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 markedely 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. 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.

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-
PERSPECTIVE

Tobacco-use status approximately 30 days after discharge (see flowchart).

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 Guideline). 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. 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. On Admission
   - Document tobacco-use status of all patients

2. During Hospital Stay
   - Deliver evidence-based cessation counseling and medication
   - Assist by providing practical counseling and medication
     - Document in record
     - Optional: provide information on quit line

3. At Discharge
   - Arrange for evidence-based counseling and prescribe medication for period after discharge
   - Arrange by referring patient for follow-up counseling
     - (via quit line, fax, or electronic means)
     - by providing prescription for medication
     - Document in record

4. After Discharge
   - Check tobacco-use status after discharge
   - Follow up by contacting patient about 30 days after discharge or use fax-to-quit record to determine tobacco-use status
     - Document in record

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 performance 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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