



New York State
Office of Alcoholism & Substance Abuse Services
Addiction Services for Prevention, Treatment, Recovery

Tobacco Regulation Impact Report

Division of Outcomes Management and System Information

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Executive Summary

This report examines the impact of the implementation of the OASAS Tobacco Regulation on patients admitted to treatment programs within major program types. It also presents data from two surveys on the perceived effect of the tobacco regulation, one for Local Government Units (LGUs) and one for programs that were included in the 2010 County Planning System local planning cycle. The analyses reflect data submitted by treatment programs from July 2007 through December 2009. During the period from July 2007 through December 2009 there were 710,740 patients admitted into treatment programs. Seventy percent of patients were smokers.

Summary of Major Findings:

- The number of admissions system-wide remained stable and was not negatively impacted by the implementation of the tobacco regulation. End-of-month census data for all treatment programs has been gradually increasing since July 2007 when the tobacco regulations went into effect.
- Selected Integrated Performance and Monitoring Evaluation System (IPMES) performance measures were analyzed to examine the effects of the tobacco regulation. In general, there does not appear to be any negative consequences of the tobacco regulation for the IPMES indices.
 - The percentages of discharged patients who completed treatment or were referred remained relatively stable.
 - Percent of patients with discontinued substance use, as well as retention rates remained stable over the study time period.
 - There was no notable change in the pattern of patients returning to treatment as a result of the tobacco regulation.
- There was no notable change in the pattern of patients returning to treatment as a result of the tobacco regulation. Forty percent (11,541 out of 29,258) of patients completing treatment reported not smoking at discharge as compared to 18% (11,537 out of 63,718) for those not completing treatment.
- Sixty-nine percent (20,046 out of 29,258) of patients who completed treatment reported either stopping smoking or maintained their non-smoking status, as opposed to 41% (26,305 out of 63,718) for non-completers.
- Thirty percent of the LGUs felt the tobacco regulation had a positive effect on patient outcomes.
- Crisis programs experienced a short-term down turn in admissions and end of month census but returned to previous levels within six months.

In summary, after carefully reviewing data from multiple sources the impact of the tobacco regulation appears to be minimal, while the long-term positive effect for patients and staff appears to be quite promising. OASAS will continue to monitor tobacco use in its treatment programs through its available data systems on at least an annual basis.

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Introduction

OASAS implemented its Tobacco Regulation in July 2008 which was designed to support long-term recovery and enhance the lives of individuals who will be able to benefit from a tobacco free lifestyle. Additionally, the regulation will provide a healthy environment for staff, patients, volunteers and visitors of OASAS certified and/or funded providers of prevention, treatment or recovery services for alcoholism, substance abuse, chemical dependence and/or gambling. In August 2008, staff from the Division of Outcome Management and System Information (DOMSI) began monitoring system admissions and performance in order to identify and track possible impacts of the Regulation. This report is based on data obtained from treatment program submissions of patient admission and discharge forms as well as Monthly Service Delivery Reports. Since there are normal fluctuations in program admissions and performance on a month-to-month and year-to-year basis, it is extremely difficult to determine with certainty that any observed changes are the direct result of the Tobacco Regulation. There may be other external factors (e.g., change in policies of referral entities) that are simultaneously impacting admissions and performance. However, it is possible to identify trends that could be attributable to the regulation change. These have been closely monitored by OASAS to determine if additional information is required and/or if any action is necessary. The analyses presented herein reflect data submitted by treatment programs from July 2007 through December of 2009.

This report examines the impact of the implementation of the OASAS Tobacco Regulations on patients admitted to treatment programs falling within the major program types (MPTs). These are listed in Table 1. Admissions to these program types make up the vast majority of admissions to OASAS-certified and/or funded programs. The program types excluded (e.g., Methadone-to-Abstinence) contain only a few programs with a relatively small number of admissions that would make patient trends and performance difficult to interpret. Data for this report is based on admission and discharge reports submitted to OASAS by April 18, 2010. Programs included for analysis from the MPTs were currently opened programs and these programs had to be operational as of 7/1/07 or sooner.

Total Treatment System Impact

Smokers Admitted

For the purpose of examining the smoking tendencies of patients admitted into OASAS-certified treatment programs, the smoking items from Patient Admission Report (PAS-44N for non-crisis programs) and the Patient Admission/Discharge Report (PAS-46N for crisis programs) were utilized. Prior to April 2009, this item only addressed smoking during the week prior to admission. Starting April 1, 2009, this item addressed smoking during the 30 days prior to admission. For the purposes of this analysis, anyone

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reporting smoking in the period addressed by the admission report is considered a smoker.

During the period from July 2007 through December 2009 there were 710,740 patients admitted into the programs in the MPTs. Of these, 70% were smokers. The percent of admissions that were smokers varied by MPT (see Graph 1). Among admissions to ambulatory programs, the percent of admissions that reported smoking was the lowest at 66%. This is the MPT with the greatest number of annual admissions. The MPT with the highest proportion of patient admissions smoking was methadone maintenance, where 84% of admissions smoked.

Graph 2 displays the system-wide, monthly percentage of admissions that were smokers. This percentage remained relatively stable over the period examined; however, a small decrease occurred at the time of the Tobacco Regulation implementation at the end of July 2008 and remained at this slightly lower level until May 2009 when the percentage returned to the pre-Tobacco Regulation level. However, this increase could be accounted for by the fact that the CDS question on smoking was changed in April, 2009 from “Smoking in the Past Week” to “Smoking in the Past 30 Days” and this increase in the time period could capture additional patients.

Program Admissions and End-of-Month Census

The number of admissions system-wide did not appear to be impacted by the implementation of the Tobacco Regulation (see Graph 3). Other than a seasonal decline typically occurring around the month of November, admission levels appear unaffected.

The end-of-month census system-wide has been gradually increasing from July 2007 onward (see Graph 4). This increase has been greater immediately following the Tobacco Regulation implementation. In July 2007 the end-of-month census stood at 91,822. This increased almost 2,400 by August 2008 and increased over 7,500 to 99,337 by August 2009.

Program IPMES Performance

Selected IPMES performance measures from July, 2007 through December, 2009 were analyzed by major program type for currently opened programs. Measures where appropriate for their respective MPTs include completion rates, retention rates and abstinence rates and data will be analyzed on a quarterly basis. Quarterly completion rates for major program types are presented for; (1.) patients who have completed treatment, and (2.) patients who completed treatment or were referred to another program (see Graph 5). For inpatient rehab programs, the percent of patients who were discharged and completed treatment remained stable over the entire period with a range of 69% to 73% across all quarterly periods. Although the 3rd quarter of 2008 was at the low end of the range, the percentages in the subsequent quarters were always higher. The ranges of

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percentages of discharged patients who completed treatment or were referred were 52%-56% (Intensive Residential); 52%-63% (RRSY/RCDY); 41%-46% (MS OP Clinic/OCDY); 45%-50% (MS OP Rehab). It should be noted that for these MPTs the percentages for the third quarter of 2008 when the tobacco regulation took effect were always higher than the lower end of the range.

Percent of discontinued substance use and retention rates (one-week, one-month, three-month, six-month, one-year) for 701,953 discharged patients are presented where appropriate for the major program types (see Graphs 6 through 13). As is evident in the graphs there is no discernable effect of the tobacco regulation on programs' IPMES performance across all quarterly periods and retention time periods.

For the same time period (July, 2007 – December, 2009) the IPMES indices of percent of patients returning to treatment (ambulatory, expanded ambulatory and other) by major program type and admission year/quarter was examined for changes at the time of the implementation of the tobacco regulation. This data is based on 339,630 discharges occurring from currently opened programs and opened as July 1, 2007 or sooner for the time period July 1, 2007 to December 31, 2009. As shown in Graph 14, there is no notable change in pattern of patients returning to treatment as a result of the tobacco regulation. All major program types exhibit slight variations from quarter to quarter which is just normal random fluctuations. This analysis was also repeated for the IPMES indices percent of patients discharged who completed treatment and percent of patients who were discharged, completed treatment and were referred to another treatment program. Again, there are normal slight random variations across all measures and program types (see Graph 15) but no discernable pattern. Around the time that the tobacco regulation went into effect there do not appear to be any negative consequences for these IPMES indices. Graph 16 shows the percent of patients who completed treatment in a crisis program who were admitted into another non-crisis treatment program following discharge.

Treatment Completion and Smoking

The percent of patients who were discharged and had a smoking status (smoking, not smoking in the past 30 days) at both admission and discharge was examined by major program type excluding crisis programs and by treatment completion (completed treatment, did not complete treatment). This analysis represents a discharge cohort for the period April, 2009 through December, 2009 and for currently open programs that were also open as of July 1, 2007. There were 92,976 discharges for this time period; 63,718 patients did not complete treatment and 29,258 patients completed treatment. Graphs 17 and 18 present data on patient's smoking status at admission versus discharge. Of particular interest are patients who smoked at admission but not at discharge as related to treatment completion. With the exception of medically supervised outpatient clinics and methadone treatment, patients in all other major program types who completed treatment were more likely to quit smoking at the point of discharge than those who did not complete treatment. Collapsing across all program types for treatment completers and non-completers, 39.4% of treatment completers did not smoke at discharge as

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opposed to 18.1% non-completers not smoking at discharge. Further, if one combines the categories “Not smoking at Admission and Discharge” and “Smoking at Admission, not Smoking at Discharge” we see that 69% of patients who completed treatment either quit smoking or retained their non-smoking status, as opposed to 41% for patients who did not complete treatment. While it is not possible to determine if this difference is due to the tobacco regulation, one could infer that completing treatment process which addresses smoking cessation contributes to reduced levels of smoking. In addition, the tobacco regulation introduced a major cultural change for our treatment programs and the positive impact of the regulation systemically will take time to be demonstrated in the OASAS data systems.

