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

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February 19, 2015

Save the Dates

Upcoming IPFQR Program educational webinars:

- **March 19, 2015** Follow-Up After Hospitalization for Mental Illness (FUH)
- **April 16, 2015** IMM-2 & Influenza Vaccination Coverage Among Healthcare Personnel
- **May 21, 2015** Proposed Rule

Learning Objectives

At the conclusion of the program, attendees will:

- Know the history of the Tobacco Measure Set
- Understand the Keys to Implementing the Tobacco Measures
- Understand TOB-1: Tobacco Use Screening Measure
- Understand TOB-2: Tobacco Use Treatment Provided or Offered Measure
- Understand TOB-2a: Tobacco Use Treatment Measure
- Know about Submission of Non-Measure Data

Acronyms

- **APN** Advanced Practice Nurse
- **BRFSS** Behavioral Risk Factor Surveillance System
- **CDC** Centers for Disease Control and Prevention
- **CMO** Comfort Measures Only
- **5As** Ask, Advise, Assess, Assist, and Arrange
- **5Rs** Relevance, Risks, Rewards, Roadblocks, Recognition
- **FY** Fiscal Year
- **FDA** US Food and Drug Administration
- **H&P** History and Physical
- **LOC** Level of Consciousness
- **PA** Physician Assistant
- **PHS** Public Health Service
- **SUD** Substance Use Disorder
- **TJC** The Joint Commission
- **TOB** Tobacco
- **UTD** Unable to Determine

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Integrating the Treatment of Tobacco Dependence into the Behavioral Health Care Delivery System

Bruce Christiansen, PhD

February 19, 2015

Outline

1. Burden of tobacco generally and on those with a mental illness and/or other substance use disorder
2. How integrated is your organization?
3. Why isn't there more integration?
4. What have organizations that have integrated learned?

Outline

1. Burden of tobacco generally and on those with a mental illness and/or other substance use disorder

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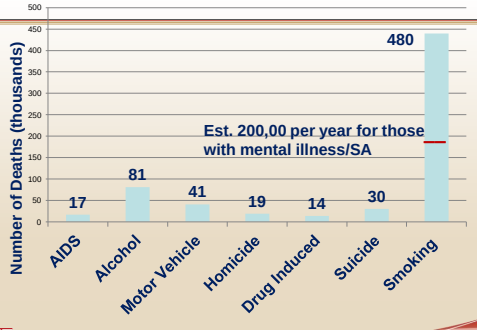
Annual US Deaths



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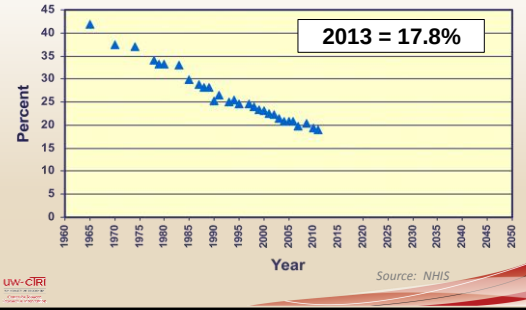
Smoking Prevalence Among Adults 18 and Older, United States, 1965-2013



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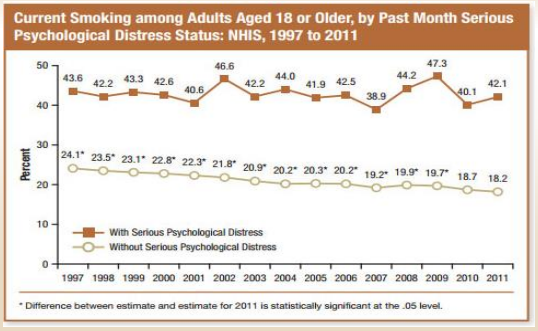


Statistics You Need to Know

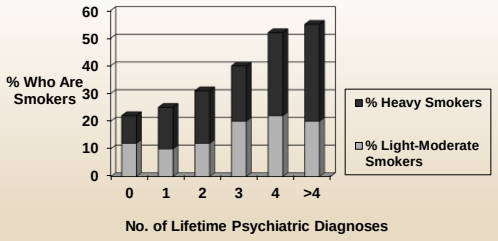
- **Very elevated prevalence among those with mental health and substance use disorders**

