Utilization of Inpatient Smoking Cessation Consultation 2014-15 UCSF OHNS Quality Improvement Initiative

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Introduction
Tobacco use is a principle risk factor for the development of carcinomas of the upper aerodigestive tract²,³. Continued use of tobacco products, particularly inhaled products such as cigarettes and cigars, place both our cancer and non-cancer patients at much greater risk for new malignancies, exacerbation of comorbid cardiopulmonary conditions, and post-operative wound healing complications²,⁴. Counselling on the etiologic role of tobacco use and importance of tobacco cessation is inconsistent and heterogeneous in the outpatient setting owing to provider idiosyncrasies and disparate value determinations, clinic time constraints, knowledge of support systems in place (psychological, pharmacological, social), and a multitude of patient factors among other things⁵,⁶. Admission to the hospital provides a unique time to provide this counseling and explanation of available resources through utilization of the UCSF formal, standardized consultation service on smoking cessation for our inpatients who are currently smoking or have recently quit.

QI Project Goal
For all patients admitted to the Otolaryngology - Head and Neck Surgery service, not including 23hr observation admissions, who were also documented in APEX to be current smoking tobacco users would receive a consultation prior to discharge on smoking cessation by Respiratory Therapists in the UCSF Respiratory Care Services Department. Our goal was that at least 80% of these patients would receive such consultations for our Mount Zion (through Feb 2015), Parnassus, and Mission Bay (starting Feb 2015) services, assessed on a quarterly basis.

Results
Our results are represented in the graph below. To date, we have have met our goal for 2 of the first 3 quarters and are well on track to finish above our goal of 80%.

Discussion
Smoking cessation is considered a central component of both past and contemporary patient counseling for traditional, alcohol and tobacco-induced carcinomas of the upper aerodigestive tract. As such, the addition of smoking cessation consultations to our inpatient management of such patients was a natural addition to current management. It was not second nature to consider tobacco use as part of the global patient care considerations for patients admitted to our service for non-cancer reasons such as deep space neck infections, anterior and lateral skull base tumors, chronic otologic and rhinosinusitis complications, and for patients transferred to our center for a variety of problems not directly associated with their concomitant tobacco use. Possibly as a result of the ease with which some aspects of the medical history can be gathered through auto-populated fields in an electronic medical record, the social history seemed to have been overlooked with some patients leading to our failure in requesting tobacco cessation consultations. For other patients who did not receive such consultation, they were newly committed to a cessation program through a variety of means including nicotine supplementation, support groups, and electronic cigarettes. Our team did not update the social history in the medical record to account for these changes and was not in accordance with our QI protocol.

Conclusions
Tobacco abuse is a well-established risk factor for a number of wide ranging health problems. It represents a risk that is often misunderstood by the public and there are many systems from a diverse array of approaches to support cessation of tobacco use and abuse. A standardized approach to smoking cessation counseling represents an ideal method to minimize health morbidity from this common practice and addiction. Our team has demonstrated that this can be a standard component of inpatient admission. Additional efforts are taking place through outpatient referrals at the VA hospitals in particular. Subsequent steps and follow-up are needed to determine the effectiveness and longevity of these interventions on smoking cessation.

References