

The Joint Commission's goal to promote tobacco use screening and when this screening is positive, to offer counseling and pharmacotherapy is laudatory. For decades, tobacco use has ranked amongst the top preventable causes of morbidity and mortality. Healthcare intervention for tobacco use disorders has historically been ignored and not reimbursed.

However, good clinical practice should not be lost as electronic algorithms define and incentivize priorities for patient care (assuming limited resources).

#### "The Right Treatment at the Right Time"

- 1) A nicotine or tobacco user's stage of change needs to be assessed. Interventions geared towards a patient in precontemplation are different than those geared towards someone who is in the action phase and ready to quit.
- 2) It may be more helpful to distinguish between "current use," "past use," and "no history of use" *instead of or in addition to* the "light" and "heavy" smoker categories.
  - a. A pregnant ex-smoker needs relapse prevention once she gives birth.
- 3) All forms of nicotine and tobacco use (present and future) should be included. E-cigarettes exploit the loophole of not containing tobacco. Hookah and other forms of nicotine and tobacco use also exist.
- 4) Assessments need include important medical, psychiatric, and addiction co-morbidities and socioeconomic factors.
  - a. Personalized reasons to quit (whether the patient has asthma, congestive heart failure, bladder cancer, chronic pain, healing wounds, and/or is pregnant, etc) are helpful motivators.
- 5) Nicotine and other abused drugs are mood altering and share some of the same brain pathways.
  - a. Alcohol and illicit drugs are often concomitant with tobacco use. Do we address nicotine and tobacco and ignore the alcohol when a patient only smokes when they get high?
  - b. As states decriminalize and legalize marijuana, we may find a prevalence of marijuana use that exceeds nicotine and tobacco use. This may already be the case in California and Colorado. It takes years to define quality metrics; marijuana is on the horizon.
- 6) Treatment planning should take into account the multidimensional assessments and be holistic. We need to get away from care silos.
- 7) The intervention and intensity of treatment should be tailored and not 'cookie cutter.'
  - a. A patient with depression may need concomitant treatment of this diagnosis in order for an intervention about nicotine/tobacco use to be successful.
  - b. As persons with tobacco use disorders of less severity have quit, co-morbid assessment and treatment are becoming increasingly important. If the only referral is to a quitline, this staff may not qualified to properly assess or address such co-morbidities.
- 7) There needs to be an allowance for longitudinal care, continuity of care, and follow-up.
  - a. There may be more urgent needs that are the focus of the hospitalization
  - b. The metrics proposed would penalize the following case despite better than average care:

A patient who had a detailed assessment prior to hospital admission, is given motivational interviewing and periodic education over the next year. S/he is prescribed medication at a time s/he is ready to quit, and given relapse prevention skills building thereafter.

The data capture, analysis, and reporting associated with this goal is no small feat. While I agree with the importance of addressing nicotine and tobacco use, I am unsure about the implementation and ramification of this (and other) quality measures.

Medical care is both complex and needs to be streamlined. It should neither be unduly simplified (assessments that only contain type of tobacco and frequency & amount of use) nor burdened (nominal interventions at inopportune times).

Thank you for the opportunity to comment on this important electronic clinical quality measure.

I am submitting these comments in my individual capacity as a primary care and addiction medicine practitioner.

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