



WELCOME

Practical Applications of the New Joint Commission Tobacco Standards: Revenue and Clinical Opportunities for Tobacco Specialists and Hospital Administrator

Monday, May 14, 2012 - 1:00 pm ET

During the Webinar

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- Webinar is being recorded
- Questions are encouraged throughout via the **Q&A** box
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Webinar Objectives:

- ▶ Provide a brief overview of the Joint Commission's new tobacco Core Measures
- ▶ Understand the potential clinical benefits both specific to hospitals (e.g. reduced readmission, reduced surgical and procedural complication rates) and other beneficial outcomes
- ▶ Discuss the potential revenue sources (billing) for hospitals and how the standards are an opportunity for positive return on investment
- ▶ Address challenges facing hospitals considering adoption of the tobacco measures
- ▶ Discuss lessons learned and challenges from a pilot site

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Moderator

- ▶ **Steven A. Schroeder, MD**
 - ▶ Director, Smoking Cessation Leadership Center
 - ▶ Distinguished Professor of Health and Health Care, Department of Medicine, UCSF



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Agenda

- ▶ **Welcome**
 - ▶ Michael Steinberg, President, ATTUD
 - ▶ Steve Schroeder, Director, SCLC
- ▶ **Panel Presentation**
 - ▶ Nancy Lawler
 - ▶ Michael Fiore
 - ▶ Matt Bars
 - ▶ Chris Kotsen
 - ▶ Audrey Darville
- ▶ **Questions & Answers**
- ▶ **Technical Assistance and Closing Remarks**

Disclosures: Faculty speakers, moderator, and planning committee members have disclosed no financial interest/arrangement or affiliation with any commercial companies who have provided products or services relating to their presentation or commercial support for this continuing medical education activity.

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Welcome

- ▶ **Michael Steinberg, MD,
MPH, FACP**
 - ▶ Associate Professor of Medicine,
UMDNJ/Robert Wood Johnson
Medical School
 - ▶ Director of the UMDNJ Tobacco
Dependence Program
 - ▶ President, ATTUD



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ATTUD

Association for the Treatment of
Tobacco Use and Dependence

www.attud.org

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Association for the Treatment of Tobacco Use and Dependence

**ATTUD is an organization of providers
dedicated to the promotion of and
increased access to evidence-based
tobacco treatment for the tobacco user.**

www.attud.org

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Goals of the Organization:

1. Provide forums (e.g. a listserv) for information exchange on best practices, innovations, etc
2. Promote evidence-based practices
3. Explore the need for credentialing of tobacco training programs, of treatment providers and of treatment organizations.

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Goals (Continued)

4. Serve as a resource regarding implementation of evidence-based treatment
5. Advocate for increased access to evidence-based treatment modalities via policy, funding, and system changes.
6. Advocate both for smokers and for treatment specialists

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Overview

- Approximately 500 members
- Established Council for the Accreditation of Tobacco Treatment Training Programs
- Consultant to FDA, CMS, AHRQ, WHO, State of Florida, etc.
- Very active list-serve

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Membership

Any individual who is currently active or has been historically active in the treatment of tobacco use and dependence, including:

- Health Care Providers (e.g. counselors, tobacco treatment specialists, physicians, nurses, respiratory therapists, health educators, pharmacists, social workers, dentists, PA's, addiction specialists, etc.)
- Researchers
- Educators/Trainers
- Policy makers
- Students

For more information: www.attud.org

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Panelist

- ▶ **Nancy K. Lawler, RN**
 - ▶ Associate Project Director
 - ▶ The Joint Commission

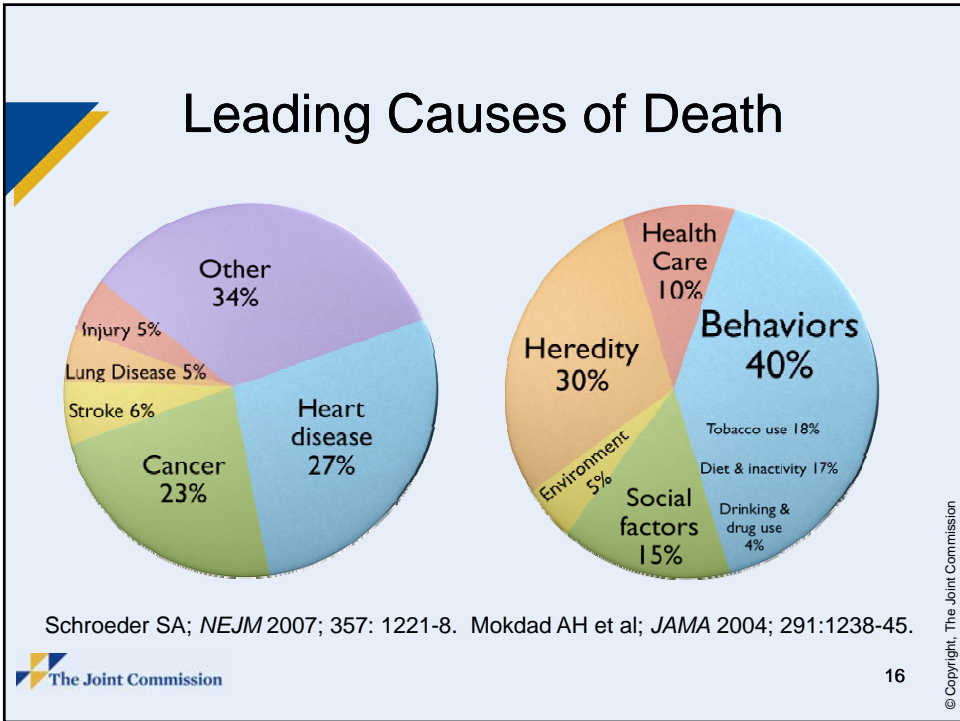
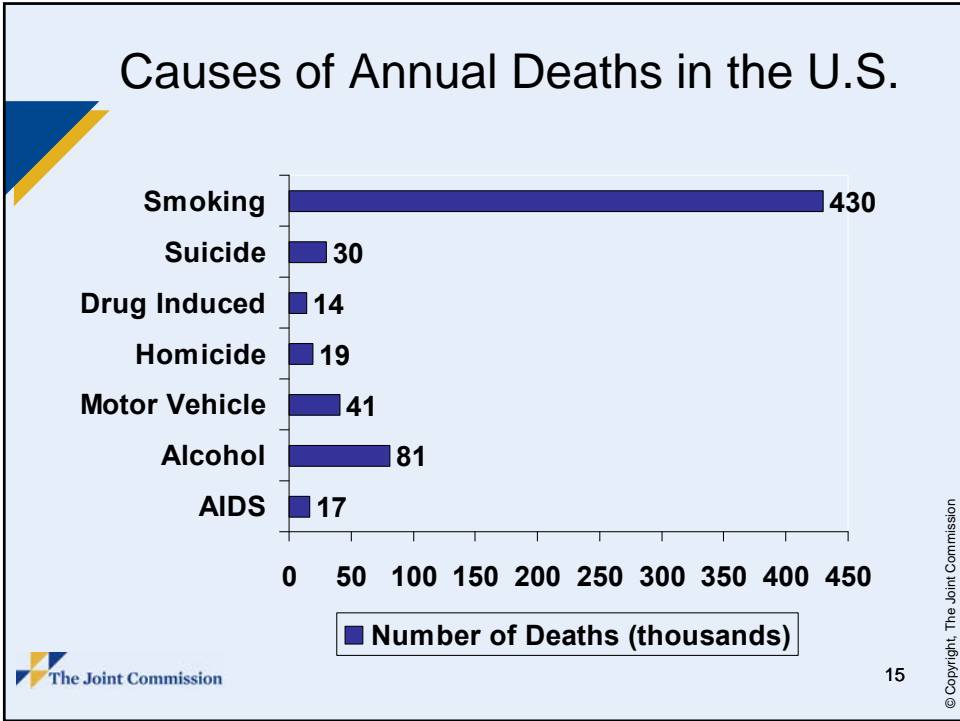


