HHS Public Access

Author manuscript

N Engl J Med. Author manuscript; available in PMC 2015 June 09.

Published in final edited form as:

N Engl J Med. 2012 March 29; 366(13): 1172–1174. doi:10.1056/NEJMp1115176.

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.**

Center for Tobacco Research and Intervention, University of Wisconsin School of Medicine and Public Health, Madison (M.C.F.); the Smoking Cessation Leadership Center, University of California, San Francisco, San Francisco (S. A. S.); the National Opinion Research Center, University of Chicago, Chicago (E.G.); and the Technical Advisory Panel appointed by the Joint Commission (M.C.F., S.A.S., E.G.). The other members of the Technical Advisory Panel are Robert Adsit, Steven Bernstein, Katharine Bradley, Larry Gentilello, Connie Revell, Nancy Rigotti, Linda Sarna, Frank Vitale, and Constance Weisner

Few factors influence health care standards in the United States today more than the actions of the Joint Commission (formerly the Joint Commission for the Accreditation of Healthcare Organizations). And few opportunities hold more promise for increasing the rate of tobacco-use cessation than patient contact with the health care system. Health care visits represent "teachable moments" when a patient's very real fears and concerns about tobacco can provide a particularly powerful motivation to quit. The Joint Commission's new Tobacco Use Performance Measure Set took effect on January 1, 2012. Will implementation of these measures improve smoking-cessation treatment by capitalizing on the Joint Commission's power to change hospital care and the opportunity offered by health care encounters? Or will hospitals neglect this opportunity, citing the pressures of other priorities?

There is a continued, urgent need for effective tobacco-cessation interventions. Tobacco use remains the chief avoidable cause of illness and death in our society, responsible for inestimable suffering, almost half a million deaths annually, and about $200 billion in added costs for health care and lost productivity each year. Tobacco-use rates in the United States have declined markedly over the past 60 years, yet they now appear frozen at about 20% of all adults, with rates sharply higher among the poor, the least educated, and people with coexisting mental health conditions or alcohol or substance abuse.[1] Moreover, although about 70% of smokers visit a primary care physician each year, only about 30% report that they leave health care visits having received evidence-based counseling and medication for smoking cessation.[2]

Hospitalization provides a particularly propitious opportunity to deliver tobacco-use interventions. First, many tobacco users are hospitalized because of a tobacco-caused disease (for example, chronic obstructive pulmonary disease, cardiovascular diseases, cancer, or infections), making the need to stop tobacco use particularly salient. Second, most U.S. hospitals are now smoke-free, and many have smoke-free campuses, which makes

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

smoking during hospitalization difficult and inconvenient and therefore encourages cessation. Third, evidence-based treatments could be made readily available in hospital settings, allowing hospitalized patients to receive expert advice on how to quit smoking and information on how their diseases and symptoms are related to tobacco use. Patients could also directly experience the mitigation of withdrawal symptoms provided by tobacco-cessation medications during forced abstinence in a hospital.

Although hospitalization is seldom a desired health care outcome, it can at least offer tobacco users the chance to receive cessation interventions. Unfortunately, this potential is uncommonly realized. Studies show that many hospitals do not consistently provide cessation services to their patients.[3,4] One reason is that previous Joint Commission performance measures, starting in 2004, required U.S. hospitals to report only the proportion of smokers who received tobacco-cessation *advice*, and then only for those adults admitted for acute myocardial infarction, congestive heart failure, or pneumonia. Thus, the previous measure set focused on a limited population and did not require the provision of effective cessation interventions, such as counseling or cessation medications approved by the Food and Drug Administration and recommended in the Public Health Service's 2008 Clinical Practice Guideline *Treating Tobacco Use and Dependence*.[2] In addition, a recent analysis documented that hospitals were able to "game the system," with scores approaching 100% on the tobacco treatment measure,[5] prompting the National Quality Forum (NQF) to abandon tobacco-use intervention as a quality measure. In sum, the previous performance-measure set fell short. Many hospitals reported high compliance rates, but in reality, too many tobacco users left hospitals with too little help.

