Implementing Cessation Programs: Inpatients & Outpatients

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What is the purpose of the bedside cessation program?

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Bedside Cessation Objectives

- Additional or front information of SFE policy
- To prevent nicotine withdrawal through use of NRT with appropriate patients
- To use hospitalization as a springboard to cessation

- How many people should you expect to see – 17 - 35% of all hospitalizations – we think!!

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Basic Components of Bedside Program

- Smoke-free Environment
- Inpatient Smoking Policy
- Identification of Tobacco Users
- Suggested Units for Inpatient Intervention
  - Staged implementation
- Tobacco Treatment Specialist
- Components of the Inpatient Intervention

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Basic Components of Bedside Program *(cont.)*

- Post discharge follow-up
- Communication with PCP
- Education materials
- Tracking patient visits
- Paper/Electronic chart forms
- Program media
- Interdepartmental support

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Smoke-free Environment

- Not necessarily need for inpatient program but inpatient <u>is necessary</u> for SFE
- Plan to attend to nicotine withdrawal issues of patient while on SFE property
- An opportunity to be the patient's advocate in asking about their comfort

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Inpatient Smoking Policy

- Defines the process of responding to smoking violations across all departments
- The policy needs to address who contacts whom, how to attend to the needs of the patient – getting treating physicians, nursing, security, etc. involved in the process

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Identification of Tobacco Users

- Bedside visit for all users – spit and smoke
- Identify hospital admittance access
  - Schedule admits, ER admits, transfer admits, direct admits (from outpatient clinics)
- Admitting screen fields
- Nursing assessment form
- Sooner users are identified and visited, the stronger the message of the seriousness of the policy

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Staged Implementation

- Identify your easy units
  - Medicine vs Surgical
  - Tobacco aware unit (e.g., cardiology, pulmonary)
- What is working with CORE measures – how can you build throughout the whole hospital
- Identify units where bedside program is not appropriate (e.g., ICU, psych)

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Tobacco Treatment Specialist

- Identify who is already doing the work
  - Cardiology, pulmonary
- Optimal timing for intervention is first 24 hours
  - Remember nicotine withdrawal begins 90 -120 minutes after last dose
- Need flexible schedules – AM visits best contact
- Get training for MI, addiction, nicotine addiction
- TTS provides the intervention but their best job is training other healthcare providers

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Inpatient Intervention

- 5 A's and Motivational Interviewing
- Introducing counselor as an advocate for the patient
- Answer questions about SFE, NRT
- Address patient concerns
- Suggestions NRT
- Cognitive / behavioral coping strategies
- Stage appropriate message

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Post Discharge Follow-up

- Identifying who you are going to call
- Increase cessation rates / new attempts at cessation
  - Nice reflection on patient care and your facility
  - Most patients, whether quit or not, will be pleased you have called
- Create pipeline for outpatient program
- Program evaluation

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Follow-up with PCP

- Goal to include PCP in continuation with intervention started in hospital
- Medical record
  - Discharge summary
  - Tobacco note
  - Suggestions for other healthcare providers
    - Staged example statement for physician
- Avoid letters to PCP

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Educational Materials

- Existing JCAHO requirements – brochure
- Economics & content – in-house vs commercial
- Recommend benefits of quitting and cessation strategies

Database

- Track patient visits, repeat visitors, and follow-up contact
- Missed visits contact

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Chart forms

- Visit form – outcome & recommendations
- Medical chart information
- Order set

PR Media

- Materials needed for the patient, notify staff of program, and guests / family members
- Patient channel, room posters, tent cards

Interdepartmental Support

- Physician champions
  - Assist with buy-in and education of clinical staff
  - Development of facility guidelines for NRT with populations (e.g., cardiology, orthopedics)
  - Willingness to work with treating physician concerns
- Leadership with nursing – development and standardization of referral process
  - How this is going to assist the nurse in his or her job
- Senior leadership to actively (visibly) participate in the development and support of polices
- Security Service buy-in