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Prevention Measures Tobacco Treatment

Nancy Lawler
Associate Project Director
Department of Quality Measurement
Division of Healthcare Quality Evaluation





Toll of Tobacco in the USA

- ▶ Tobacco use is the single most preventable cause of death in the USA
 - 1 in 5 deaths
 - > 400,00 deaths each year
- ▶ \$81.9 billion in annual productivity losses
- ▶ \$96 billion in annual smoking related health care cost

Development and Testing

- ▶ Funded Project
 - Partnership for Prevention and DHHS (SAMHSA & CSAT)
- ▶ Project duration = 1.5 year
- ▶ Development (6/09-12/10)
 - Technical Advisory Panel
 - Stakeholder comment period
 - Alpha Test
 - Pilot Test
 - Final Specifications

Pilot Test

- ▀ Six month duration
- ▀ Participants: 24 hospitals across 19 states
- ▀ Actual data collection and monthly submission
- ▀ 9,038 records submitted

Rankings of 25 Preventive Services Recommended by the USPSTF

The National Commission on Prevention Priorities ranked services by:

How much disease, injury, and death would be prevented if services were delivered to all targeted individuals? **Preventable Burden (PB)**

How many dollars would be saved for each dollar spent? **Return on Investment (ROI)**

Maciosek, *Am J Prev Med* 2006; Solberg, *Am J Prev Med* 2008;
<http://www.prevent.org/content/view/43/71>

Rankings of 25 Preventive Services Recommended by the USPSTF

#	Service	PB	ROI
1	Aspirin to prevent heart attack & stroke	5	5
2	Childhood immunizations	5	5
3	Smoking cessation	5	5
4	Alcohol screening & intervention	4	5

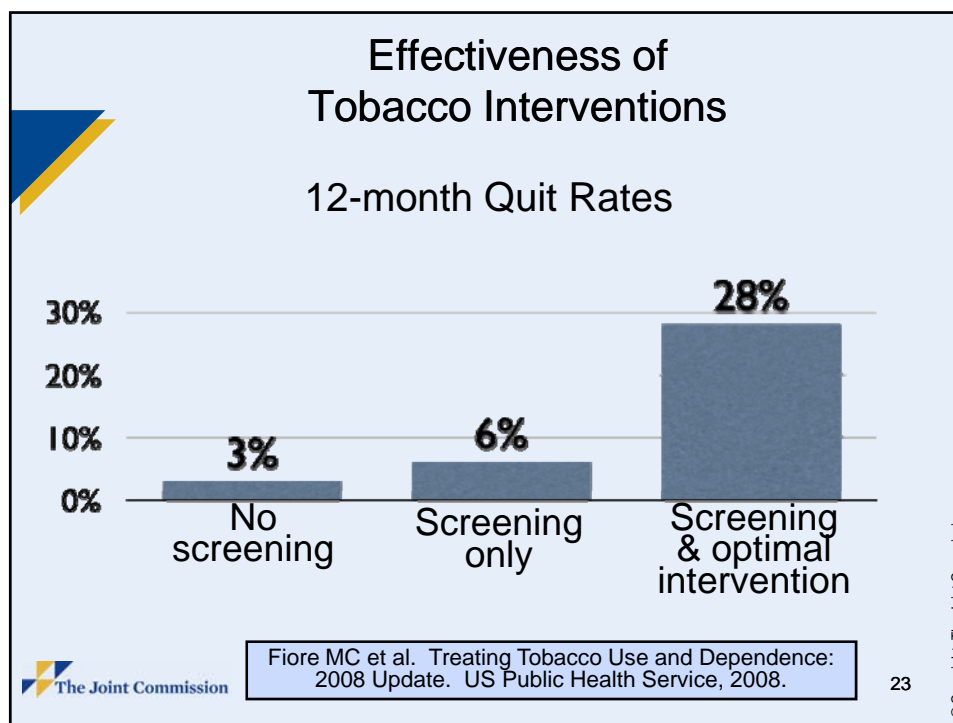
PB & ROI scoring: 1 = lowest ; 5 = highest

Maciosek, *Am J Prev Med* 2006; Solberg, *Am J Prev Med* 2008;
<http://www.prevent.org/content/view/43/71>

Tobacco Screening/Intervention **# 3** Alcohol Screening/Intervention **# 4** Ranked higher than:

- Screening for high blood pressure or cholesterol
- Screening for breast, cervical, or colon cancer
- Adult flu, pneumonia, or tetanus immunization
- Sexually transmitted infection screening
- All nutritional advice or supplementation
- Osteoporosis screening
- Vision & hearing screen

Maciosek, *Am J Prev Med* 2006; Solberg, *Am J Prev Med* 2008;
<http://www.prevent.org/content/view/43/71>



Tobacco Treatment Measures

- ▀ Based on Treating Tobacco Use And Dependence Clinical Practice Guideline 2008 Update.
 - Citation: Fiore MC, Jaen CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.
 - http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf
- ▀ Based on solid evidence

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Tobacco Treatment National Hospital Inpatient Quality Measures

- ▶ TOB-1 Tobacco Use Screening
- ▶ TOB-2 Tobacco Use Treatment Provided or Offered (during hospital stay)
- ▶ TOB-2a Tobacco Use Treatment
- ▶ TOB-3 Tobacco Use Treatment Provided or Offered at Discharge
- ▶ TOB-3a Tobacco Use Treatment at Discharge
- ▶ TOB-4 Tobacco Use: Assessing Status After discharge

Final Tobacco Treatment Measures

- ▶ TOB-1 Tobacco Use Screening
- ▶ Numerator Statement: The number of patients who were screened for tobacco use status
- ▶ Denominator Statement: The number of hospitalized inpatients 18 years of age and older
- ▶ Key Points
 - Any tobacco use within the past 30 days prior to hospital admission
 - Tobacco use includes all types of tobacco products (cigarettes, pipe, cigars, smokeless products)
 - Screening addresses the type of product, and amount used