The current performance measures were developed by a voluntary external Technical Advisory Panel (TAP) appointed by the Joint Commission in 2009 and comprising experts in the science and practice of treating tobacco dependence. We served on this panel, whose charge was to make recommendations regarding new measures to the Joint Commission, which would then make all final decisions. The TAP's chief goal was to ensure that any new performance measures mandated the delivery of evidence-based tobacco-dependence counseling and medication for all admitted patients who use tobacco. In 2011, after pilot testing in 24 hospitals, a public comment period, and additional modifications, the final measures were adopted by the Joint Commission.

Tactically, the new measure set is powerful, in that it mandates comprehensive evidence-based tobacco-dependence treatment during hospitalization and on discharge. Specifically, its four components (see flowchart) require that hospitals identify and document the tobacco-use status of all admitted patients, provide both evidence-based cessation counseling and medication during hospitalization for all identified tobacco users (absent contraindications or patient refusal), provide a referral at discharge for evidence-based cessation counseling and a prescription for cessation medication (absent contraindications or patient refusal), and documentation of tobacco-use status approximately 30 days after discharge.

Does the new performance-measure set improve on the previous set, and will it deliver on its promise? Our perspective is that, although tactically impressive, the measure set is

strategically flawed because its adoption is optional. Accredited hospitals are required to report on only four of the Joint Commission's performance-measure sets from among the 14 available, with no requirements regarding which must be chosen (The other measure sets are acute myocardial infarction, heart failure, pneumonia, surgical care improvement project, perinatal care, children's asthma care, hospital outpatient care, venous thromboembolism, stroke, hospital-based inpatient psychiatric services, immunization, emergency department, and substance abuse). Our concern is that most hospitals will eschew the tobacco-use measure set because, compared with others, it requires greater effort and resources (intensive identification, treatment, and post-discharge follow-up of all tobacco users).

Of course, Joint Commission actions are not the only routes to improved tobacco intervention in the health care setting. For instance, "meaningful use" criteria and incentives, a key component of the 2010 Patient Protection and Affordable Health Care Act, include tobacco dependence as a core required outcome measure for health care systems. The act also mandates that, by 2014, new insurance plans provide coverage for evidence-based prevention treatments, including those for tobacco cessation. In other areas, the NQF is considering adopting the new Joint Commission tobacco-use standard, and the Centers for Medicare and Medicaid Services has added the treatment of tobacco dependence as a topic for potential regulation in 2013; such regulation could link documentation of the consistent delivery of tobacco-dependence treatment in health care settings with reimbursement. Despite these alternative approaches to enhancing health care, the Joint Commission performance standards remain critically important.

Although the Joint Commission has not prioritized the tobacco-use performance-measure set over other quality-assurance measure sets, we believe that U.S. hospitals face a medical and moral imperative to select it and meet its requirements, given the continuing prevalence of tobacco use, its profound costs in health and happiness, and the ready availability and feasibility of effective treatments. Helping patients quit using tobacco is one of the greatest preventive care efforts in which hospitals can engage and it is likely that other regulatory bodies will soon require such efforts. To this end, the 2012 Joint Commission Tobacco Use Performance Measure Set represents an ideal opportunity to apply a very meaningful set of effective interventions in the health care setting — if only hospitals adopt them.

References

1. Fiore MC, Baker TB. Clinical practice. Treating smokers in the health care setting. New Engl J Med. Sep 29; 2011 365(13):1222–1231. [PubMed: 21991895]
2. Fiore, MC.; Jaen, CR.; Baker, TB., et al. Treating tobacco use and dependence: 2008 update. Rockville, MD: U.S. Department of Health and Human Services, U.S. Public Health Service; 2008.
3. Williams SC, Morton DJ, Jay KN, Koss RG, Schroeder SA, Loeb JM. Smoking cessation counseling in U.S. hospitals: A comparison of high and low performers. J Clin Outcomes Manag. 2005; 12(7):345–352.
4. Jonk YC, Sherman SE, Fu SS, Hamlett-Berry KW, Geraci MC, Joseph AM. National trends in the provision of smoking cessation aids within the Veterans Health Administration. Am J Manag Care. Feb; 2005 11(2):77–85. [PubMed: 15726855]
5. Levy DE, Kang R, Vogeli CS, Rigotti NA. Smoking Cessation Advice Rates in US Hopsitals. Arch Intern Med (Letter). Oct 10; 2011 171(18):1682–4.