Tobacco Use by Diagnosis

Schizophrenia	62-90%
Bipolar disorder	51-70%
Major depression	36-80%
Anxiety disorders	32-60%
Post-traumatic stress disorder	45-60%
Attention deficit/ hyperactivity disorder	38-42%
Alcohol abuse	34-80%
Other drug abuse	49-98%

(Beckham et al., 1995; De Leon et al., 1995; Grant et al., 2004; Hughes et al., 1986; Lasser et al., 2000; Morris et al., 2006; Pomerleaue et al., 1995; Stark & Campbell, 1993; Ziedonis et al., 1994)

Prevalence



Adapted from Lasser, 2000

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Statistics You Need to Know

- Very elevated prevalence among those with mental health and substance use disorder
- **This mental illness tobacco gap is getting larger, not smaller**

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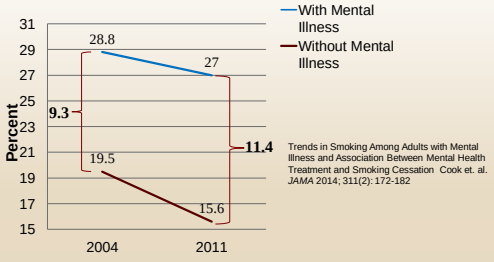
Widening Mental Illness Tobacco Disparity Gap



Trends in Smoking Among Adults with Mental Illness and Association Between Mental Health Treatment and Smoking Cessation Cook et. al. *JAMA* 2014; 311(2): 172-182

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The Need: Statistics You Need to Know

- Very elevated prevalence
- This mental illness tobacco gap is getting larger, not smaller
- **Those with mental illness/SUD consume about 40% of all cigarettes**

Figure 1. Any Mental Illness (AMI) or Substance Use Disorder (SUD) in the Past Year among Adults Aged 18 or Older: 2009 to 2011

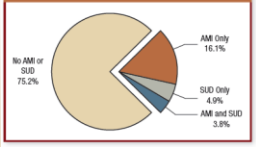
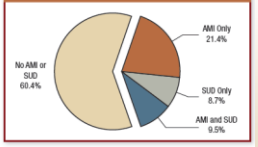


Figure 2. Percentage of Cigarettes Smoked in the Past Month among Adults Aged 18 or Older, by Any Mental Illness (AMI) or Substance Use Disorder (SUD) in the Past Year: 2009 to 2011



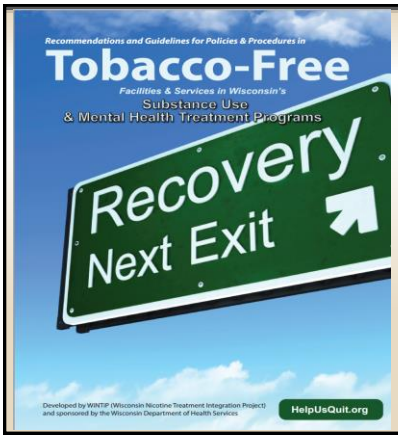
Source: 2009 to 2011 National Surveys on Drug Use and Health (NSDUHs). NSDUH is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their places of residence.

The Need: Statistics You Need to Know

- Very elevated prevalence
- This mental illness tobacco gap is getting larger, not smaller
- Those with mental illness/SUD consume about 40% of all cigarettes
- **People who have a mental illness die about 20 - 24 years before those who do not**

Outline

1. Burden of tobacco generally and on those with a mental illness and/or other substance use disorder
2. **How integrated is your organization?**



1. **Tobacco Policy**
2. **Treating Tobacco Dependence**
3. **Helping Staff Quit**

Survey of Wisconsin Behavioral Health Treatment Providers

- 49.7% treat both mental illness and substance use disorders; 36.6% primarily mental illness
- 95.0% treat both men and women
- 96.9% treat adults; 67.5%, adolescents; 58.1%, children

Selected Results

- 89.0% record smoking status
- 18.0% record the diagnosis (305.1)
- 57.7% assess interest in quitting
- 39.1% provide motivational intervention for those that don't want to quit
- 70.0% provide support to those that want to quit
- 62.1% provide cessation medications (or explain why not)
- 57.9% make referrals to the Wisconsin Tobacco Quit Line

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Selected Results (con't.)