Strength of Evidence = A
Recommendation found on Page 77 of Guideline

Final Tobacco Treatment Measures

- TOB-2 Tobacco Use Treatment Provided or Offered
 - Numerator Statement: The number of patients who received or refused practical counseling to quit **AND** received or refused FDA-approved cessation medications.
 - Denominator Statement: The number of hospital inpatients age 18 years of age and older identified as current tobacco users (all products with in past 30 days).
- TOB-2a Tobacco Use Treatment
 - Numerator Statement: The number of patients who received practical counseling to quit **AND** received FDA approved cessation medications
 - Denominator Statement: Same as above

Strength of Evidence = A
Recommendation found on pg 82, 83, 101 of Guidelines

Final Tobacco Treatment Measures

- TOB-3 Tobacco Use Treatment Provided or Offered at Discharge
 - Numerator Statement: The number of patients who were referred to or refused evidence-based out-patient counseling **AND** received or refused a prescription for FDA approved cessation medication at discharge
 - Denominator Statement: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.
- TOB-3a Tobacco Use Treatment at Discharge
 - Numerator Statement: The number of patients who were referred to evidence-based outpatient counseling **AND** received FDA-approved medication at discharge
 - Denominator: Same as above

Strength of Evidence = A
Recommendation found on pg 82, 83, 101, 150

Final Tobacco Treatment Measures

- ▶ TOB-4 Tobacco Use: Assessing Status after Discharge
- ▶ Numerator Statement: 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 statement: The number of discharged patients 18 years of age and older identified as current tobacco users.

Recommendation for follow up found on pg 150 of Guideline
Level of Evident = A for proactive telephone counseling, page 88

TOB 4 Documentation Requirement


- ▶ Record follow-up Information in the Medical Record
- ▶ Joint Commission Standard
 - RC.02.01.01: The medical record contains information that reflects the patient's care, treatment, and services.
 - 4. As needed to provide care, treatment, and services, the medical record contains the following additional information
 - Any records of communication with the patient, such as telephone calls or e-mail

Future Modifications

- ▶ Follow up timeframe changes to within 15 to 30 days post discharge
- ▶ Cap has been added to the number of follow up attempts
- ▶ Tobacco Use Post Discharge Status will be used to calculate the follow-up measure in the future.
- ▶ Changes effective January 2013


?Questions?

- ▶ Submit to the Joint Commission Performance Measurement Network Q & A Forum
- ▶ <http://manual.jointcommission.org>




- ▶ “There is no clinical Treatment available today that can reduce illness, prevent death, and increase quality of life more than effective tobacco treatment interventions.”

Treating Tobacco Use and Dependence
U.S. Department of Health & Human Services




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Panelist

- ▶ **Michael C. Fiore, MD, MPH, MBA**
 - ▶ Professor of Medicine
 - ▶ Director, Center for Tobacco Research and Intervention, University of Wisconsin, School of Medicine and Public Health



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Clinical Application and Benefits of Joint Commission Tobacco Measures

May 14, 2012

Michael C. Fiore, MD, MPH, MBA
Professor of Medicine
Director, Center for Tobacco Research & Intervention
University of Wisconsin School of Medicine and Public Health

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The Joint Commission and Hospitalized Smokers: A New Performance Measure-Set for Tobacco Cessation



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Joint Commission Technical Advisory Panel (TAP) for Tobacco and Alcohol

- Michael Fiore, MD MPH, MBA, Chair
- Eric Goplerud, PhD MA, Co-Chair
- Nancy A. Rigotti, MD
- Linda Sarna, RN, DNSc, FAAN
- Frank Vitale, MA
- Steven Schroeder, MD
- Robert Adsit, M.Ed.
- Larry Gentilello, MD, FACS
- Steve Bernstein, MD
- Constance Weisner, DrPH, MSW
- Katharine Bradley, MD, MPH

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Performance Set Measures

(October 2010)

- Performance Measure 1:
Tobacco Use Screening
- Performance Measure 2:
**Tobacco Use Treatment, and Counseling
& Medication during Hospitalization**
- Performance Measure 3:
**Tobacco Use Treatment Management
at Discharge**
- Performance Measure 4:
**One Month Follow-Up Assessing Treatment
Use and Cessation**

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The NEW ENGLAND JOURNAL of MEDICINE

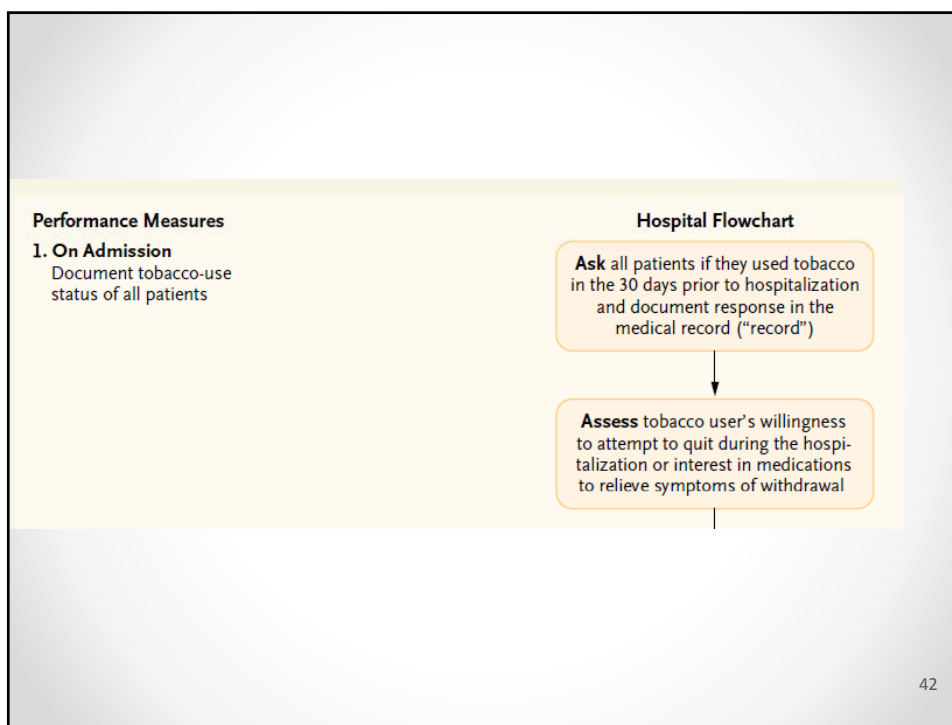
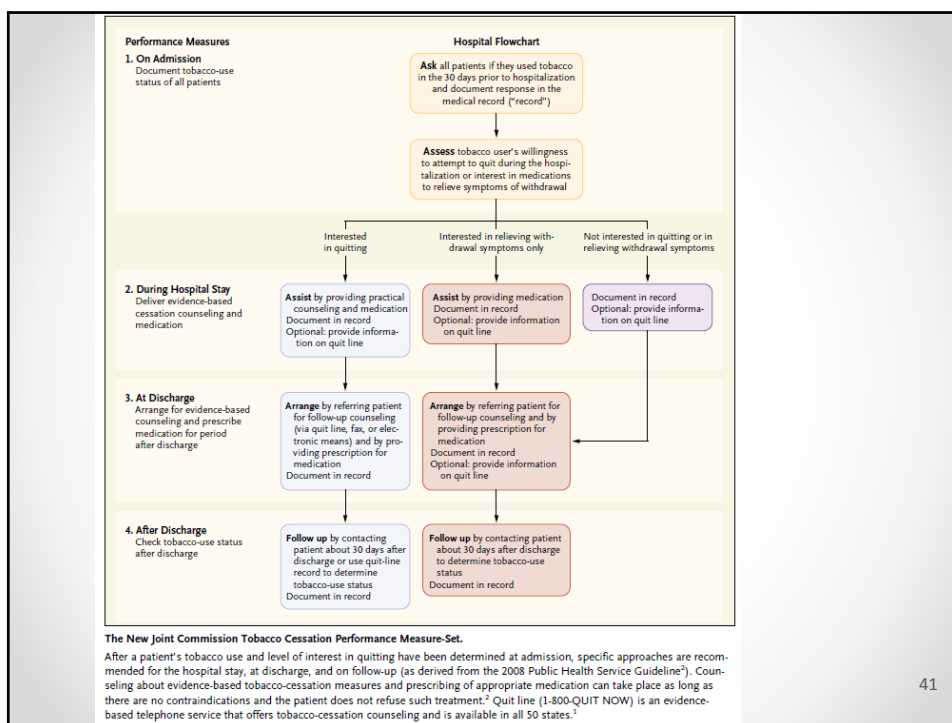
Perspective