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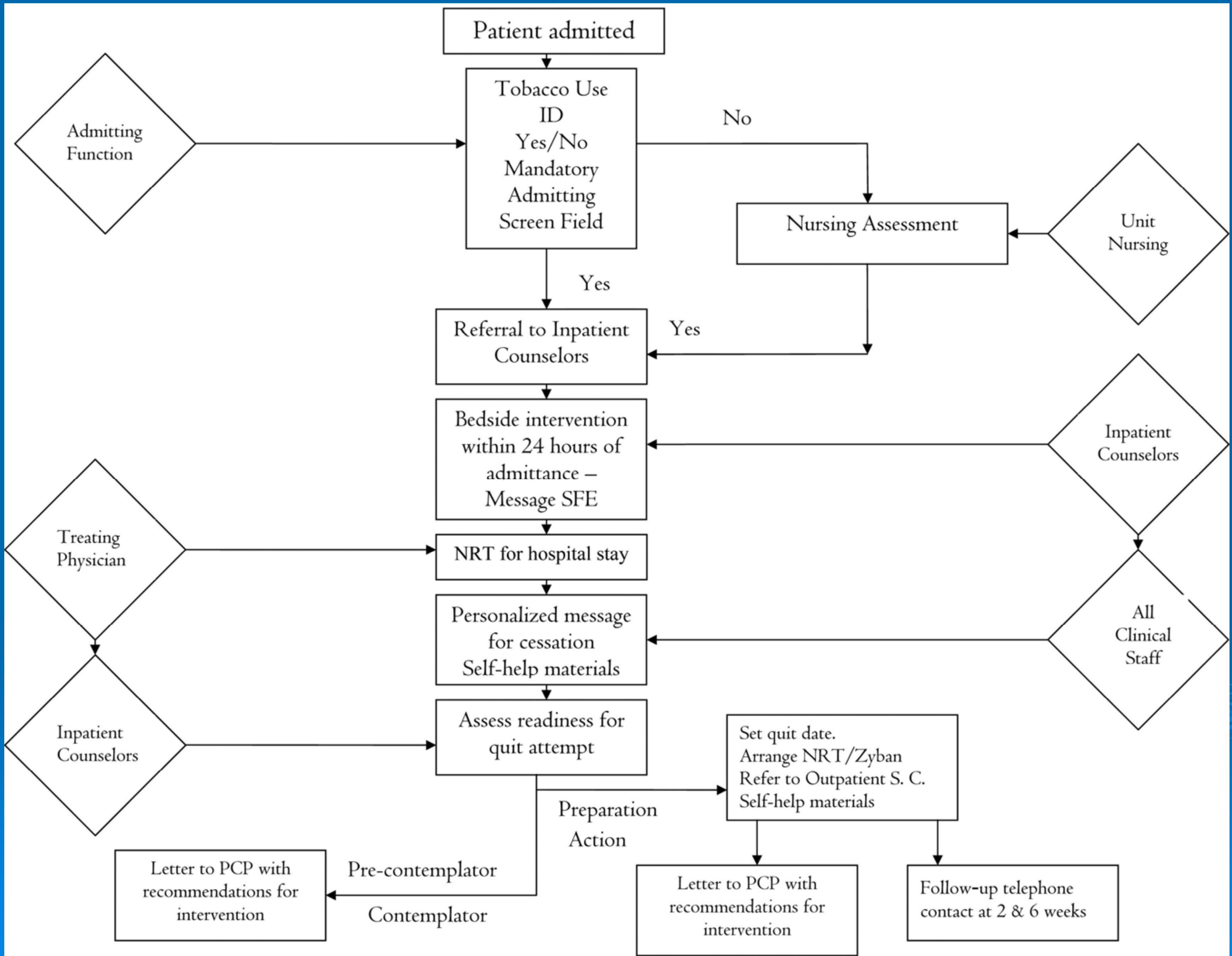

Patient admitted
Tobacco Use
ID
Yes/No
Mandatory
Admitting
Screen Field
Admitting
Function
No
Nursing Assessment
Unit
Nursing
Yes
Referral to Inpatient
Counselors
Yes
Bedside intervention
within 24 hours of
admittance –
Message SFE
Inpatient
Counselors
Treating
Physician
NRT for hospital stay
Personalized message
for cessation
Self-help materials
All
Clinical
Staff
Inpatient
Counselors
Assess readiness for
quit attempt
Set quit date.
Arrange NRT/Zyban
Refer to Outpatient S. C.
Self-help materials
Preparation
Action
Letter to PCP with
recommendations for
intervention
Pre-contemplator
Contemplator
Letter to PCP with
recommendations for
intervention
Follow-up telephone
contact at 2 & 6 weeks

Outpatient Program

What works for successful quitters?

- High level of motivation
- Enroll in a support (cessation) program (CBT)
- Use of tobacco treatment pharmacological intervention
- Implementation of an exercise program as part of the cessation effort

Number 1 reason a quitter fails to quit…

Lack of a plan

75% of relapsed users will report negative moods state(s) as cause for relapse

Current Quit Rates

- National yearly quit rate approx. 5%
- Expected quit rates with good program approx. 20%
- Real good program over 30%

- Intensity of intervention is directly related to quit rates

Treatment Modalities

- Group program
- Individual Counseling
- Telephone Counseling
- Computerized program
- Self-help materials

Groups

- Best cost to success – 5 to 8 sessions
  - Set schedule for preparation, quitting and relapse prevention work
- Time 60 – 90 minutes
- More cost effect – more people with professional at a time
- Optimally 8-10 people per group
- Power of the group

Groups *(cont.)*

- For patient - Pros
  - Going through program with others in same situation
  - Sense of accountability with group members
  - Good for those who rather listen than talk
- Cons
  - Not everyone is a group type person – men
  - Assistants/problem people
  - Set schedule – not flexible
  - Focusing on issues as group rather than individual