Non-smoking Patients at discharge who Return to Treatment

This analysis focused on patients from non-crisis programs who were discharged between April, 2009 and December, 2009; who smoked at admission but not at discharge and were readmitted between April, 2009 and December, 2009 to treatment in 14 days or longer after discharge. This time period was selected as tobacco related questions on the CDS admission form were expanded in 4/09. This resulted in 4,803 discharges who were readmitted to treatment. Because the number of patients for this analysis was relatively small, there were only two major program types where there were a sufficient number of patients for analysis, inpatient rehabilitation and medically supervised outpatient/OCDY. For inpatient rehabilitation, of the 3,137 patients who were discharged and readmitted, 87% smoked at readmission. Likewise, for medically supervised outpatient/OCDY, of the 1,080 patients who were discharged and readmitted, 87% smoked at readmission. While the number of patients in the other major program types was too small for analysis, the percent of patients who smoked at readmission ranged from 81% for RRSY/RCDY and intensive residential to 89% for methadone treatment clinics. Across all program types the percent smoking at readmission was 86%. This suggests that quitting smoking during treatment is relatively short-lived for those that return to treatment in inpatient rehabilitation and medically supervised outpatient clinic. However, it should be noted that nationally it is reported that it takes seven attempts at quitting smoking before the individual completely stops smoking.

Tobacco Policy Survey (County) and Tobacco Use Survey (Treatment Programs)

As noted in the introduction, the above data utilized the CDS for examining the impact of the tobacco regulation. In addition, it was important to examine the impact of the tobacco regulation from the perspective of the Local Government Unit (LGU) (County) and the treatment programs. The OASAS County Planning System (CPS) was used to obtain information from these perspectives. Two surveys were developed and included in the 2010 CPS local planning cycle, one for the LGU and one for treatment programs. Again, it must be emphasized that the tobacco regulation introduced a major cultural shift in our treatment programs, one which will take time to be fully embraced.

Fifty-seven of 62 counties responded to the LGU survey. Eighty-two percent of the LGUs reported that they received feedback from their treatment providers as a result

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of the tobacco regulation. Graph 19 shows the LGU response from providers feedback related to four factors, admission, retention, service provision and patient outcomes. There was general agreement among providers that the tobacco regulation had no effect on admissions, retention or service provision. While only 26% of providers felt the tobacco regulation had no effect on patient outcomes, 30% felt the regulation had a positive effect on patient outcomes. Sixty-seven percent of the LGUs indicated they used the IPMES/Workscope or other transaction/performance data to validate the data in Graph 19. The LGUs were essentially evenly split (51% - Yes, 49% - No) with respect to whether they had copies of tobacco free policies from programs.

Fifty-four percent of the LGUs reported that they have tobacco free policies for other programs under their jurisdiction. Graph 20 displays the percentages of LGUs who have a tobacco free policy by program type. Eighty-one percent of LGUs report that mental health programs have a smoking policy which is almost twice the percentage of other programs.

Treatment programs also completed a survey regarding the perceived effect of the tobacco regulation on the delivery of services. There were completed surveys from 1004 of 1050 programs or a 95.6% response rate. A majority of programs (95%) require all patients to stop smoking on program grounds at admission and 99% of programs inform patients of its no smoking policy when they seek admission to treatment. Programs were presented with the same question as LGUs regarding the continuing impact of the smoking regulations on admissions, retention, service provision and patient outcome. As shown in Graph 21, programs were in general agreement with the LGUs indicating that the regulation basically had no effect. Again, in agreement with the LGUs, programs felt that the smoking regulation had a more beneficial effect on service provision and patient outcomes. Likewise, 67% of programs indicated they reviewed data to determine if it supported their responses.

Programs were asked if their staff took advantage of the tobacco training that was provided by the University of Albany Professional development Program Regional Consortiums. Graph 22 displays the percentage of staff who participated in these consortiums. Generally, across the five types of staff, approximately 35% took advantage of the available training.

One concern initially expressed by programs was there could be higher staff turnover of program staff that smoked. However, 98% of the programs surveyed indicated that staff turnover was not an issue. Of the 2% (22 programs) that indicated staff turnover was an issue, a total of 37 staff left because of the tobacco regulation.

Two additional concerns of programs was keeping tobacco and tobacco related products from being brought into the program and there were concerns regarding safety and damage caused by smoking secretly. Graph 23 shows the percent of programs that have issues with tobacco/tobacco related products being brought into their program. A patient bringing in tobacco was the greatest problem for 69% of programs while staff was the lowest at 25%. Graph 24 displays the percent of programs who indicated there were

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safety or damage issues related to the tobacco regulation. A majority of programs did not have safety/damage issues. A quarter of the program indicated that there was negative community feedback which is most likely the result of patients and staff leaving the facility to smoke off program grounds in the surrounding community.

Programs were asked to estimate the percentage of the programs smoking patients who have violated the non-smoking policy. Graph 25 presents this data by quartiles. There were 908 acceptable responses to this question. A majority of programs (71%) fell into the first quartile (0%-25%) with the remaining 29% distributed among the top three quartiles.

Additional data from the survey is outlined below:

- Programs indicated if the percentage of smoking policy violations changed since the implementation of the OASAS smoking regulation. Twenty-six percent indicated it increased, 38% remained the same, 20% decreased and 16% don't know.
- Almost all programs (99%) inform patients of its non-smoking policy when they seek admission to treatment.
- While 67% of programs indicated patients have not refused admission to the program, 22% indicated patient refused admission and 11% didn't know.
- A majority (96%) of programs addressed the use of tobacco in the patients' treatment plans.
- Almost two thirds (62%) of programs offer group counseling sessions focused on smoking cessation.
- Since implementation of the tobacco-free regulation, the use of Nicotine Replacement Therapies (NRTs) has increased at 52 percent of all programs while remaining unchanged at 28 percent of programs. Only 3 percent reported a decrease in the use of NRTs, while the remaining 17 percent could not say if there has been a change in NRT use.

While some of the data obtained from these two surveys seem to indicate the tobacco regulation may have adversely affected treatment with respect to the number of admissions and retention in treatment for some programs or program types, systemically it is not supported by data from the CDS. Programs will vary with respect to the way they implement and enforce the tobacco regulation. So while we will likely see some variation in the responses of programs to the surveys regarding tobacco, there will likewise be variation in the way programs approach AOD treatment. In summary, after carefully reviewing data from multiple sources the impact of the tobacco regulation appears to be minimal, while the positive long-term change in culture for patients and staff appear to be increasing. We anticipate that the tobacco regulation will have a positive health impact for patients and staff and enhance patients' long term recovery. OASAS will continue to monitor tobacco use in its treatment programs through its available data systems.