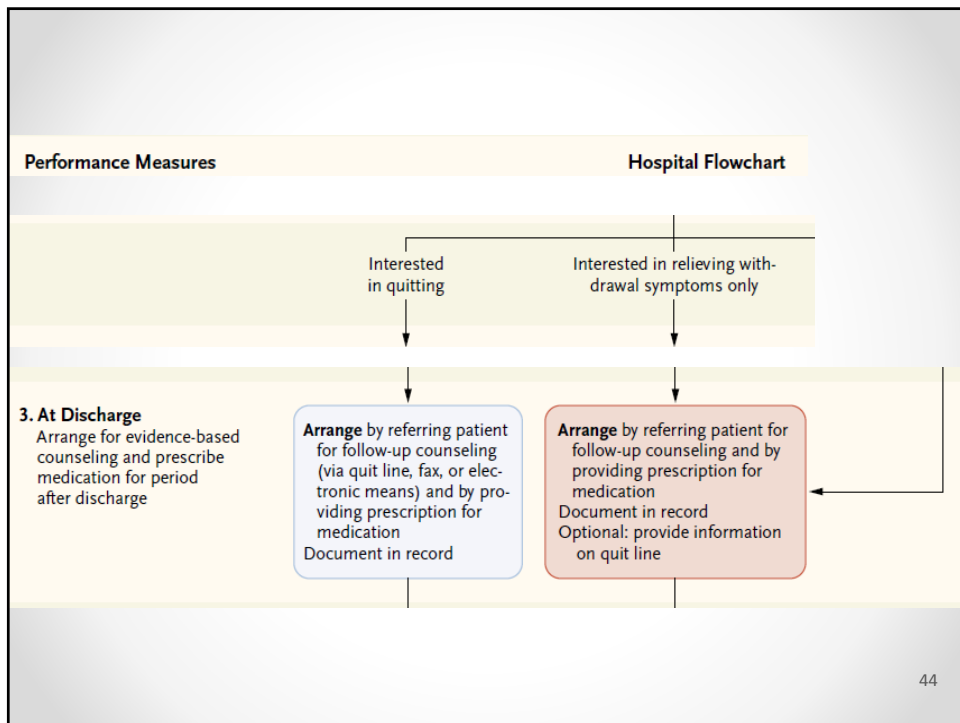
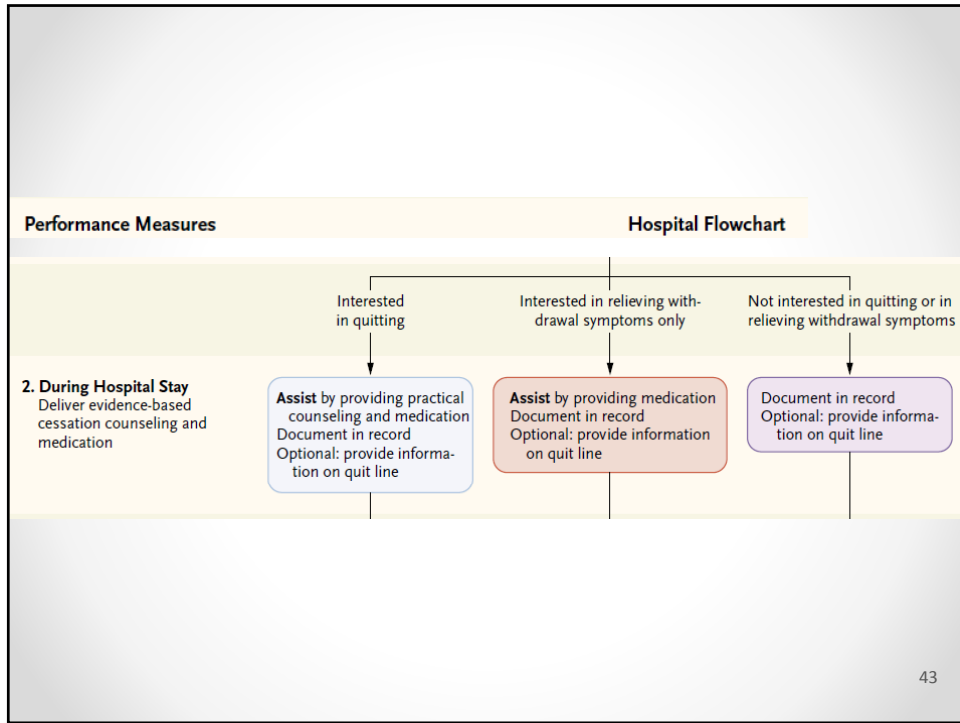
The Joint Commission's New Tobacco-Cessation Measures — Will Hospitals Do the Right Thing?