Individual Counseling

- Five to seven sessions – 30 – 60 minutes
- Can have higher quit rates than group program
- Flexible with schedules
- Intensive treatment to issues of person
- Support is only counselors
- Time/professional resource intensive
- Good way to begin program – word of mouth PR

Individual Counseling *(cont.)*

- For patient - Pros
  - Individual focus vs shared time
  - Better for MH patients/those not good in social situations
- Cons
  - Only support is counselor
  - Limited accountability
  - Fewer sessions/treatment time

Telephone Counseling

- Flexibility with number of contacts and time of contact
- Cost effective use of professional
- Reach people who do have transportation or too great a distance to travel to on site program

Telephone Counseling *(cont.)*

- For Patient: Pro
  - Can be at home or work and receive treatment
  - Can negotiate increase number of contacts
  - Get assistance when no assistance is available in geographic area
- Cons
  - More difficult to discuss barriers/intense subjects over phone
  - Phone effects relationship between patient/TTS
  - Limits communication

Computerized Cessation

- Research has shown well written, patient tailoring programs can have very good outcomes
- Expensive
- Multiple contacts
- Tailored interventions based on patient responses

Computerized Cessation *(cont.)*

- For Patient – Pros
  - Younger, tech patient may prefer and enjoy electronic communication
  - Can read and complete exercises at own pace without timeline with TTS
  - Complete at any time
- Cons
  - Lack of computers/internet access for large portion of tobacco users
  - Lack of computer skills/reading level for programs
  - Lack of human contact

Self-help materials

- Easiest
- Cost
- Meets the TJC current rule
- Abundance of materials already exist for multiple populations

Self-help materials *(cont.)*

- For the patient – Pro
  - Can take materials home and review/revisit as needed and at own pace
  - Some people learn better with reading than listening
  - Some patients like a lot of information
- Cons
  - Self-help materials tend to not be read $\leq$ 4%
  - Right materials for the right person

Program Components

- Identification of Barriers and Reasons to Quit
- Development of Plan
  - Behavioral
  - Pharmacological
  - Cognitive
  - Social support/System
- Education
  - Effects of nicotine
  - Withdrawal – why, symptoms, remedies

Program Components *(cont.)*

- Education *(cont.)*
  - Learning new adaptive ways to deal with stress and both negative/positive mood states
  - New communication skills
  - Treatment of depression/anxiety
  - “Filling the holes”

Program Components *(cont.)*

- Tailoring pharmacological meds
  - Working with treating physician
    - Educating clinicians on multiple dosing, proper dosing, proper med for person
  - Monitoring physical withdrawal symptoms – adapting meds as needed for better success
- Implementing exercise program as appropriate for patient

Program Components *(cont.)*

- Monitor/assist with daily living issues that effect cessation attempts
  - Diet, sleep hygiene, fluid intake, stress management, medical compliance
- Relapse prevention
  - Identifying past relapses – developing a plan
- Referring to appropriate treatment as necessary
  - Depression/anxiety

Implementing and Sustaining

- Steps for implementing
  - Identifying program for institution
    - In-house program vs. “canned” program
    - Cost versus no cost
    - Cessation is not a money make but a money saver
  - Identifying professionals
  - Obtaining training for professionals
  - Logistics – materials, location, scheduling
  - Materials

Implementing and Sustaining *(cont.)*

- Educating clinicians – VERY IMPORTANT
  - Smokers tend to see their physicians more than non-smokers
  - Clinician buy of program will produce you pipeline to fill outpatient program
- PR
- Get program going
  - Best PR is patients talking to clinicians
- Set reasonable schedule

Implementing and Sustaining *(cont.)*

- Make outpatient cessation program a service – part of the medical services
  - Electronic notes
  - Referrals
  - Treatment algorithms
- Take steps to adapt to needs of institution, employees and community

Outpatient Program

- The merger of public health and medicine – changing how we do things
- Clinician referral should fill outpatient program
  - Moving appropriate stage referrals from inpatient to outpatient programs
  - Education of clinicians
- Tobacco cessation should be treated as chronic disease management

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Outpatient Program *(cont.)*

- Broadbase cessation program – open to staff, patients, family members, and community
- Individual vs. Group vs. Telephone vs. Computer – Advantages & Disadvantages
  - The power of the group vs. one-on-one attention of counselor
  - Economics
  - Greater numbers vs. greater cessation rates
  - Groups – 8 sessions – 90 minute contacts
    - Less # of contacts = quit rates decrease
    - More # of contacts = quit rates do not increase

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Outpatient Program *(cont.)*

- Purchased program vs. In-house program
  - ACS, ALA
  - The intervener
- Successful quitters
  - Cognitive-behavioral program
  - Nicotine replacement therapy
  - High level of motivation
  - Exercise