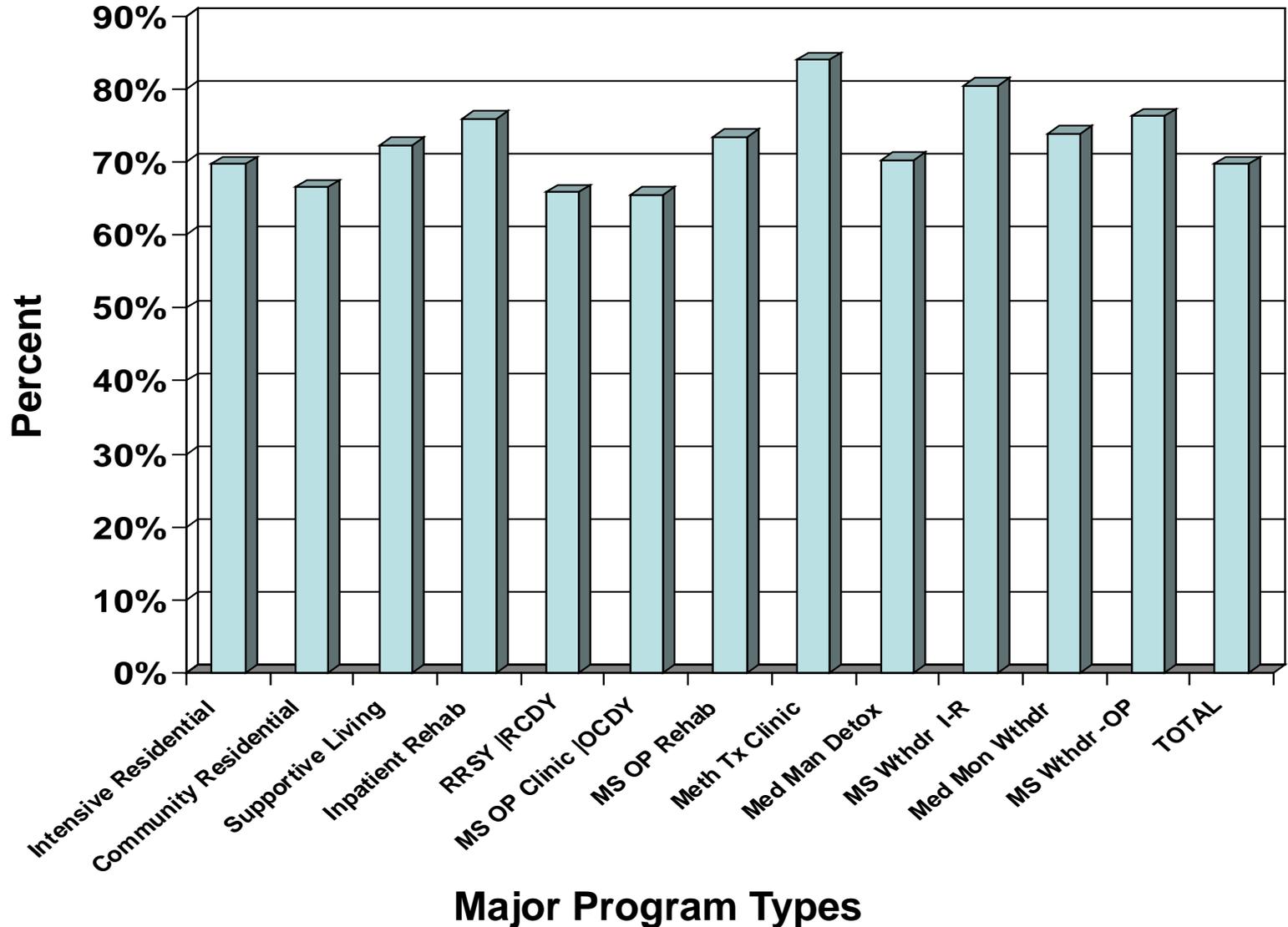
Table 1

OASAS Major Treatment Program Types

- Intensive Residential
- Community Residential
- Supportive Living
- Inpatient Rehabilitation
- RRSY/RCDY
- Medically Supervised Outpatient (MS OP) Clinic/OCDY
- Medically Supervised Outpatient (MS OP) Rehabilitation
- Methadone Treatment Clinic
- Medically Managed Withdrawal
- Medically Supervised Withdrawal - Inpatient
- Medically Monitored Withdrawal - Outpatient

Graph 1

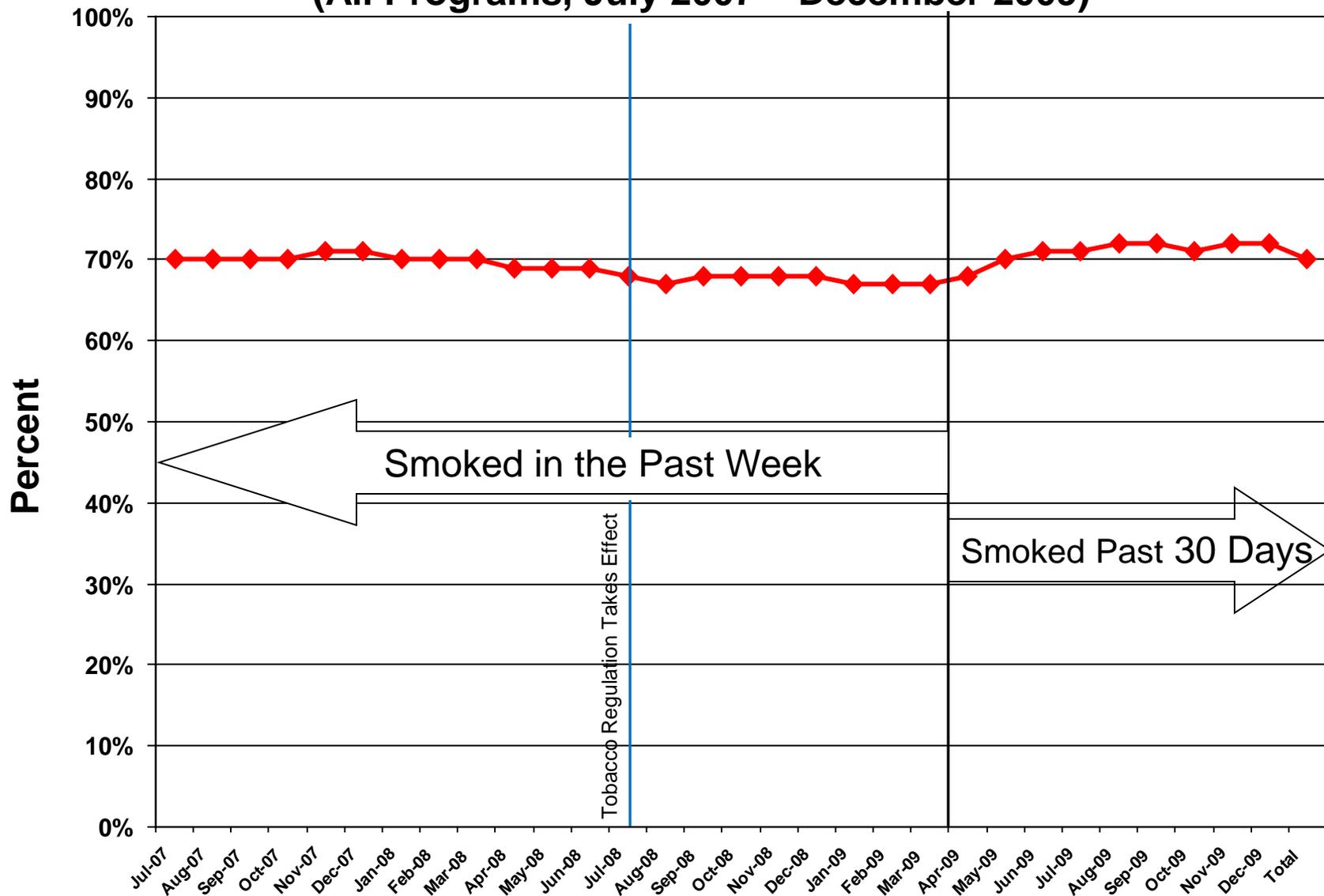
Percent of Patients who Smoked at Admission to Treatment by Major Program Type (July 2007 to December 2009)



Source: Client Data System – 565,632 Admissions

Graph 2

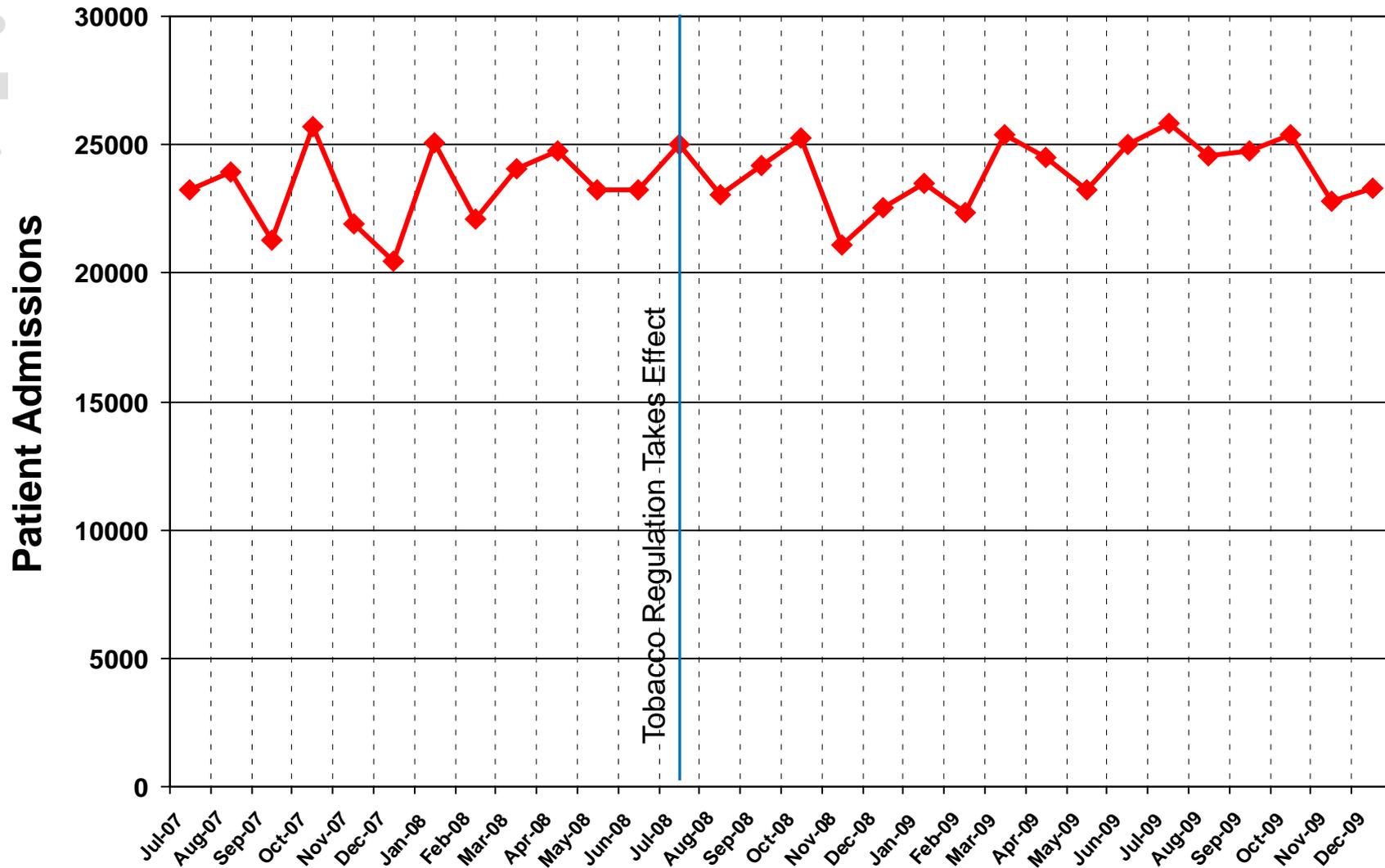
Patients Who Smoked at Admission to Treatment by Month of Admission (All Programs, July 2007 – December 2009)