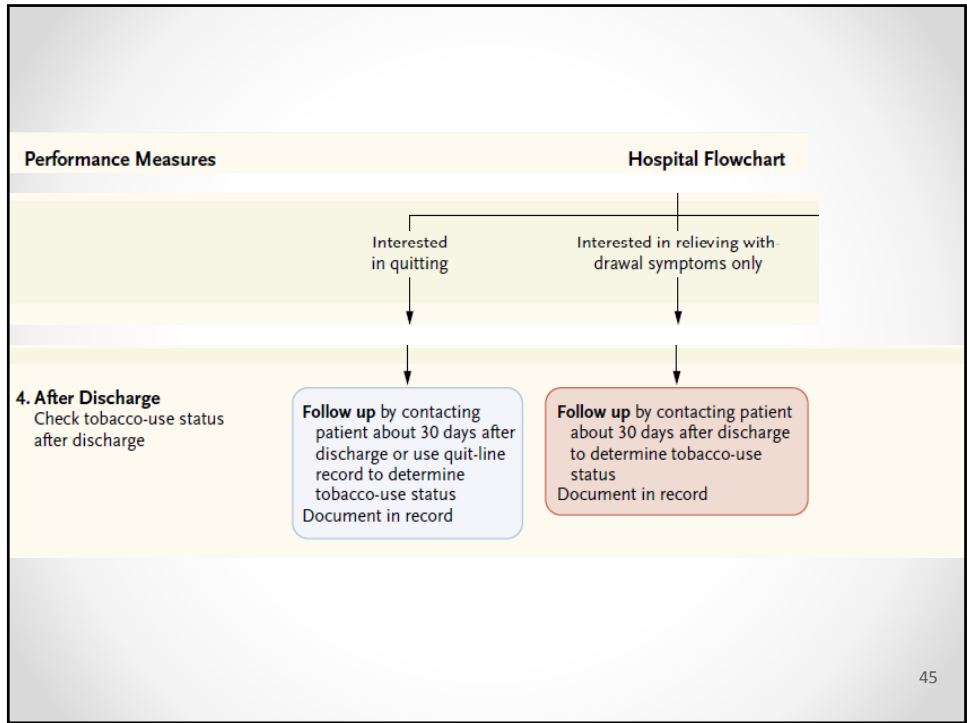
Michael C. Fiore, M.D., M.P.H., M.B.A., Eric Goplerud, Ph.D., and Steven A. Schroeder, M.D.

Fiore MC, Goplerud E, Schroeder SA. The Joint Commission's new tobacco-cessation measures – will hospitals do the right thing? NEJM. 2012;366(13):1173-1174.

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Benefits of the Joint Commission Tobacco Measures

- Improved Patient Health
- Meaningful Use Compliance
- Health Care Reform Compliance

Benefits of the Joint Commission Tobacco Measures - Improved Patient Health

- In-patient smoking cessation treatments have been associated with:
- Decreased Post-Discharge Mortality
- Decreased Post-Discharge Mortality for MI patients
- Decreased Rate of Re-Hospitalization and Decreased Mortality
- Increased Survival, Decreased Phlegm, Decreased Re-Hospitalization in COPD pts

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References – Improved Patient Health

- Borglykke, A., C. Pisinger, et al. (2008). "The effectiveness of smoking cessation groups offered to hospitalised patients with symptoms of exacerbations of chronic obstructive pulmonary disease (COPD)." [The Clinical Respiratory Journal](#) 2(3): 158-165.
- Gadomski, A., J. Gavett, et al. (2011). "Effectiveness of an inpatient smoking cessation program." [Journal of Hospital Medicine](#) 6(1): E1-E8.
- Ladapo, J. A., F. A. Jaffer, et al. (2011). "Projected cost-effectiveness of smoking cessation interventions in patients hospitalized with myocardial infarction." [Arch Intern Med](#) 171(1): 39-45.
- Mohiuddin, S. M., A. N. Mooss, et al. (2007). "Intensive smoking cessation intervention reduces mortality in high-risk smokers with cardiovascular disease." [Chest](#) 131(2): 446-452.
- Van Spall, H. G. C., A. Chong, et al. (2007). "Inpatient smoking-cessation counseling and all-cause mortality in patients with acute myocardial infarction." [American Heart Journal](#) 154(2): 213-220.

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Benefits of the Joint Commission Tobacco Measures

- Meaningful Use

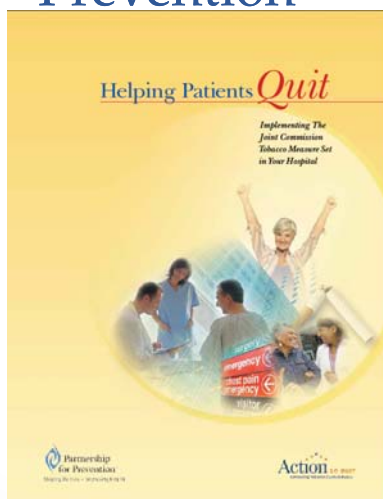
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Benefits of the Joint Commission Tobacco Measures

- Health Care Reform Compliance

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Resources – Partnership for Prevention



<http://www.prevent.org/data/files/resourcedocs>

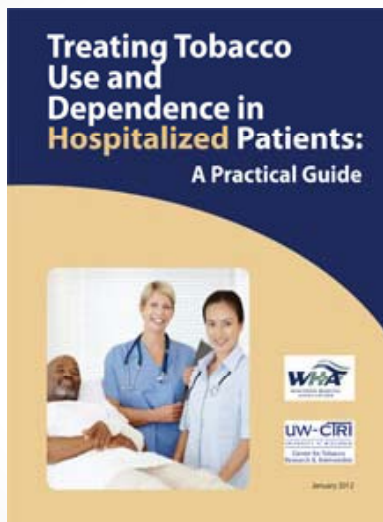
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Resources: UW-CTRI Hospital Manual



<http://www.ctri.wisc.edu/HC.Providers/h0spit8ls/2012hospitalmanual.pdf>

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Treating Tobacco Use and Dependence in Hospitalized Patients

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Selected text adapted with permission from Partnership for Prevention's Helping Patients Quit: Implementing the Joint Commission Tobacco Measure Set in Your Hospital. <http://www.prevent.org/files/HelpingPatientsQuit.pdf>

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Panelist

- ▶ **Matthew P. Bars, MS, CTTS**
 - ▶ Director, Fire Dept of the City of NY Tobacco Treatment Program, World Trade Center Medical Monitoring & Treatment Program
 - ▶ Director, IQuit Smoking Centers of Excellence



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Joint Commission Tobacco Treatment Measures & Your Hospital Revenues

Where There's Smoke.....There's Help!