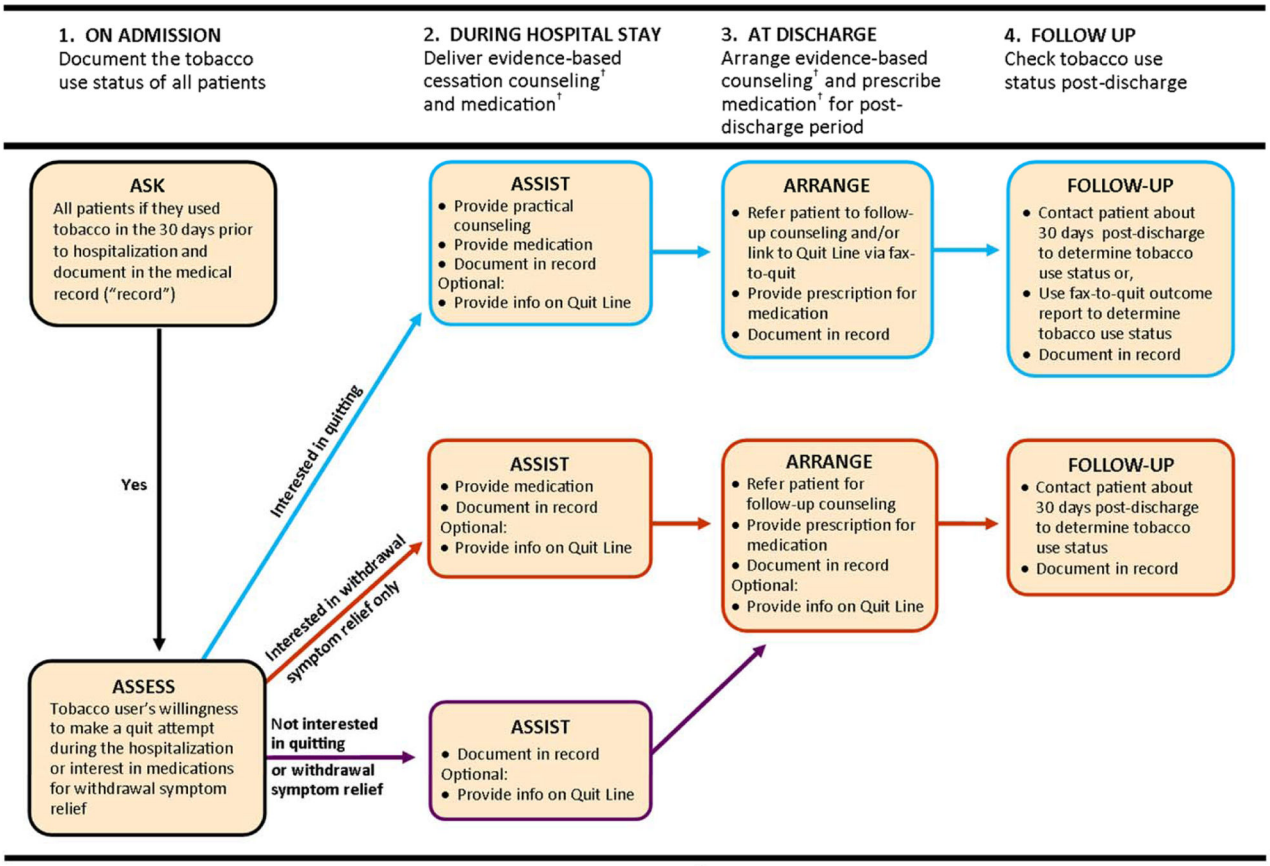

Figure 1. The Four Components of the New Joint Commission Tobacco Use Performance Measure Set with Inpatient Flowchart*

* Adapted from 2008 PHS Guideline, *Treating Tobacco Use and Dependence*, 5As[2]

†Absent contraindications or patient refusal