Source: CDS – 564,632 Admissions; Tobacco question changed April 2009

Graph 3

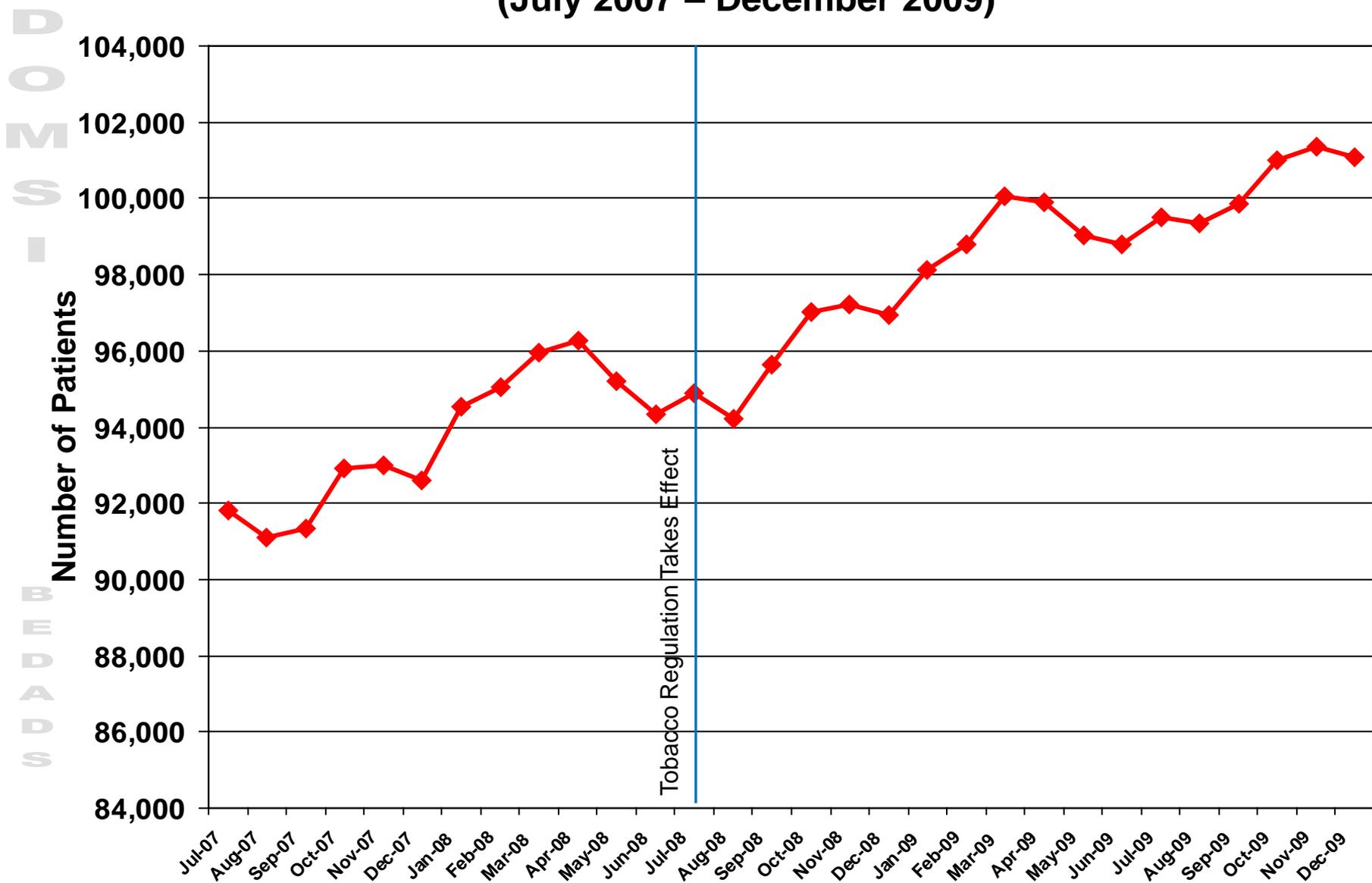
Number of Patient Admissions by Month (July 2007 – December 2009)



Source: CDS 710,740 Admissions

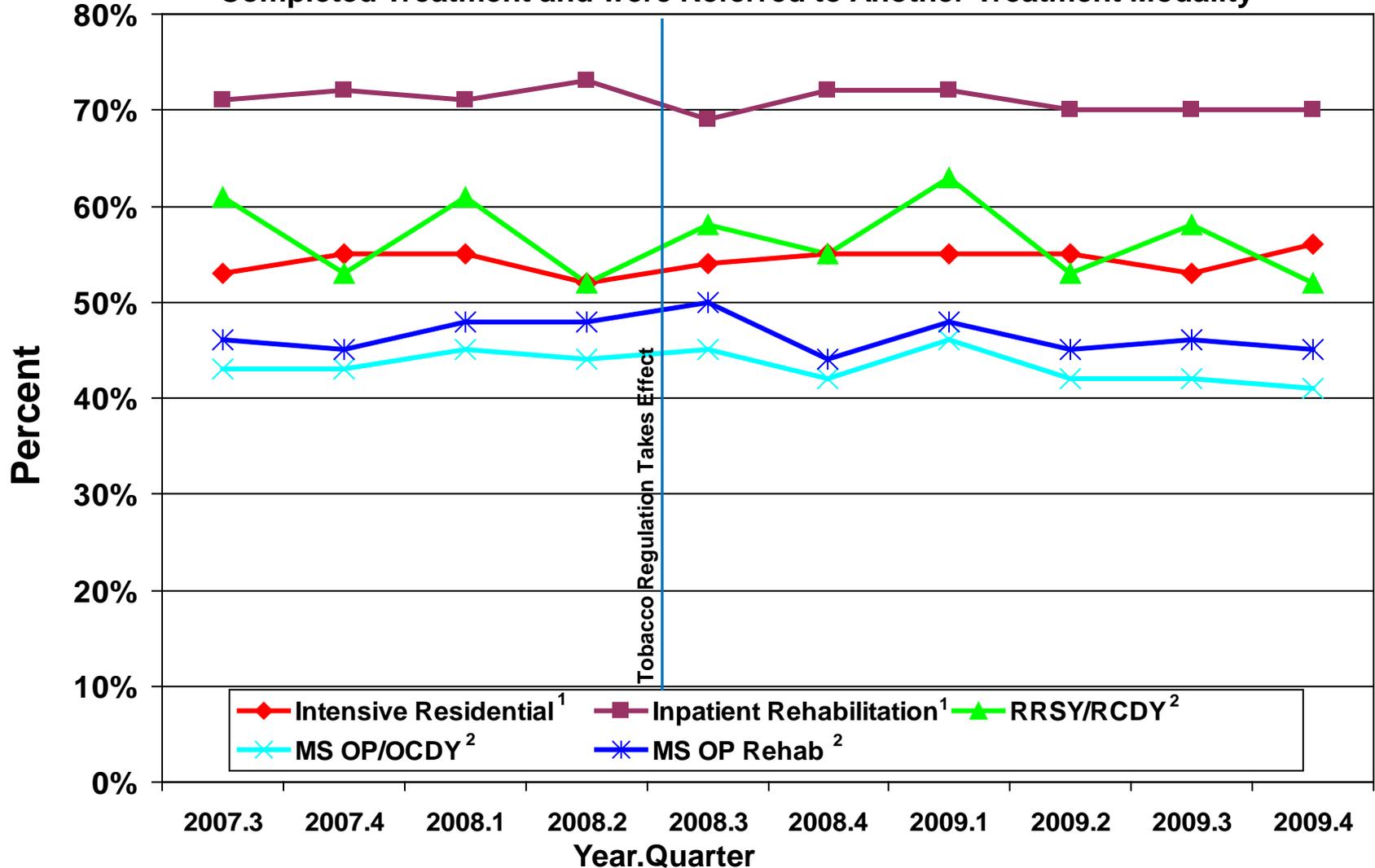
Graph 4

End of Month Census for All Treatment Programs (July 2007 – December 2009)



Graph 5

IPMES Indices – Percent of Patients who Completed Treatment or who Completed Treatment and were Referred to Another Treatment Modality