Practical Applications of the New Joint Commission Tobacco Standards – Revenue and Clinical Opportunities for Tobacco Specialists and Hospital Administrators

Webinar May 14, 2012



Matthew P. Bars, MS, CTTS
 Clinical Director, IQuit Smoking Programs of Excellence, Jersey City, NJ

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 New York, New York


Chairman, Policy & Government Affairs Association for the Treatment of Tobacco Use & Dependence www.ATTUD.Org

Core Committee Author-ACCP Tobacco Treatment Toolkit



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Joint Commission Tobacco Measure Set



Set Measure ID#	Tobacco Measure Set Specifications
TOB-1 Tobacco Use Screening	<p>Numerator: The number of patients who were screened for tobacco use status.</p> <p>Denominator: The number of hospitalized inpatients 18 years of age and older.</p>
TOB-2 Tobacco Use Treatment Provided or Offered	<p>Numerator: The number of patients who received or refused practical counseling to quit and received or refused U.S. Food and Drug Administration (FDA) approved cessation medications.</p> <p>Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.</p>
TOB-2a Tobacco Use Treatment	<p>Numerator: The number of patients who received practical counseling to quit and received FDA-approved cessation medications.</p> <p>Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.</p>
TOB-3 Tobacco Use Treatment Provided or Offered at Discharge	<p>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.</p> <p>Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.</p>
TOB-3a Tobacco Use Treatment at Discharge	<p>Numerator: The number of patients who were referred to evidence-based outpatient counseling and received a prescription for FDA-approved cessation medication at discharge.</p> <p>Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.</p>
TOB-4 Tobacco Use: Assessing Status after Discharge	<p>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.</p> <p>Denominator: The number of discharged patients 18 years of age and older identified as current tobacco users.</p>

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Joint Commission TAMs represent a unique opportunity for revenues



Tobacco Treatment is Good Medicine & Good Business

Aggressive tobacco treatment programs offer a teachable moment to reduce hospital readmissions and other medical co-morbidities

Hospital based in-patient tobacco treatment decrease patient discomfort and represent a “marketing” opportunity

TOB Measure Set offers greater engagement in your communities and directly increases medically appropriate revenues – a Direct Marketing Opportunity

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Case Study



F.C. 59 y.o caucasian male

40 cpd then 30 cpd x 17 mos 67.5 pkyrs FTND= 8/10
COHb 5.5% TT1st C < 5 mins; 6-7cp2amh; Nocturnal smoking

Dyspnea

Hx of CAD, uncontrolled HTN, AMI Feb 2005 then 30 cpd

Active EtOHic x >20 yrs

CPFT: reversible airway obstruction consistent c/ hyperinflated lung fields, reduced DLCO 65% of pred, consistent c/ COPD

Abnormal CXR: blunting rt costophrenic angle not observed c/ prior studies, possible small pleural effusion, atelectasis or infiltrate, COPD, linear density rt hemithorax, possible pleural parenchymal thickening, possible trace fluid rt minor fissure

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Dx & Tx



Abnormal CXR → CT Thorax Dx:

- Stable 4mm nodule RUL
- Ø Pericardial or pleural effusion
- Ø Infiltrates
- Hyperinflation
- Emphysema
- Abdominal aortic aneurysm maximal dilation A/P 6.2cm x transverse 6.3cm x length 11.6cm (infrarenal to level of bifurcation of the aorta & origin of left iliac artery)

Tx: Endovascular repair of AAA c/ modular bifurcated graft
Pt recovered w/o complication
Pt tobacco abstinent > 5 years TQD 8/24/06

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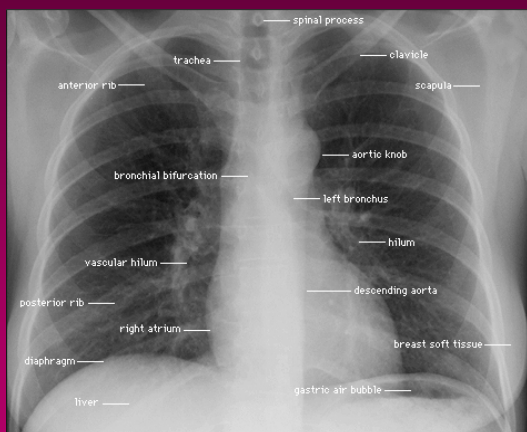
Complete PFT



76.9% of IQuit Tobacco Program Patients

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CXR under-reading conveys permission to smoke



Under-reading smokers CXRs increases the probability of continued tobacco use

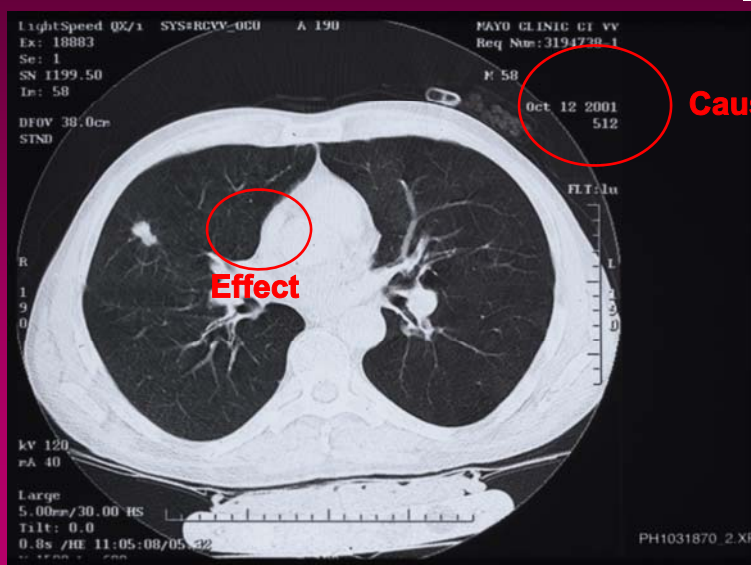
Highlight:

- Lung field hyperinflation
- Increased interstitial markings
- Vertebral wedging
- Subtle findings
- Abnormal CXR may prompt CT Thorax

68.5% of IQuit Tobacco Patients

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CT Chest (w & w/o Contrast, HRCT) 26% of IQuit Tobacco Patients



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Δ consumption secondary to tx plans necessitates biochemical quantification



- Tremendous bio-available variability
- Δ inhalation depth
- Tobacco dysgeusia
- Tobacco anhedonia
- Δ puffs/ cigarette
- compensatory smoking
- Δ cpd



all demonstrate the need for biochemical quantification of tobacco consumption (i.e COHb%, cotinine assays)

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Diagnostic assessment of tobacco caused medical co-morbidity



- Smoking effects every cell, organ, and organ system. The investigation of tobacco caused morbidity is limited only by clinical findings and the clinician's medical concerns and training. Investigation increases medical appropriate revenues
- Emphasis on tobacco related abnormalities and early detection
- Test results reviewed with each smoker and forwarded to referring physician/ PCP

Motivational counseling

“...We see changes here consistent with the damage caused by your smoking. It's not too late. We have medicines to help you stop...even if you're not ready to quit. How about we give it a try...”