- 32.4% inform users about outside resources at time of discharge
- 28.1% provide a relapse prevention plan at time of discharge
- 83.6% do not provide specific training to staff
- For those programs that do formal QA such as chart reviews, 21.6% check for the presence of a tobacco dependence treatment plan

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Outline

1. Burden of tobacco generally and on those with a mental illness and/or other substance use disorder
2. How integrated is your organization?
3. **Why isn't there more integration?**

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Three Myth Barriers

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A. People with a mental illness don't want to quit.

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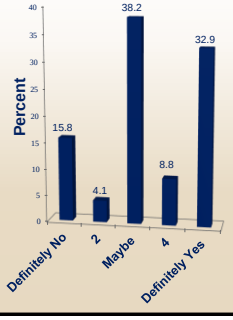
Survey of People with Severe and Persistent Mental Illness

Would you like to quit?



- **83.1% of smokers have tried to quit**
- **46.7% said this was a good time to quit**

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B. People with a mental illness can't quit.

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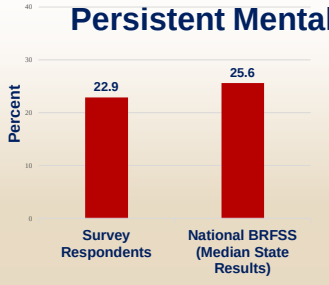
Ex-Smokers Who Have Significant, Persistent Mental Illness



63.5% have known people like themselves who have quit

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C. Trying to quit is bad for, or will hurt, those with a mental illness:

- It will increase symptoms/destabilize the patient
- It will undue the progress I've made
- It will lead to relapse
- It will erode their confidence
- Smoking is one of patient's very few coping mechanisms
- Now is not the time; we'll do it later when … patient is more stable, there is less stress, etc.
- Smoking is one of the few enjoyments they have left
- Smoking is one of the few things they control
- Tobacco addiction is not as important as what I'm treating

Substance Use Disorders

A meta-analysis of 19 studies found that providing smoking cessation interventions during addictions treatment was associated with a 25% greater likelihood of long-term abstinence from alcohol and illicit drugs. Contrary to concerns, smoking cessation interventions during addictions treatment appears to enhance rather than compromise long-term sobriety. (Abstinence from smoking was far more modest.)

Procheska, Delucchi, and Hall, (2004) A Meta-Analysis of Smoking Cessation Interventions with Individuals in Substance Abuse Treatment or Recovery. *Journal of Consulting and Clinical Psychology* 72(6) 1144-1156

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Mental Illness

A meta-analysis found that compared to those that did not quit, those that did, experienced significant improvements in depression and anxiety and significant reductions in stress.

The amount of reduction in anxiety and depression was equal to or bigger than what would have been expected from medications used to treat anxiety and depression.

Taylor, McNeil, Girling, Farley, Linson-Hawley, Avegard "Change in Mental Health after Smoking Cessation: Systematic Review and Meta-analysis" *BMJ* 2014; 358:g1151

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D. Other Barriers to Integration

- I'll lose business.
- My treatment program will get disrupted.
- My staff won't accept.
- Staff don't know how to treat.
- I won't get paid.
- You can't make people quit if they don't want to.
- It's unethical to force patients to quit.

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Outline

1. Burden of tobacco generally and on those with a mental illness and/or other substance use disorder
2. How integrated is your organization?
3. Why isn't there more integration?
4. **What have organizations that have integrated learned?**

Integration Considerations Based on the PHS 5As

1. Ask – record smoking status in EHR as a vital sign
2. Advise to quit, ideally personalized to the smoker
3. Assess motivation to quit ("Would you like to make a quit attempt at this time?")

Integration Considerations Based on the PHS 5As

4. Assist
   - Assist those who want to quit (pre-2008)
     - Medication
     - Coaching/counseling
   - Assist those who don't want to quit (post-2008)
     - Motivational Interviewing
     - 5Rs
5. Arrange for follow-up
   - Include in whatever follow-up is provided by treatment program
   - Discharge with Lapse Prevention and Relapse Recovery Plan
   - Provide outside resources, especially telephone quitline information

Keys to Integration

- Cultivate a “Champion.”
- Establish an implementation committee.
- Specific preparation period including building the case
- Provide training and support before and throughout the process.

Results of Successful Integration – Video

Technical Tips:

- You must have computer speakers or headphones connected to hear the audio portion of the video.
- Please be sure that your computer speakers/headphones are turned up.
- Please be sure your computer sound is not muted.
- If you have difficulty hearing this video, we can provide a link to it in the chat window for you to view after today’s session.