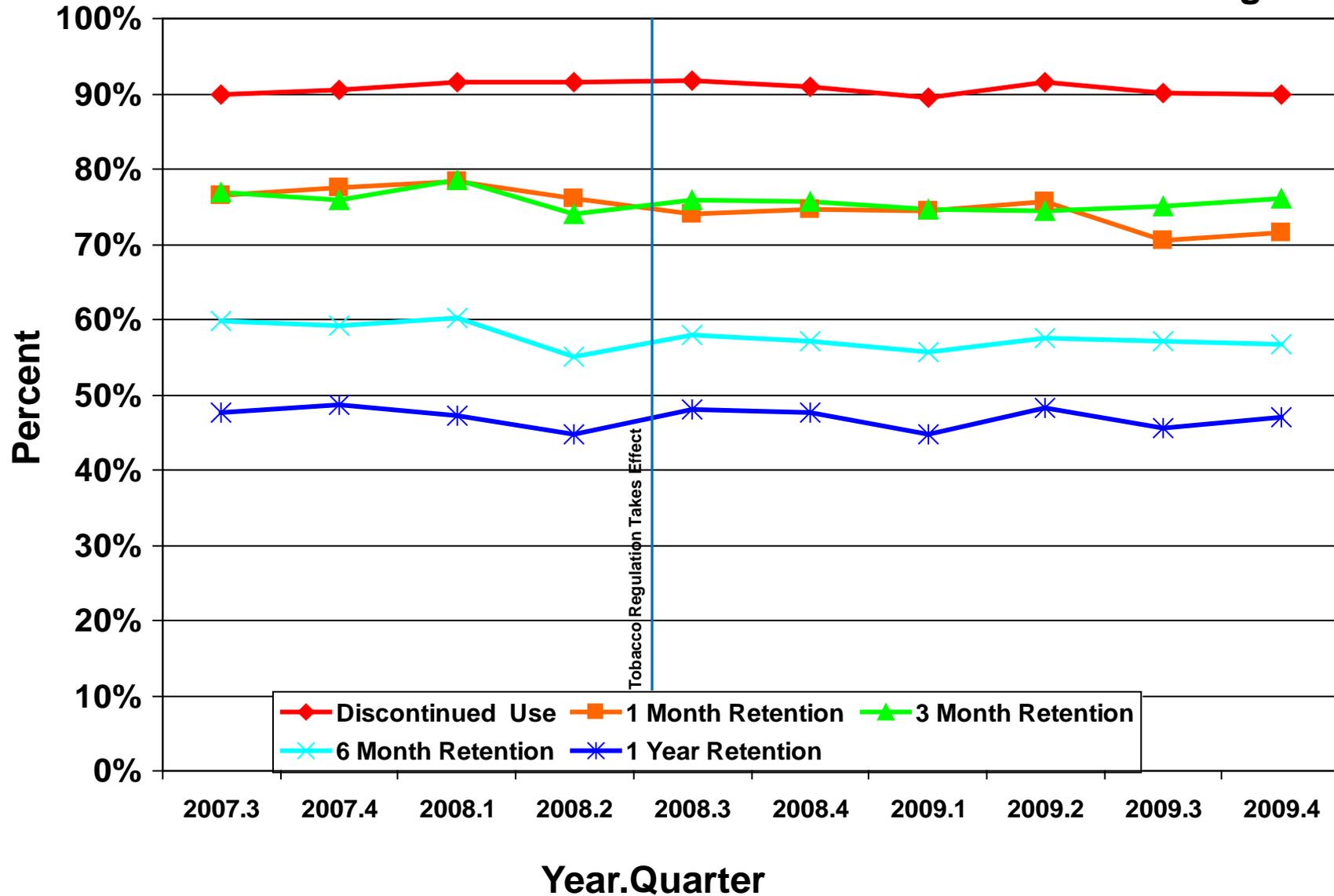


¹ Patients Discharged who Completed Treatment or who ² Completed Treatment or were Referred

S D A D E B - S M O D

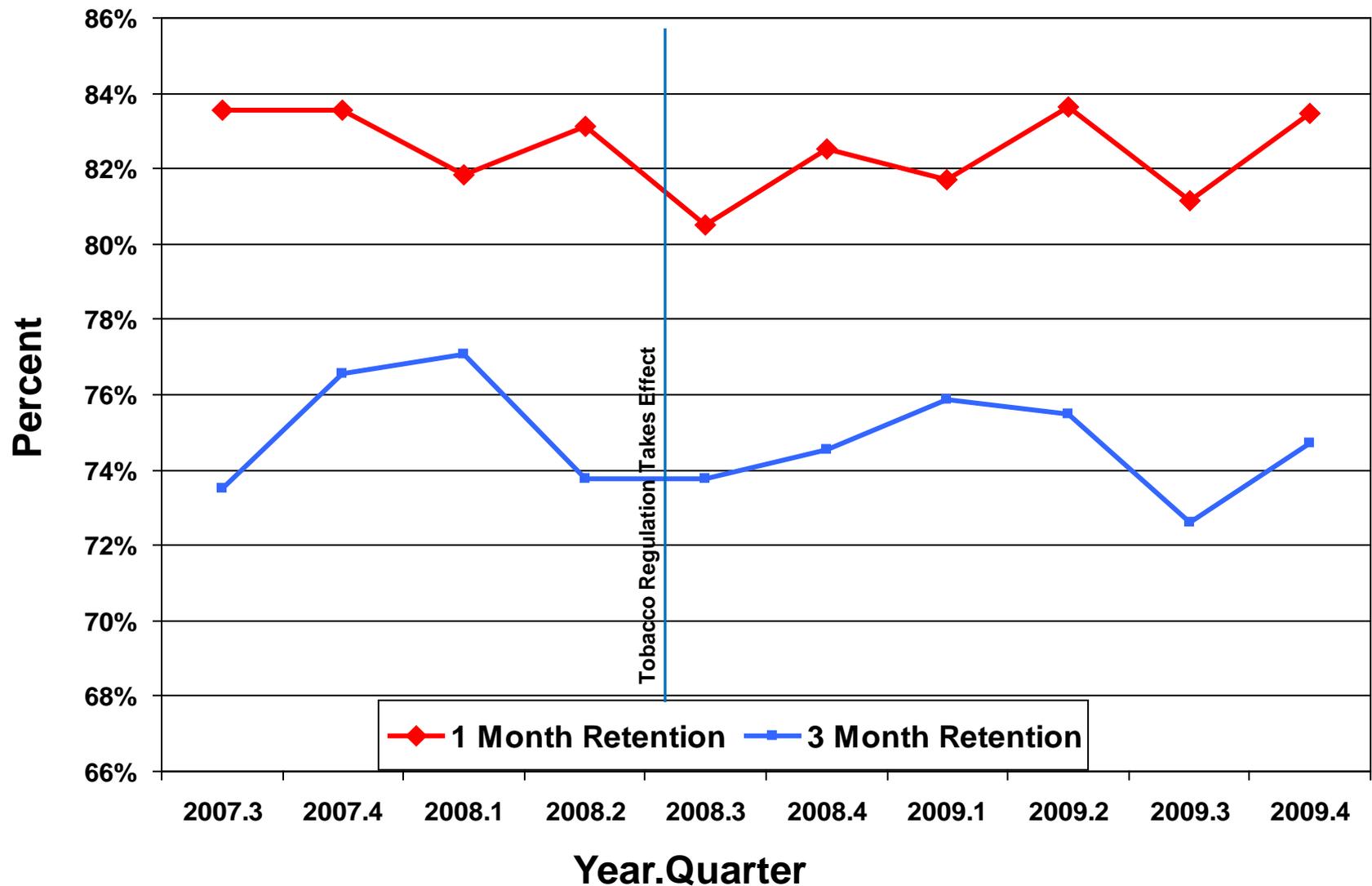
Graph 6

IPMES Indices - Retention Rates for Intensive Residential Programs



Graph 7

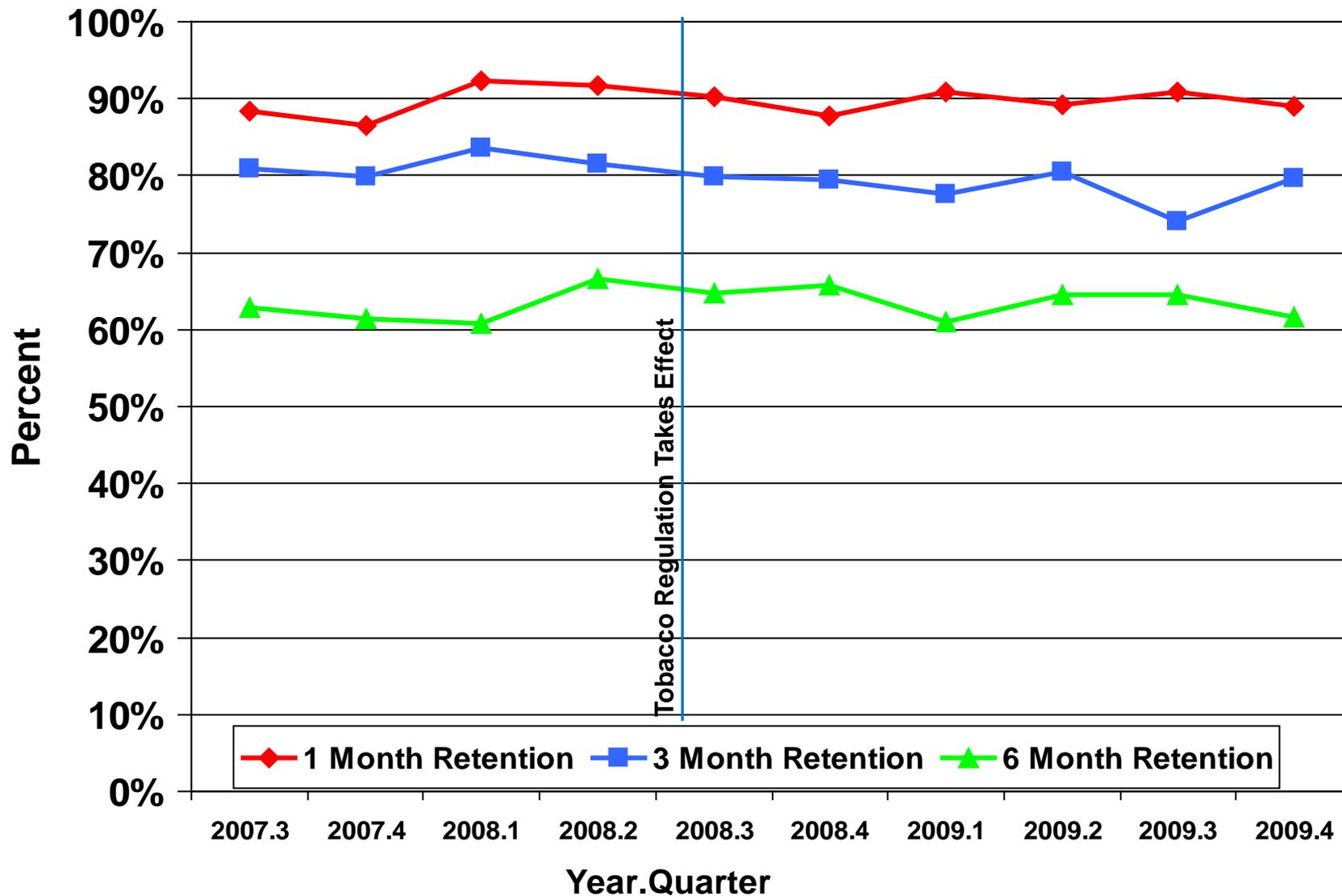
IPMES Indices – Retention Rates for Community Residential Programs