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Even young intermittent smokers have pulmonary symptoms



Among young smokers (~20 y.o) smoking only 1-4 days/month

>60% experienced cough/ sore throat ≥ 1 or more days/mo

>40% experienced SOB ≥ 1 or more days/mo

Symptoms of Cough and Shortness of Breath Among Occasional Young Adult Smokers. An LC, Berg CJ, Klatt CM, et al, Presented at SRNT Annual Conference Feb 27 to Mar 1, 2008, Portland, OR

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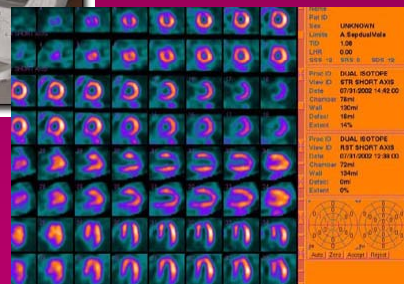
Echocardiogram



Smoking patients with suspected cardiovascular disease or dyspnea and/or chest pain unexplained by pulmonary evaluation may receive cardiac work-ups including but not necessarily limited to ECG, echocardiogram &/or nuclear stress tests

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Nuclear stress tests



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Resources



Helping Patients *Quit*

Implementing The Joint Commission Tobacco Measure Set in Your Hospital

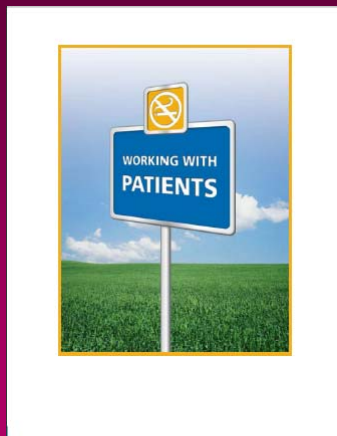
Partnership For Prevention
Shape the future - improving health

Action to Quit
www.prevent.org

<http://www.prevent.org/data/files/resourcedocs/hpq,%20full,%20final,%202010-31-11.pdf>

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Smoking Cessation Leadership Center



<http://smokingcessationleadership.ucsf.edu/DestTobFree/WorkingwPatients.pdf>

American College of Chest Physicians Tobacco Treatment Toolkit



<http://tobaccodependence.chestnet.org/>

Access is available at no charge

Waiting Room



- Patient Registration
- Patient Forms Self-completion

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Consultation Room



- SmokTrac Data Entry
- Patient Counseling
- CXR Viewbox

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Each Office Visit



Δ BP
 Auscultation
 Δ Weight
 Δ COHb
 Δ TWS/ADE
 Δ Pulmonary Status
 ↑↓ SOB, Cough, MH, CP, etc
 Δ Smoking/ Abs Status
 ↑↓ CPD, cp2amh,
 TTFC, Tob dysgeusia/
 taste perversion

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Summary & Recommendations



- View the Joint Commission TOB measures a direct marketing opportunity
- Identify hospital champions for the program (administrators , clinicians {multi-disciplinary}, community leaders)
- Establish systems for identifying, treating and referring patients to the program
- All tobacco dependent patients should be offered tob tx meds and (at least) brief counseling on admission- Reimbursement for tobacco tx counseling (99406 or 99407) is appropriate
- As reimbursement systems (e.g. ACOs) financial rewards for effective preventive and coordinated care, tobacco tx will become even more valuable

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Summary & Recommendations



- At discharge, referral to the Tobacco Treatment Program should be reinforced with an outpatient appt ASAP-at the very least program literature
- Tob Tx staff should make post discharge follow-up calls ASAP to schedule or confirm appts
- The investigation of tobacco caused morbidity is limited only by clinical findings and the clinician's medical concerns
- Comprehensive outpatient programs can generate >\$1,000 per smoker depending on a number of factors-Your mileage may vary
- Financial success is directly proportional to clinical success
- Clinical and financial success directly proportional to staffing (FTEs, PTEs), training, hospital resources and hospital champions and population specifics

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Yearning to breathe free



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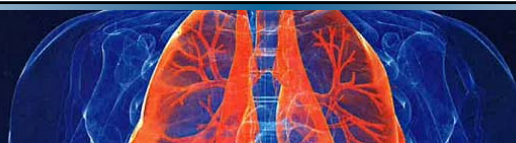
Panelist

▶ **Chris Kotsen, PsyD, CTTS**

- ▶ Program Manager, Tobacco Quitcenter
- ▶ Lung Cancer Institute, Steeplechase Cancer Center, Somerset Medical Center



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Comprehensive Tobacco Treatments and Lung Cancer Screenings:

Clinical and Revenue Opportunities

May 14, 2012



at Somerset Medical Center

Chris Kotsen, PsyD, CTTS

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Objectives

- Describe clinical and revenue opportunities and challenges for tobacco treatments across inpatient and outpatient treatment settings
- Highlight clinical and revenue opportunities at a Comprehensive Lung Cancer Screening Center



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New Surgeon General Reports

- "tobacco smoke...the same poisonous chemicals reach **every organ** in your body...damage is immediate..."(2010)
- Cigarette smoking by youth and adults is proven to cause serious and potentially deadly health effects immediately and into adulthood...increased physical damage... early abdominal aortic atherosclerosis... and reduced lung function..." (2012)



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Services Provided

Tobacco Quitcenter Treatment Program

- Treated > 2,400 Patients, > 10,700 Visits
- Individual Counseling (inpatient/outpatient)
- Group Counseling
- Carbon Monoxide Assessments
- Prescription Medication Consultations (Chantix, Zyban, Nicotine Inhaler, Nicotine Nasal Spray)
- Discounted Nicotine Replacement Therapy (OTC)
- Corporate Lunch & Learns for Employees on Tobacco Treatment
- Corporate Lunch & Learns on Designing a Comprehensive Tobacco Treatment Benefit for HR Departments
- Corporate/Community Quit Group Programs



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Fee for Service Model – Hospital Revenue Opportunities

- Tobacco treatment services are billable. However, billing coding is not unified/standardized.
- “it is incumbent on the clinician...to recognize that reimbursement of these codes may vary by payer or benefits package.”*

*Treating Tobacco Use and Dependence. Clinical Practice Guideline 2008 Update. US Department of Health and Human Services.



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Valid CPT Codes for Tobacco Treatment Specialists

- CPT 99407 (>10 minutes), symptomatic smokers
- CPT G0437 (>10 minutes), “asymptomatic” smokers, Preventive Code
- CPT 96150-96155 (Health and Behavior Assessment/Intervention Codes), Physical Medicine Codes billed in 15 minute units
- CPT 94250 Carbon Monoxide Assessment



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Episode of Care Reimbursement Model Hospital Revenue

- CHF readmission rate within 30 days leads to reduced reimbursement by Medicare
- Surgical Outcomes – complications/readmissions impact on hospital revenue



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Patient Protection and Affordable Care Act of 2010 (PPACA)

- Pendulum has now swung towards reimbursing for mandated preventive care services
- Tobacco treatments reimbursed with \$0 patient cost sharing
- Essential Health Benefits now being established in states – statutory language may be needed (e.g., Mass Medicaid Tobacco Cessation Model)
- A need for tobacco treatment specialists to collaborate more with hospital administrators, billing department, state professional associations, and possibly statewide legislators



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Our Institutes

Multidisciplinary Disease Site Teams comprised of various medical professionals, including Oncologists, Radiologists, Radiation Oncologists, Nurse Navigators, Social Workers, Tobacco Treatment Specialists and others review and discuss cancer cases.