New IPFQR Program Resources

New Resources Available Online

- IPFQR Program
- IPF Abstraction Tools
- Frequently Asked Questions for the IPFQR Program

All of the documents listed above can be found on the Quality Report Center website at the following link:

www.qualityreportingcenter.com/resources/tools/ipf/

The documents will also be available soon on *QualityNet.org* under Inpatient Psychiatric Facilities Resources.

TOB-1: Tobacco Use Screening

Chart Abstracted

Description: Hospitalized patients who are screened within the first three days of admission for tobacco use (cigarettes, smokeless tobacco, pipes, and cigars) within the past 30 days.

Numerator: The number of patients who were screened for tobacco use status within the first three days of admission.

Denominator: The number of hospitalized inpatients 18 years of age and older.

TOB-1: Excluded Populations

Excluded Populations:

- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who have a duration of stay less than or equal to three days or greater than 120 days
- Patients with Comfort Measures Only documented

Data Element: Comfort Measures Only

Definition: Comfort Measures Only (CMO) refers to the medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort.

- This measure includes attention to the psychological and spiritual needs of the patient, as well as support for both the dying patient and the patient's family. CMO 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 Do Not Resuscitate (DNR).

CMO
Allowable Values

Allowable Values:

1. **Day 0 or 1**: The earliest day the physician/APN/PA documented CMO was the day of arrival (Day 0) or day after arrival (Day 1).
2. **Day 2 or after:** The earliest day the physician/APN/PA documented CMO was two or more days after arrival day (Day 2+).
3. **Timing unclear:** There is physician/APN/PA documentation of CMO during this hospital stay, but whether the earliest documentation of CMO was on day 0 or 1 OR after day 1 is unclear.
4. **Not Documented/UTD:** There is no physician/APN/PA documentation of CMO, or unable to determine from medical record documentation.

CMO
Notes for Abstraction

- Only terms identified in the list of inclusions will be accepted. No other terminology will be accepted.
- Physician/APN/PA documentation of CMO (hospice, comfort care, etc.) mentioned in the following contexts suffices:
  - CMO recommendation
  - Order for consultation or evaluation by a hospice care service
  - Patient or family request for CMO
  - Plan for CMO
  - Referral to hospice care service
  - Discussion of comfort measures
- Determine the earliest day CMO was DOCUMENTED by the physician/APN/PA. If any of the inclusion terms are documented by the physician/APN/PA, select value “1,” “2,” or “3” accordingly.

Primary data element:
Tobacco Use Status

Definition: Documentation of the 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, and the timeframe of use.

Primary data element: *Tobacco Use Status*

Allowable Values:

1. The patient has smoked cigarettes daily, on average in a volume of five or more cigarettes (≥1/4 pack) per day and/or cigars daily and/or pipes daily during the past 30 days.
2. The patient has smoked cigarettes daily, on average in a volume of four or less cigarettes (< 1/4 pack) per day and/or used smokeless tobacco and/or smoked cigarettes but not daily, and/or cigars but not daily, and/or pipes but not daily during the past 30 days.
3. The patient has not used any form of tobacco in the past 30 days.
4. The patient refused the tobacco use screening.
5. The patient was not screened for tobacco use during this hospitalization or unable to determine the patient's tobacco use status from medical record documentation.
6. The patient was not screened for tobacco use during the first three days of admission because of cognitive impairment.

Primary data element: *Tobacco Use Status*

Inclusions

- Chewing (spit) tobacco
- Dry snuff
- Moist snuff
- Plug tobacco
- Redman
- Smokeless tobacco
- Snus
- Twist

Exclusions

- E-cigarettes
- Hookah pipe
- Illegal drug use only (e.g., marijuana)

TOB-1 Notes for Abstraction: Screening

- There is no specific tool required or recommended.
- Any healthcare provider can complete the screening for tobacco use and provide initial counseling.
- The patient does not need to sign the screening tool.
  - The nurse must document that the screening occurred during a face-to-face interaction.