Source: CDS : July 2007 – December 2009

Graph 8

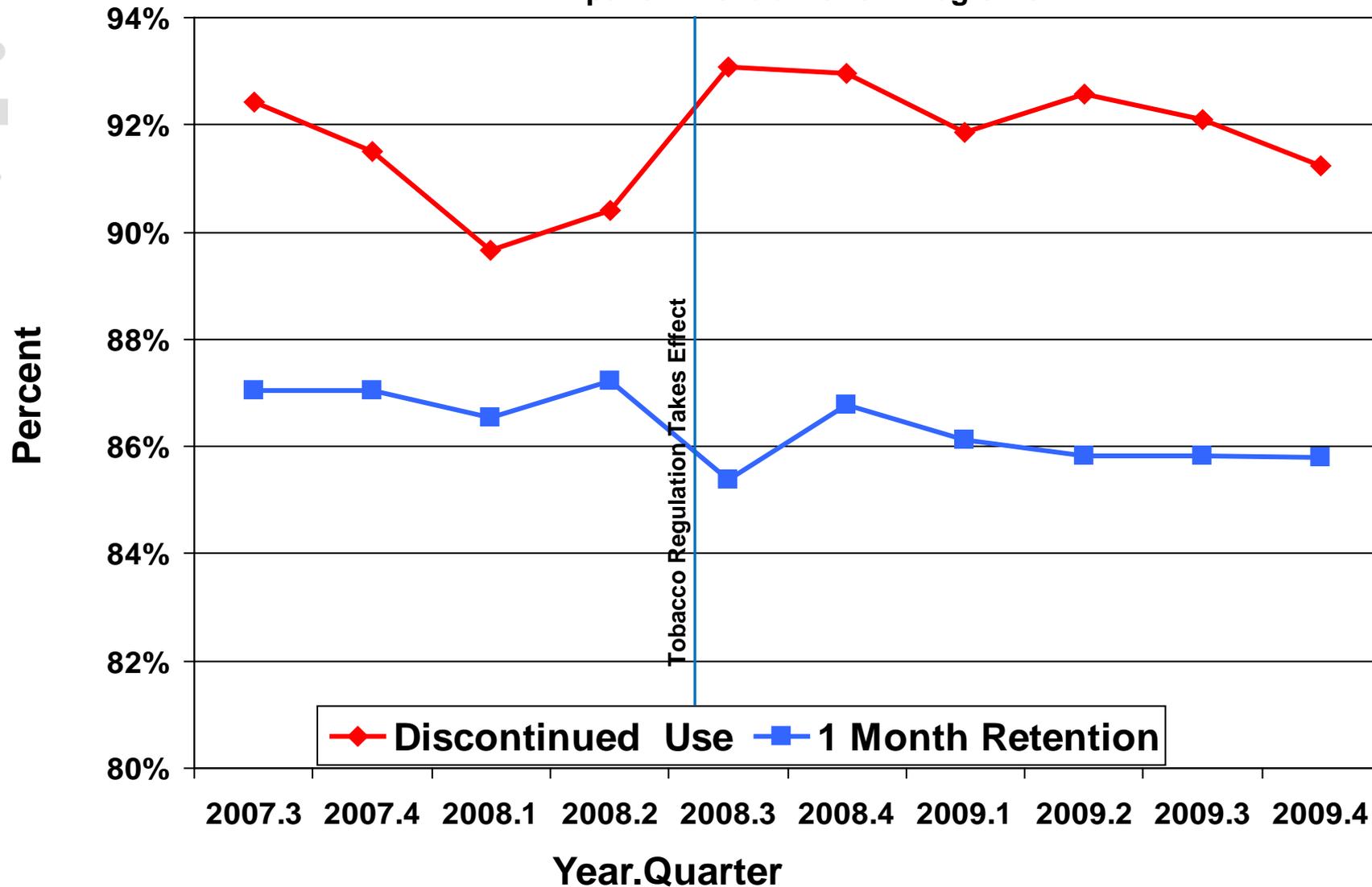
IPMES Indices – Retention Rates for Supportive Living Programs



Source: CDS : July 2007 – December 2009

Graph 9

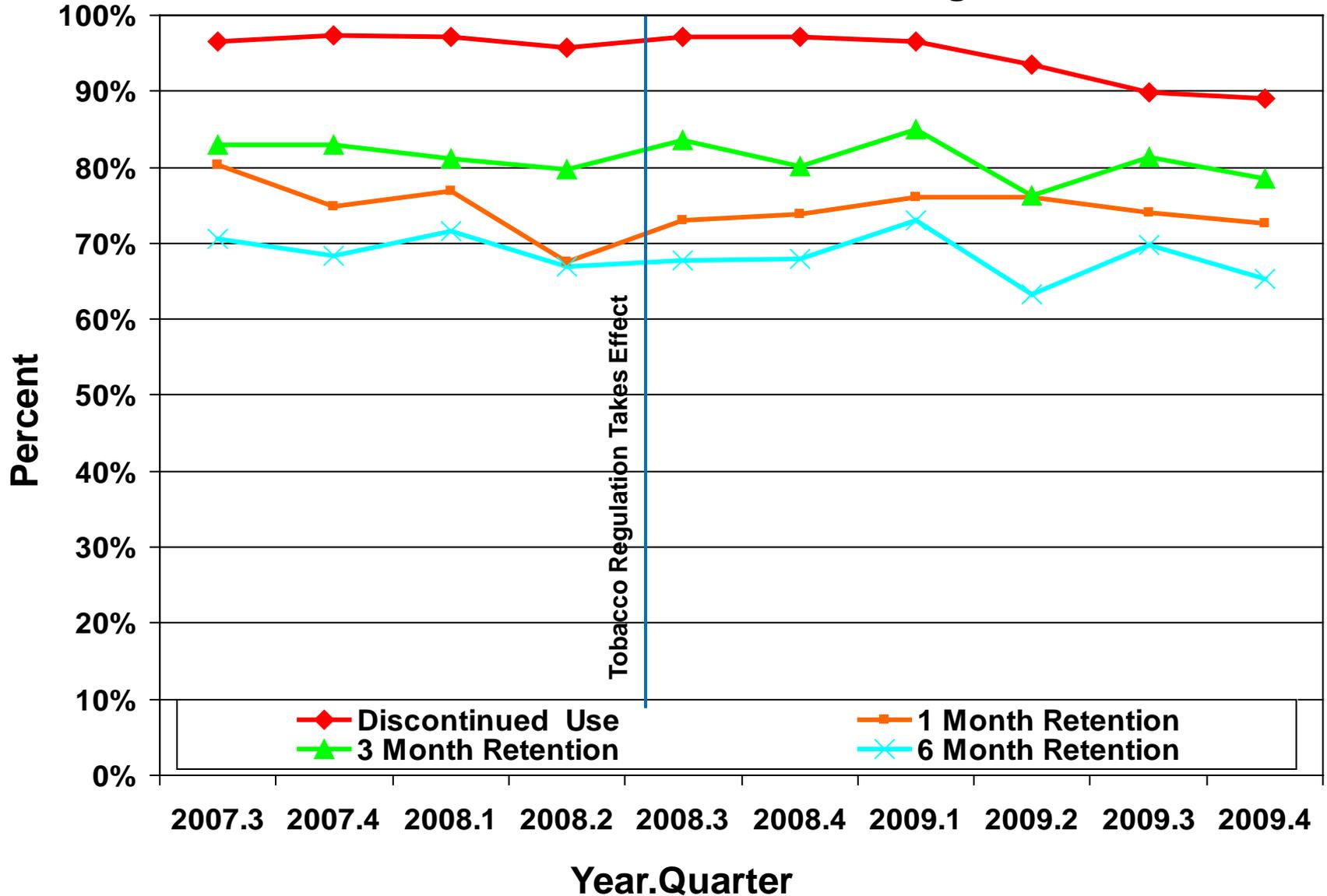
IPMES Indices – Rates for Discontinued Use and One Month Retention Rates for Inpatient Rehabilitation Programs



