2. But, remember, 2a is a subset of this, so, we'll talk about that in a couple of slides.

The excluded populations for TOB-2 is that they must be, again – they're less than 18 years of age and they're cognitively impaired or excluded, patients who are not currently tobacco users as long as that was not – they didn't quit within the last 30 days, and patients who refused or were not screened for tobacco use during the hospital stay and, again, those who are equal to or greater – equal to three days or greater than 120 for those that

have that duration of stay and patients who are also on comfort measures only that, again, must be documented.

So, remember – now, let's talk about 2a. We screened them for TOB-1. TOB-2; they received their counseling and then were either offered and refused the medications. But, in order to land in the population to be counted for Tobacco-2a in that subset, they must have received the FDA-approved cessation medications.

And for those of you who downloaded the slide, there is a correction that needs to be made on this slide because they can't – in order to be in the numerator for TOB-2a, they must have received FDA-approved medications during the first three days of admission. They cannot refuse and become part of the TOB-2a numerator. So, again, I would just like to point that out. This slide is correct, but, for those of you who have printed off your slides, it states that they can refuse and end up in the numerator, and that is incorrect.

As we move into the next slide, it talks about the excluded populations for TOB-2a. And, again, those pretty much are the same as TOB-2: less than 18 years of age, cognitively impaired, not current tobacco users and those patients here who refused and were not screened during the hospital stay and, again, the hospital stay that was greater than or equal to three and less than 120 days. And then, again, for those patients on the ward that have documented orders for comfort measures only are excluded.

Again, this is to reiterate the difference between TOB-2 and TOB-2a, and TOB-2 includes all patients who are offered and received or offered and refused meds and practical counseling while TOB-2a includes only those patients who were offered and actually received the medications, if indicated in practical counseling. We're reporting on two rates for TOB-2 and that both are equally important. And we believe that reporting of this measure will yield information that provides meaningful distinctions in the quality of care provides across all inpatient psychiatric facility because tobacco use cessation treatment, counseling and medication is indicated – is considered an essential step in the care process for these patients. We believe that it is critical for these patients and their families and caregivers to have accurate and available information on whether the facilities integrate this into their care processes within the facility. And so, this, as Dr. Christiansen stated earlier, maybe during this time, able to identify opportunities where you can increase your rate of uptake for your tobacco cessation treatment that are being offered.

Primary data element for FDA-approved cessation medications – Again, these are the allowable values whether it was – medications was received during the first three days of admission and whether or not it was received after those first three days in admission for allowable two and, then, number three, again, that it was not offered or you are unable to determine based on your documentation.

Now, let's talk about practical counseling and the primary data element for that. Again, the patients received all components of practical counseling during the first three days after admission. And they can certainly refuse or decline practical counseling during the first three days and, if that is the case, then you would select allowable value two. And/or if you cannot find where it was documented that practical counseling was not offered during the first three days and, again, that would be allowable value three.

So, you may ask yourself, okay, what is practical counseling and what defines that? Well, that is a face-to-face interaction between the patient and a healthcare provider and that they are: number one, they recognize danger situations for them as the patients; they develop coping skills to avoid those situations; and, three, that you provide basic information about quitting, and this is not met by handing the patient a pamphlet to read on smoking cessation. So, you must meet all three of these components in order to meet the data element for practical counseling. And we do receive several questions regarding that.

As we move into the next slide, the definition of the primary data element which is *reason for no tobacco cessation medication during the hospital stay* – so this would be your rationale and your reason for not administering with their treatment plan medication that's documented in the first three days. And the acceptable values are that they had an allergy to the approved tobacco cessation medications, currently they're on formulary or drug interactions for all the medications with the other drugs the patient is currently on so, you have a drug interaction issue, and then other reasons documented by the physician, nurse, or PA.

So, let's talk about and summarize these measures. Again, the – you could use the substance abuse screening tool that you implemented last year. You can – and how you went about integrating that into your facility. You could use that as a model. You can also build upon existing documentation of the current tobacco use that is typically done, as Dr. Christiansen stated in a lot of his statistics that there is no specific tool that is required or recommended. Any healthcare provider can complete the screening for tobacco use and provide the initial counseling. The patient does not need to

sign the tool, and it must be documented that this was an interaction that occurred and there was an exchange of information.

For TOB-2 and 2a, you can establish a simple algorithm for brief counseling at the bedside to address recognizing dangerous situations, development of coping skills, and basic information on how to quit. And reasons for not administering the FDA-approved medications must be documented by the clinician, and that would be your physician, your advanced practice nurse or physician's assistant or a pharmacist.

So, we've talked a lot about the TOB measures, and I know with the manual just coming out, we wanted to highlight this because we are receiving a lot of information and a lot of questions being asked on the submission of non-measure data. So, beginning with the fiscal year 2017, IPFs will be required to submit aggregate population count for Medicare and non-Medicare discharges, and this will be done by the age strata, diagnostic groupers, and then payers. And, then, the only one that will be needed on a quarterly basis will be the total discharges that you will do by quarter and come up with an annual sum total for your discharges that year. And accuracy of the general population data recording is vital because it will allow CMS to assess the data reporting completeness for the total population and allow them to look at opportunities to improve interpretation of measure results and then the reported values and subsequent decision-making concerning measure retention or new measures in the future, as well as it will allow them to take look at, based on your discharges in the population, if you are utilizing the population and sampling for the measures that allow for that, that that is an accurate sampling number based on your discharges.