TOB-1 Notes for Abstraction: Documentation

- If there is definitive documentation that the patient either currently uses tobacco products or is an ex-user that quit less than 30 days prior to admission, select the appropriate allowable value for the type of product used, regardless of whether or not there is conflicting documentation.
- For the H&P source, use only the H&P report for the current admission. The H&P dictated report, a handwritten report on an H&P form, or a separate entry labeled as the H&P in the progress notes.
- Classify a form as a nursing admission assessment if the content is typical of a nursing admission assessment (e.g., med/surg/social history, current meds, allergies, physical assessment) AND the form is completed/reviewed by a nurse or labeled as a "nursing form."
- Disregard documentation of tobacco use history if the current tobacco use status or timeframe that patient quit is not defined (e.g., "20 pk/yr smoking history," "History of tobacco abuse").

TOB-1 Documentation

- Do not include documentation of smoking history referenced as a "risk factor" (e.g., "risk factor: tobacco," "risk factor: smoking," "risk factor: smoker"), where current tobacco use status is indeterminable.
- When there is conflicting information in the record with regard to volume, for instance, one document indicates patient is a light smoker and another indicates patient is a volume greater than light smoking, select the allowable value "1," indicating the heaviest usage.
- If the medical record indicates the patient smokes cigarettes and the volume is not documented or is unknown, assume smoking at the heaviest level and select allowable value "1."
- The tobacco use status screening timeframe must have occurred within the first three days of admission. The day after admission is defined as the first day.

TOB-1 Notes for Abstraction: Cognitive Impairment

- Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment, for the purposes of this measure set, is related to documentation that the patient cannot be screened for tobacco use due to the impairment (e.g., comatose, obtunded, confused, memory loss) during the entire first three days of hospitalization.
- Cognitive impairment must be documented at all times during the first three days of the hospitalization in order to select value "6." 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 at any other time during the first three days of the hospitalization, e.g., alert and oriented, the abstractor can select value "6."
- Documentation that a patient refuses to answer the screening question will allow the abstractor to select the allowable value for refusal.

TOB-1 Cognitive Impairment

If there is documentation that the patient has temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication), value "6" cannot be selected.

Examples of cognitive impairment include:

- Altered LOC
- Altered Mental Status
- Cognitive Impairment
- Cognitively Impaired
- Confused
- Memory Loss
- Mentally Retarded
- Obtunded

TOB-2 and TOB-2a

- Both are chart-abstracted.
- Both are reported as an overall rate that includes all patients to whom tobacco use treatment was provided, or offered and refused; and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment.

TOB-2: Tobacco Use Treatment Provided or Offered

Description: Patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the first three days after admission.

Numerator: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the first three days after admission.

Denominator: The number of hospitalized inpatients, 18 years of age and older, identified as current tobacco users.

TOB-2: Excluded Populations

Excluded Populations:

- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who are not current tobacco users
- Patients who refused or were not screened for tobacco use during the hospital stay
- Patients who have a duration of stay less than or equal to three days or greater than 120 days
- Patients with CMO documented

TOB-2a: Tobacco Use Treatment

Description: Patients who received counseling AND medication, as well as those who received counseling and had a reason for not receiving the medication, during the first three days after admission.

Numerator: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the first three days after admission.

Denominator: The number of hospitalized inpatients, 18 years of age and older, identified as current tobacco users.

TOB-2a: Excluded Populations

Excluded Populations:

- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who are not current tobacco users
- Patients who refused or were not screened for tobacco use during the hospital stay
- Patients who have a duration of stay less than or equal to three days or greater than 120 days
- Patients with CMO documented

Difference between TOB-2 and TOB-2a

TOB-2 includes all patients who were offered and received **OR** offered and refused cessation medication (if indicated) and practical counseling.

TOB-2a includes only those patients who were offered and **actually received** the cessation medication (if indicated) and the practical counseling.

Primary data element: *Tobacco Use Treatment FDA-Approved Cessation Medication*

Allowable Values:

1. The patient received one of the FDA-approved tobacco cessation medications during the first three days after admission.
2. The patient refused the FDA-approved tobacco cessation medications during the first three days after admission.
3. Not offered to the patient during the first three days after admission or unable to determine from medical record documentation.

Primary Data Element: *Tobacco Use Treatment Practical Counseling*

Allowable Values:

1. The patient received all components of practical counseling during the first three days after admission.
2. The patient refused/declined practical counseling during the first three days after admission.
3. Practical counseling was not offered to the patient during the first three days after admission or unable to determine if tobacco use treatment was provided from medical record documentation.