Source: CDS : July 2007 – December 2009

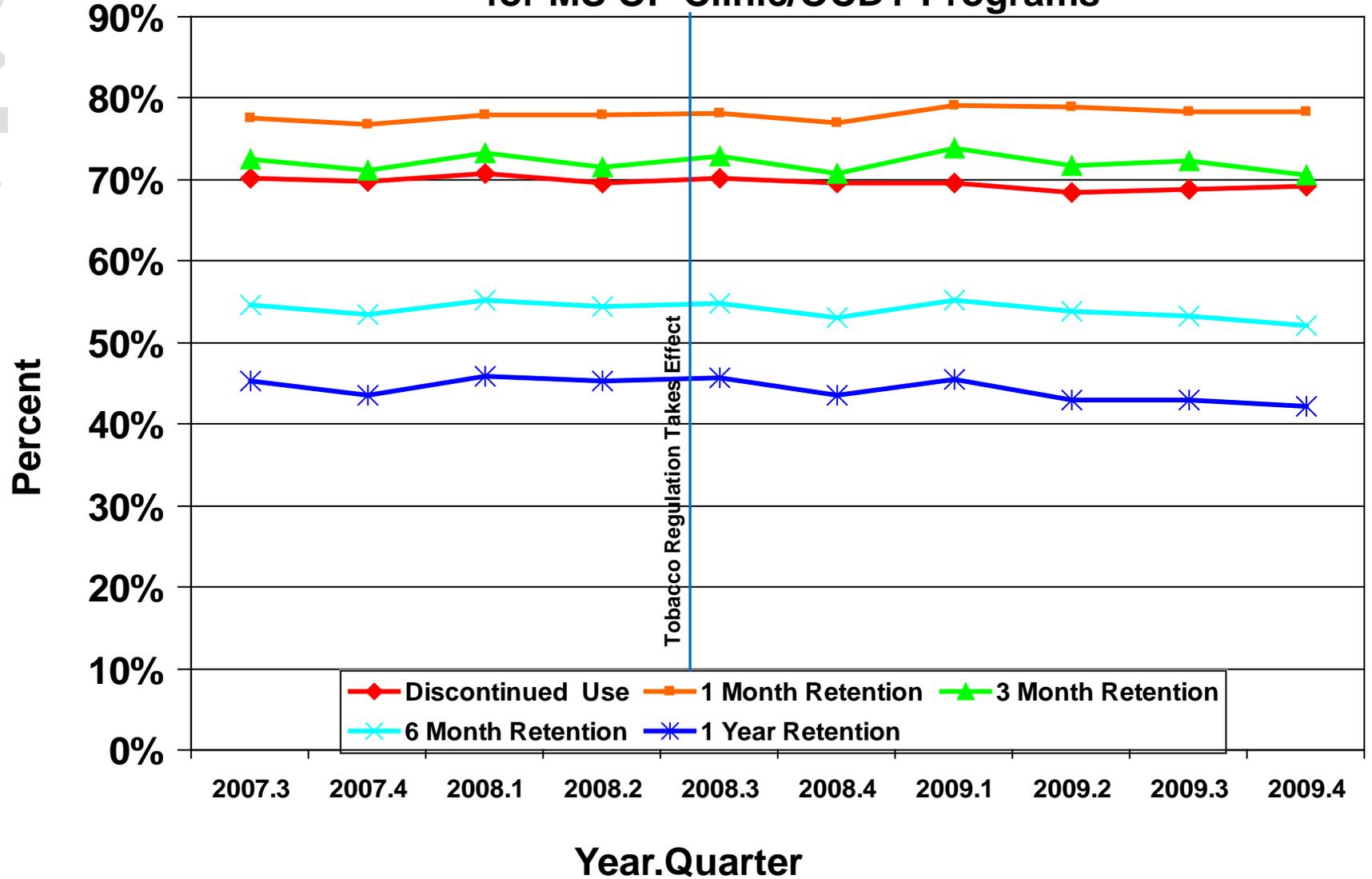
Graph 10

IPMES Indices – Rates for Discontinued Use and Retention Rates for RRSY/RCDY Programs



Graph 11

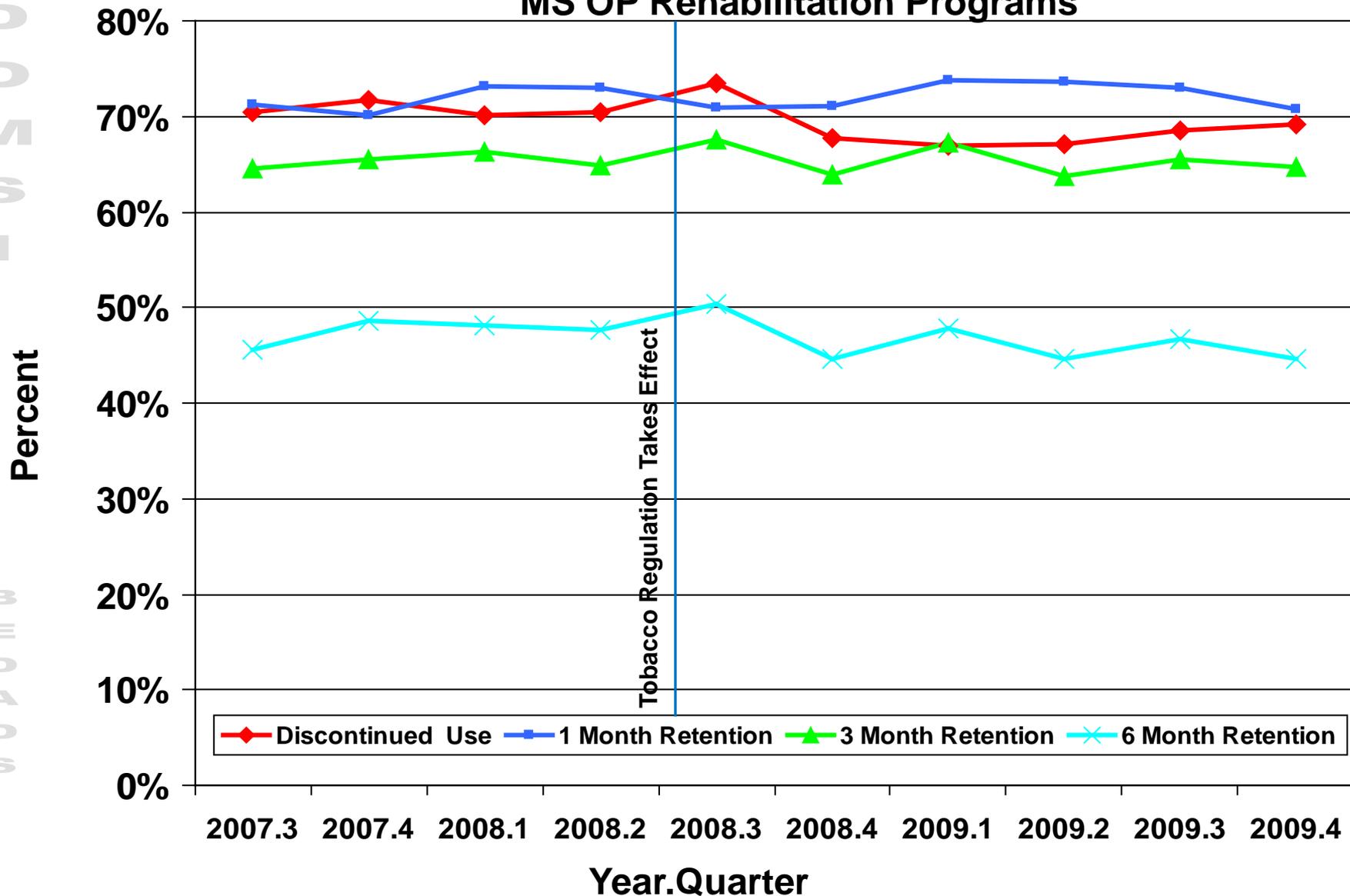
IPMES Indices – Rates for Discontinued Use and Retention Rates for MS OP Clinic/OCDY Programs



Source: CDS : July 2007 – December 2009

Graph 12

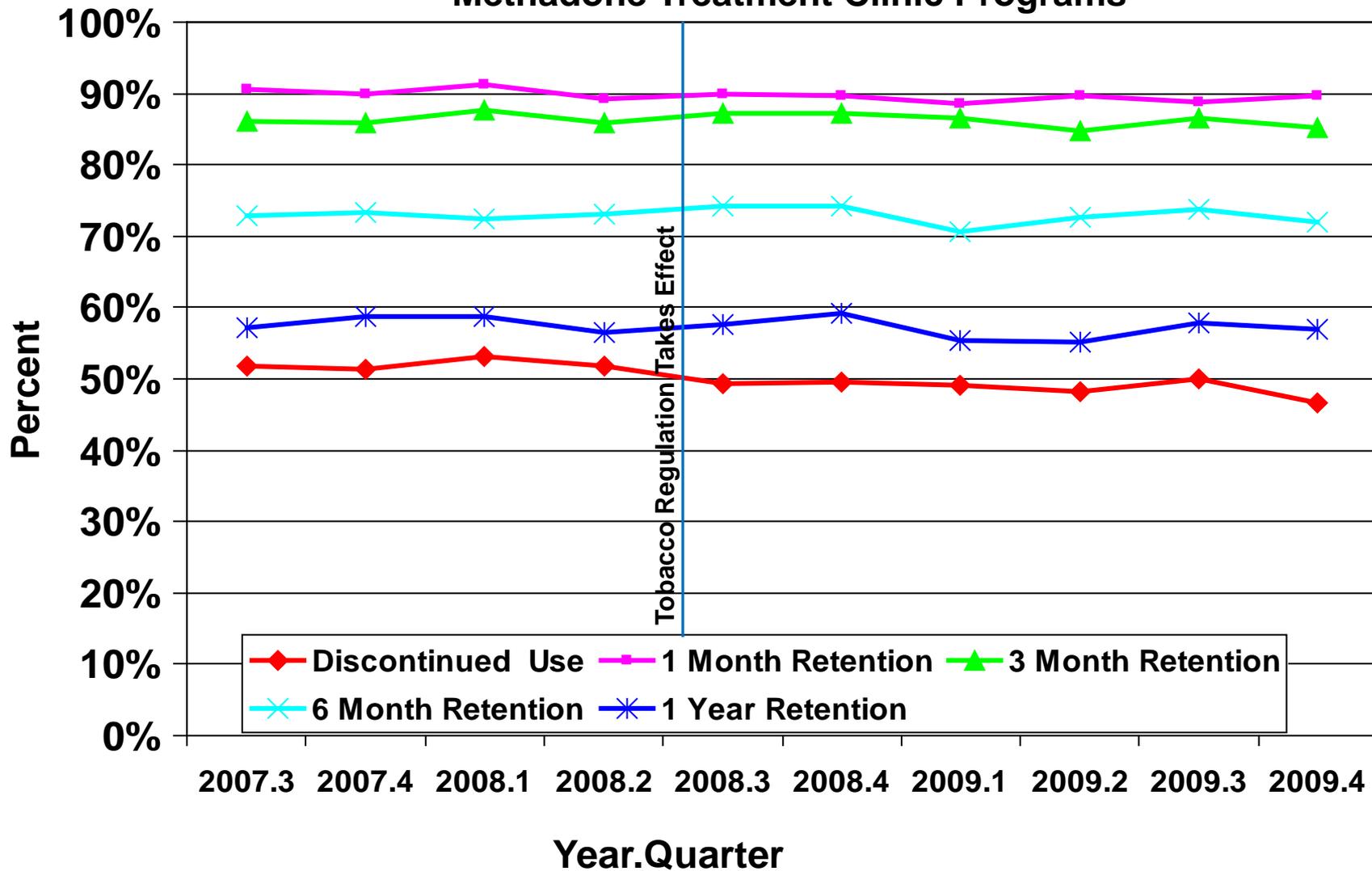
IPMES Indices – Rates for Discontinued Use and Retention Rates for MS OP Rehabilitation Programs