So, on this – the next – this next slide, there is facility data for non-measure data submission that will be required. Something similar to this will be on the Web application during the submission timeframe where you go to enter your measure level data. So, this is just an area in a chart that shows the different types of data currently – in the future that you will need to put for your non-clinical or non-measure data. And then, again, the diagnostic codes and the grouping for the purposes of reporting of the non-measure data utilizes the clinical classifications software for ICD-9. So, this clinical classifications software is a diagnosis and procedure categorizing schema that collapses individual codes into smaller numerical values and clinically meaningful categories. So, you can, as you can see by looking at this slide, the anxiety disorders – all of those are compressed into this one. And you can – in the manual that is now available – there is a link that will give you all of the ICD-9 that are affiliated with each of the domains.

And this – that concludes today's presentation.

And the next couple of slides are helpful links that are here for you that take you directly to the resources. The individual codes that I spoke of at the clinical diagnostic categories –there's the link for that. There's a wonderful quit smoking guide and index from the CDC. And, then, there is this smokefree.gov site that has lots of helpful and useful resources, as well as the *Treating Tobacco Use and Dependence* – the 2008 update and where you can find that. And, then, there is a good article on counseling patients to quit. So, again, these are here for your information and ease of use. These are certainly not all of the references but just a small sampling.

And, again, this concludes today's presentation. And I just wanted to thank Dr. Christiansen for the valuable insight and expertise that he had shared with us today. Due to time constraint, he had to leave the presentation, but, if you did submit questions through the Q&A chat feature, we will try and reach out to him and see if he can get us those answers, and we will share those when we actually post the questions and answers.

So, before we go to our panel of subject matter experts to share some of the questions that have been received today during the presentation, I would like to remind you that today's presentation has been approved for one continuing CE credit by the boards listed on this slide, and we now have an online CE certificate process.

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If you did not receive the survey once the program concludes, don't worry. We will be sending out the survey link in an email to all participants within the next 48 hours. It will not arrive today. And if there are others listening to this event that are not registered in ReadyTalk®, please pass that survey on to them.

And now, we will go to our panelists and subject matter experts who can share with us a few of your questions. And we will keep this relatively short because we are at the top of the hour, so, I would ask each of the panelists just to go with their couple of questions each.

So, Evette, would you like to start us off?

Evette Robinson: Sure. Thank you very much.

So, the first question I have here is, "Will documentation of smoker or smokeless tobacco use the size or a type of tobacco product used?"

And, yes, the use of smoker would equate to cigarette use or some other form of tobacco use, and then smokeless tobacco is the use of the smokeless tobacco type that were listed in the presentation.

Another question here is regarding "whether or not there is a specific screening tool recommended or required for the TOB measures or applies for 2017?"

And there is no recommended or required screening tool for the TOB measures. However, the tool that is used – it should at least identify the type of tobacco product that is used, the volume of the product that's used, as well as the timeframe in which that product is used.

And so, again, since we are a little short on time, I will turn it now over to Elba.

Elba Sisco: Thanks, Evette.

The first question I have is "What constitutes practical counseling?"

The components of practical counseling require face-to-face interaction and address three things: recognizing dangerous situations; developing coping skills; and providing basic information about quitting. By definition, interaction is the activity reciprocating or exchanging information, and this must occur between the patient and the caregiver.

The second question I have is, "Do the tobacco measures include e-cigarette use?"

No, electronic cigarettes are excluded from the measure. E-cigarettes contain nicotine, not tobacco, and these measures are only about tobacco use. If the patient only uses e-cigarettes, then the abstractor should select that the patient does not use tobacco products for the data element *tobacco use status*.

And I'll hand it over to Tina.

Tina Gable: Thanks, Elba.

I have a question. "The patient says she smokes only a couple times per week. Should she still receive the counseling and cessation medications?"

Yes, all smokers should get practical counseling, but, those who smoke less than or equal to four cigarettes daily or those who – you smoke with tobacco et cetera, are not required to receive cessation medication, and you can refer it to allowable value two in that data element, *tobacco use data*.

Another question is, "Patient answers 'no' to tobacco use data screening then later says 'yes.' How do we answer this?"

If the patient says 'yes' to tobacco use at any time within the first three days, you want to select the appropriate value according to the frequency and the type of tobacco use, regardless of the conflicting documentation.

And we'll go back to Reneé.

Reneé Parks: I'd like to thank our panelists, as well as everyone who participated in our webinar today and hope that you picked up some valuable information that will assist you in implementing successfully the tobacco measures in your facility. So, thank you. Stay tuned for future events and enjoy the rest of your day.

END

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