- Breast Institute
- Colon-Rectal Institute
- Lung Institute
- Prostate Institute



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Screenings and Prevention

Early Detection is Key

- Breast (Mammography)
 - Self-Referral
 - Make Time for Mammography
- Colon-Rectal (Colonoscopy)
- Lung (**NEW** Lung Cancer Screening)
- Prostate (**FREE** screenings offered several times per year)



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Our Technology

- **Robotic Technology** revolutionizes Cancer Surgery (prostate, bladder, kidney, gynecologic and general surgeries) and TORs (transoral robotic surgery) for cancers and other conditions of the head and neck
- A leader in **Video-Assisted Thoracic Surgery (VATs)** – Minimally invasive surgical technique compared to traditional chest surgery. Much easier recovery/shorter hospital stay
- **Radiation Oncology Therapies** include: IMRT, EBT, RapidArc, Knifeless surgery, Cranial stereotactic radiosurgery, Stereotactic body radiotherapy, High dose rate brachytherapy, Low dose rate brachytherapy
- **Clinical Trials** offered



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Lung Cancer Screening Center



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Lung Cancer Screening Center Clinical Services

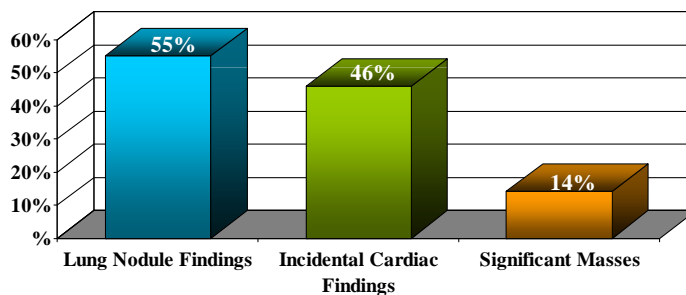
- Philosophy – Early Detection leads to better clinical outcomes
- Follows National Comprehensive Cancer Network (NCCN) Guidelines
- Low Dose Chest Cat Scan
- Spirometry at Pulmonary Function Lab
- F/U consultation with Pulmonary Specialist/ If indicated, F/U consultation with Tobacco Treatment Specialist, which includes CO Assessment
- When medically appropriate, F/U CTs at 3, 6, 12 months
- Also, referral to Intensive Tobacco Treatment at Quitcenter, Pulmonary, PCP, Cardiologist, other Medical Specialists



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Lung Cancer Screening Patients

(n = 74)



- Nodules >4 to <=6mm, F/U repeat CT in 6 mos, >6 to <=8, F/U CT in 3 mos.
- Fleischner Society Guidelines: Radiology 2005; 237:395-400
- Cardiac findings include atherosclerotic disease, atherosclerotic change of the aorta, coronary artery calcification. Patients referred to a PCP and/or cardiologist for F/U
- Significant masses include nodules >= 2cm. These masses include lung, renal, aorta, adrenal, thyroid, liver. Immediate F/U includes Pet scans and/or bronchoscopy w/biopsy, etc, and immediate consultation with PCP, etc.



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Downstream Reimbursement - Hospital Revenue

- Financial/mathematical model looks at medically necessary visits/diagnostic procedures (CPT codes) billable by the facility
- Number of patients needing LDCT at 3, 6, 12 months
- Number of patients needing Pet scans
- Number of patients needing bronchoscopy w/biopsies
- Number of patients needing surgery/VATS
- Number of patients needing chemo, radiation
- Number of patients needing cardiac/pulmonary procedures (e.g., Echo, EKG, Nuclear Stress Tests/PFTs)*
- Number of patients seen in intensive outpatient Quitcenter treatment
- Number of positive cancer diagnosis

*Subtract number of visits/procedures completed by specialists/PCPs in private practices in community



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Panelist

▶ **Audrey K. Darville, PhD, APRN, CTTS**

- ▶ Certified Tobacco Treatment Specialist, UKHealthCare
- ▶ Assistant Professor, College of Nursing, University of Kentucky
- ▶ Family Nurse Practitioner



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Tobacco Use Measures Pilot Experience

Audrey Darville, PhD, APRN, CTTS
UK HealthCare
University of Kentucky College of Nursing
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Overview of Joint Commission TAM Pilot

Objectives:

- Assess the reliability of the measures and associated data elements
- Obtain information about how the measures and specifications can be enhanced to provide more reliable data

Pilot Process:

- Tracked and transmitted data from hospital discharges in early 2010 for each of the candidate measures
- 30 discharges/month randomly selected from all inpatients 18 years and older regardless of diagnosis
- Monthly conference calls with pilot sites
- Site visits to select institutions near end of data collection period

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University of Kentucky Hospitals

- 450 + inpatient bed Academic Health Care System; Level 1 Trauma Center in Central Kentucky
- Approx. 1500 discharges/month
- Use hybrid EMR plus paper chart documentation system
- Tobacco-free campus since 2008; Tobacco Treatment Specialist position created at that time
- Tobacco use data from EMR-based Admission Profile: 25% patients reported past 12 month smoking; 20% current smoking (lower than internal audit); State prevalence 25%

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Lessons Learned:

Data collection/tracking issues:

- Used “yes” and “no/unable to assess” response in EMR profile which contributed to lower reported rates to smoking
- Did not have option to indicate patient refusal
- Hybrid documentation system made it difficult to track counseling intervention/discharge plan making these numbers low
- Could not easily determine who went home with plan to continue NRT use

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More Lessons Learned:

- Use of NRT for inpatients was very low (less than 50% of patients who were current smokers)
- “No/unable to assess” responses were not reassessed prior to discharge
- Fax to quitline rates were low; this was done on admission and quitline attempted contact while still inpatient
- Post-discharge follow up challenges: bad contact information; no mechanism to track when smokers were discharged

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Changes Made:

- Assessment for tobacco use now “yes”, “no”, “unable to assess due to cognitive impairment” which includes an IT prompt to reassess
- Added “offered” and “refused” options for NRT, QL, TTS
- Updated tobacco use assessment in profile in anticipation of new measures (with some push back...)
- Fax to quitline now done at discharge
- Patient ed materials revised based on ready/not ready to quit; now accessed through individual patient EMR with info on quitting, recognizing danger situations, and developing coping skills
- Provider education sessions regarding NRT and NRT order set increased use

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Wish List...

- Consistent electronic documentation format across the institution
- Using scripting prompts for providers/staff in EMR
- Automated electronic fax to quitline referral
- Written prescriptions for NRT provided to patients at discharge and documented in EMR
- An easy answer to the 30 day follow up challenges...

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Challenges:

- Transition institutional thinking about tobacco measures from fulfilling a Core Measure requirement to providing evidence-based care for all patients
- Orchestrating a coordinated approach across the institution: Who owns this now?
- Including tobacco treatment/avoidance plan in every discharge plan for tobacco users/those exposed to secondhand smoke
- Timely generation of data reports
- Determining best method for 30-day follow up contact and how to best document for data extraction

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Questions & Answers

- ▶ Feel free to post questions to the panelists via the **Q&A box**.



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Closing Remarks

Please help us by completing the post-webinar survey.

Thank you for your continued efforts to combat tobacco.

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