



Perspective

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

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Few factors influence health care standards in the United States today more than the actions of the Joint Commission (formerly the Joint Commission on 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 use can provide a particularly powerful motivation to quit. The Joint Commission's new Tobacco Cessation 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 practices 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 preventable cause of illness and death in our society. It is 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 who have coexisting mental health conditions or who abuse alcohol or other substances.¹ Moreover, although about 70% of smokers visit a primary care physician each year, only about 30% report that they leave these visits having received evidence-based counseling and medication for smoking cessation.²

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

ization 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 not commonly 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 set of measures focused on a limited population and did not require that hospitals provide 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 to abandon

tobacco-use intervention as a quality measure. In sum, the previous set of performance measures fell short. Many hospitals reported high compliance rates, but in reality, too many tobacco users left hospitals with too little help.

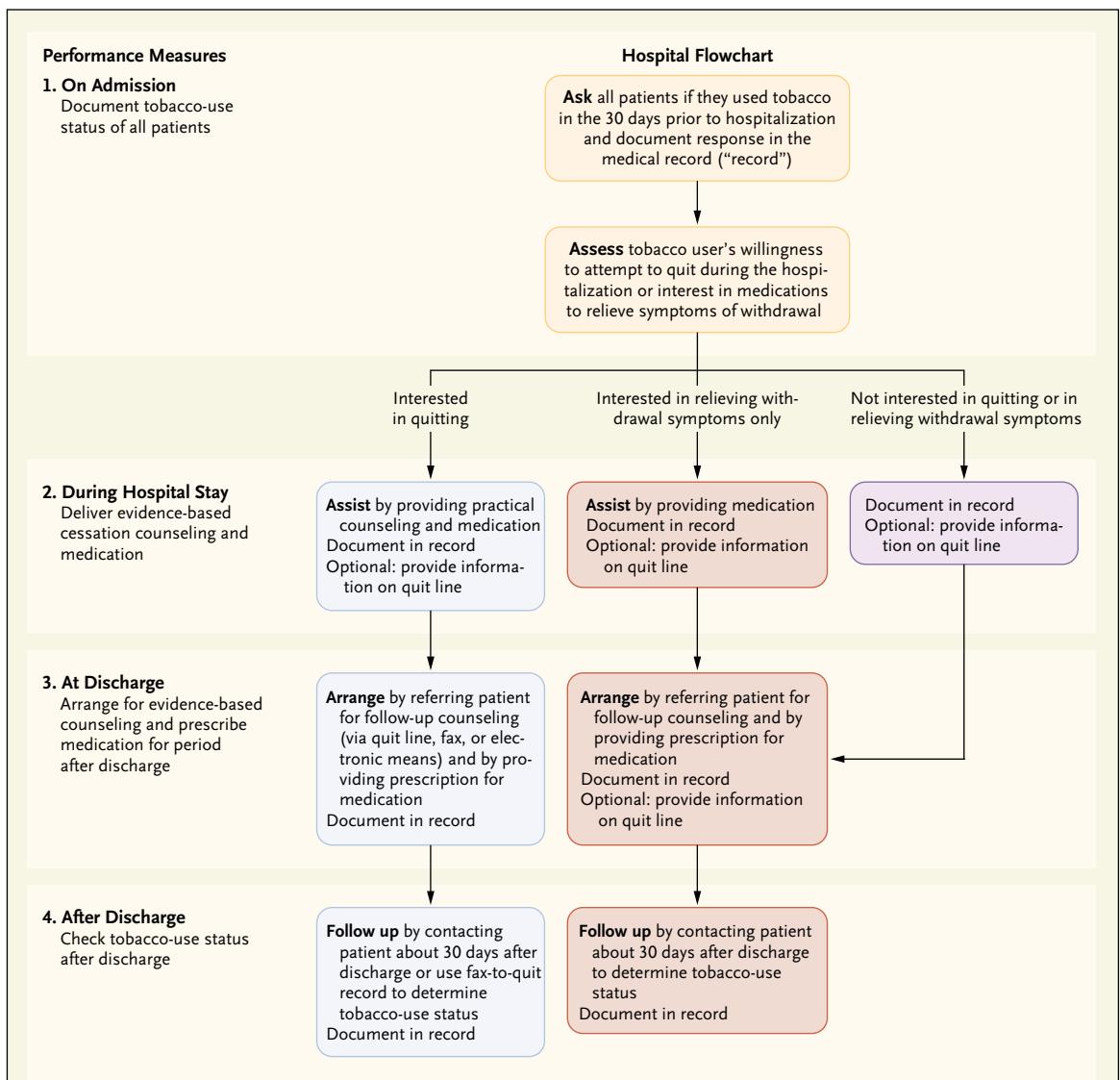
The current performance measures were developed by a voluntary, external Technical Advisory Panel (TAP) appointed by the Joint Commission in 2009 and comprising experts in the science and practice of treating tobacco dependence. The charge of this panel, on which we served, was to make recommendations 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, it requires 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 (in the absence of contraindications or patient refusal), provide a referral at discharge for evidence-based cessation counseling and a prescription for cessation medication (in the absence of contraindications or patient refusal), and document

tobacco-use status approximately 30 days after discharge (see flow-chart).

Does the new set of performance measures 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 4 of the 14 available Joint Commission sets of performance measures, with no requirements regarding which must be chosen. (The other 13 measure sets are for acute myocardial infarction, heart failure, pneumonia, surgical care improvement, perinatal care, children's asthma care, hospital outpatient care, venous thromboembolism, stroke, hospital-based inpatient psychiatric services, immunization, the emergency department, and substance abuse.) Our concern is that most hospitals will eschew the tobacco-cessation measure set because it requires greater effort and resources (intensive identification, treatment, and postdischarge follow-up of all tobacco users), than the other measure sets do.

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 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 National Quality Forum is con-



The New Joint Commission Tobacco Cessation Performance Measure-Set.

After a patient's tobacco use and level of interest in quitting have been determined at admission, specific approaches are recommended for the hospital stay, at discharge, and on follow-up (as derived from the 2008 Public Health Service Guideline²). Counseling about evidence-based tobacco-cessation measures and prescribing of appropriate medication can take place as long as there are no contraindications and the patient does not refuse such treatment.² Quit line (1-800-QUIT NOW) is an evidence-based telephone service that offers tobacco-cessation counseling and is available in all 50 states.¹

Considering the adoption of the new Joint Commission tobacco-use standard, and the Centers for Medicare and Medicaid Services have added the treatment of tobacco dependence as a topic for potential regulation in 2013; such regulation could link the documentation of consistent delivery

of tobacco-dependence treatment in health care settings to 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 perfor-

mance measure set for tobacco cessation over other sets of quality-assurance measures, 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 terms of 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 Cessation Performance Measure-Set represents an ideal opportunity to apply a very meaningful set of effective interventions in the health care setting — if only hospitals will adopt them.

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

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