Primary Data Element:
Reason for No Tobacco Cessation Medication During the Hospital Stay

Definition: Reasons for not administering an FDA-approved tobacco cessation medication documented during the first three days of admission include:

- Allergy to all of the FDA-approved tobacco cessation medications
- Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking
- Other reasons documented by physician, APN, PA, or pharmacist

Summary for Implementation of Tobacco Measures

- Use SUB-1 measure as a model.
- TOB-1: Build upon existing documentation of tobacco use.
  - There is no specific tool required or recommended.
  - Any healthcare provider can complete the screening for tobacco use and provide initial counseling.
  - The patient does not need to sign the screening tool.
    - The nurse must document that the screening occurred during a face-to-face interaction.
- TOB-2/2a: Establish a simple algorithm for brief counseling at bedside to address:
  - Recognition of dangerous situations
  - Development of coping skills
  - Basic information about quitting, including a simple treatment guide
- Reasons for not administering FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist.

Submission of Non-Measure Data

- Beginning FY 2017, IPFs are required to submit aggregate population counts for Medicare and Non-Medicare discharges by:
  - Age Group
  - Diagnostic Group
  - Payer
  - Quarter
- Accuracy of general population data reporting is vital for CMS to assess:
  - Data reporting completeness for the total population
  - Opportunities to improve interpretation of measure results
  - Stability of reported measure values and subsequent decision-making concerning measure retention
  - Relevance and impact of potential future measures

Submission of Non-Measure Data

Facility data for non-measure data submission will be required as displayed in the tables below.

Discharges by Quarter	1Q	2Q	3Q	4Q	Annual Sum of Discharges

Age Strata	Total Discharges Annually
Children (≥ 1yr. and < 13 yrs.)	
Adolescent (≥ 13 and < 18 yrs.)	
Adult (≥ 18 yrs. and < 65 yrs.)	
Older Adult (≥ 65 yrs.)	

Payer	Total Discharges Annually
Medicare	
Non-Medicare	

Diagnostic Categories	Total Discharges Annually
Anxiety disorders (651)	
Delirium, dementia, and amnestic and other cognitive disorders (653)	
Mood disorders (657)	
Schizophrenia and other psychotic disorders (659)	
Alcohol-related disorders (660)	
Substance-related disorders (661)	
Other diagnosis – Not included in one of the above categories	

Helpful Links

TOB Measure Information

- Specifications Manual for National Hospital Inpatient Quality Measures: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228773989482
- List of individual codes for each clinical diagnostic category: www.hcup-us.ahrq.gov/toolssoftware/ccs/AppendixASingleDX.txt

Literature References

- CDC – Quit Smoking: www.cdc.gov/tobacco/quit_smoking/index.htm
- Smokefree.gov: http://smokefree.gov

Helpful Links

Literature References

- Public Health Service Guidelines
  - Treating Tobacco Use and Dependence-2008 Update: www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf
- Counseling Patients to Quit: www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/counsel.pdf
- Fiore MC, Goplerud E, Schroeder SA. "The Joint Commission's New Tobacco-Cessation Measures – Will Hospitals Do the Right Thing?" New England Journal of Medicine 366.13 (2012): 1172-1174. Print.
- Prochaska JJ, Hall SE, Delucchi K, Hall SM. "Efficacy of Initiating Tobacco Dependence Treatment in Inpatient Psychiatry: A Randomized Controlled Trial." American Journal of Public Health 104.8 (2013): 1557-1565. Print.

Continuing Education Approval

- This program has been approved for 1.0 continuing education (CE) unit given by CE Provider #50-747 for the following professional boards:
  - Florida Board of Nursing
  - Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
  - Florida Board of Nursing Home Administrators
  - Florida Council of Dietetics
  - Florida Board of Pharmacy
- Professionals licensed in other states will receive a Certificate of Completion to submit to their licensing Boards.

CE Credit Process

- Complete the ReadyTalk survey you will receive by email within the next 48 hours.
- The survey will ask you to log in or register to access your personal account in the Learning Management Center.
  - A one-time registration process is required.

Thank You For Participating!

Please contact the IPFQR Support Contractor if you have any questions:

Submit questions via email to:
IPFQualityReporting@HCQIS.org

OR

Call the IPFQR Support Contractor at 844.472.4477

This material was prepared by the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. HHSM-500-2013-13007I, FL-IQR-Ch8-02172015-02