Source: CDS : July 2007 – December 2009

Graph 13

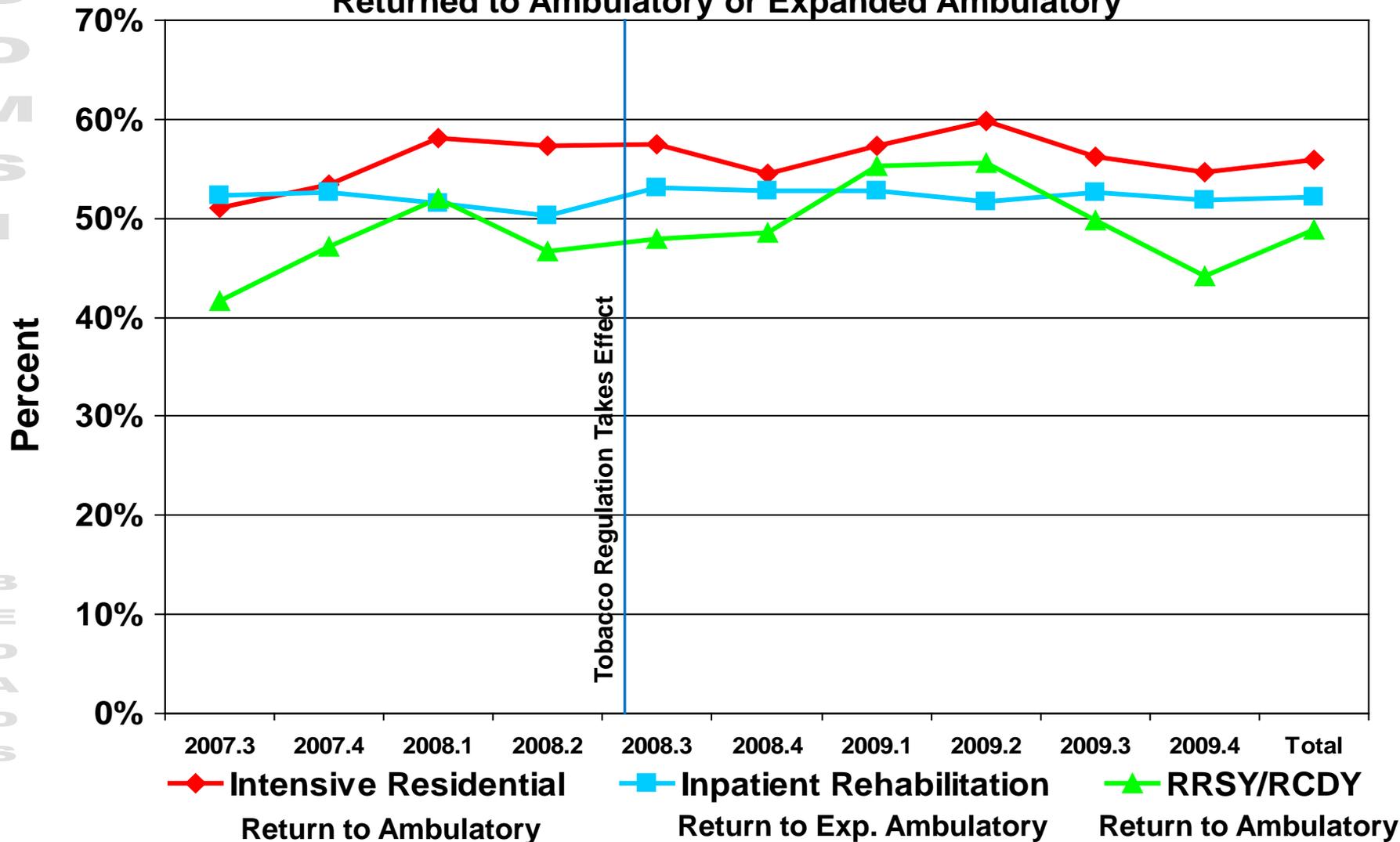
IPMES Indices – Rates for Discontinued Use and Retention Rates for Methadone Treatment Clinic Programs



Source: CDS : July 2007 – December 2009

Graph 14

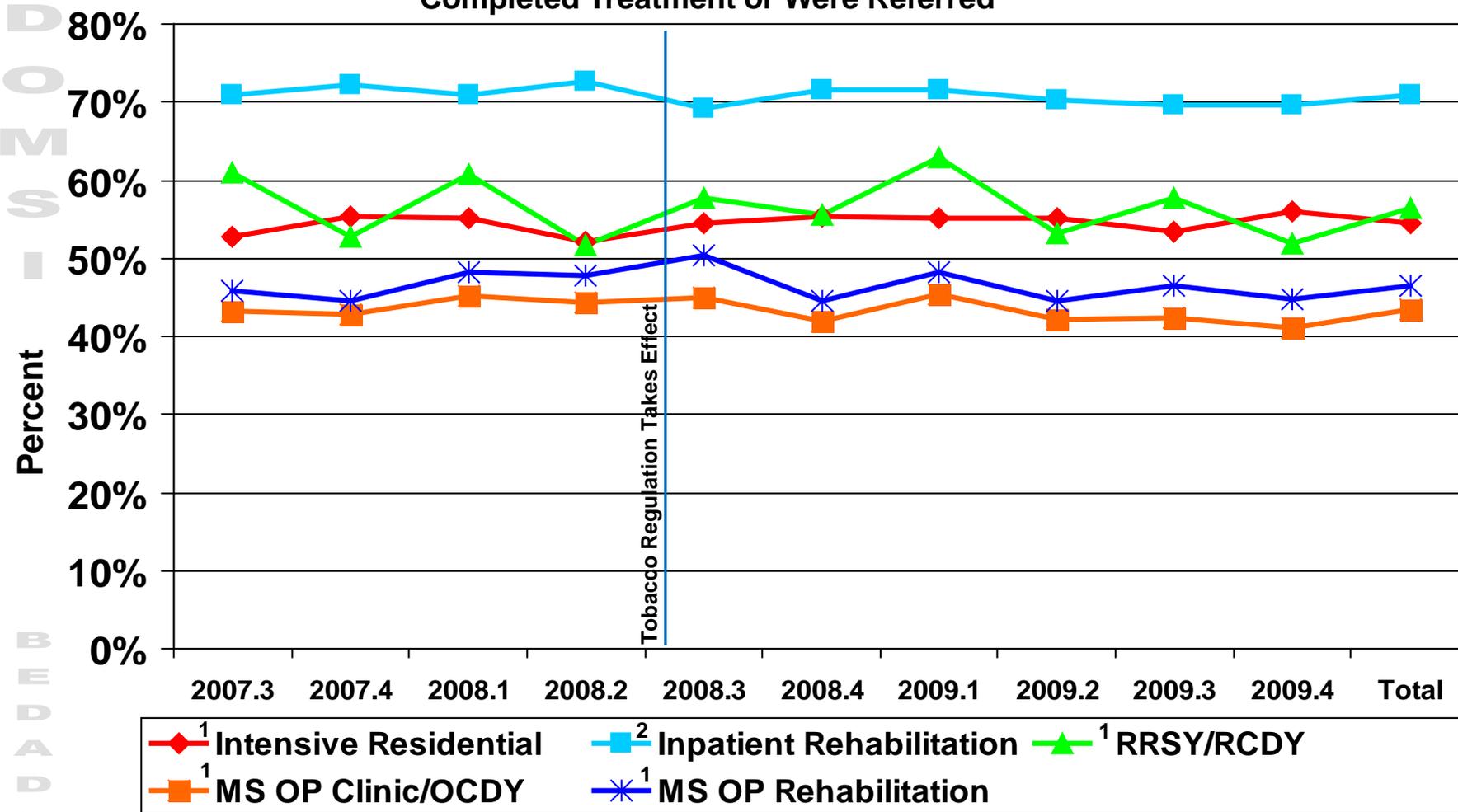
IPMES Indices - Clients Completing Residential Treatment Who Returned to Ambulatory or Expanded Ambulatory



Source: CDS : July 2007 – December 2009

Graph 15

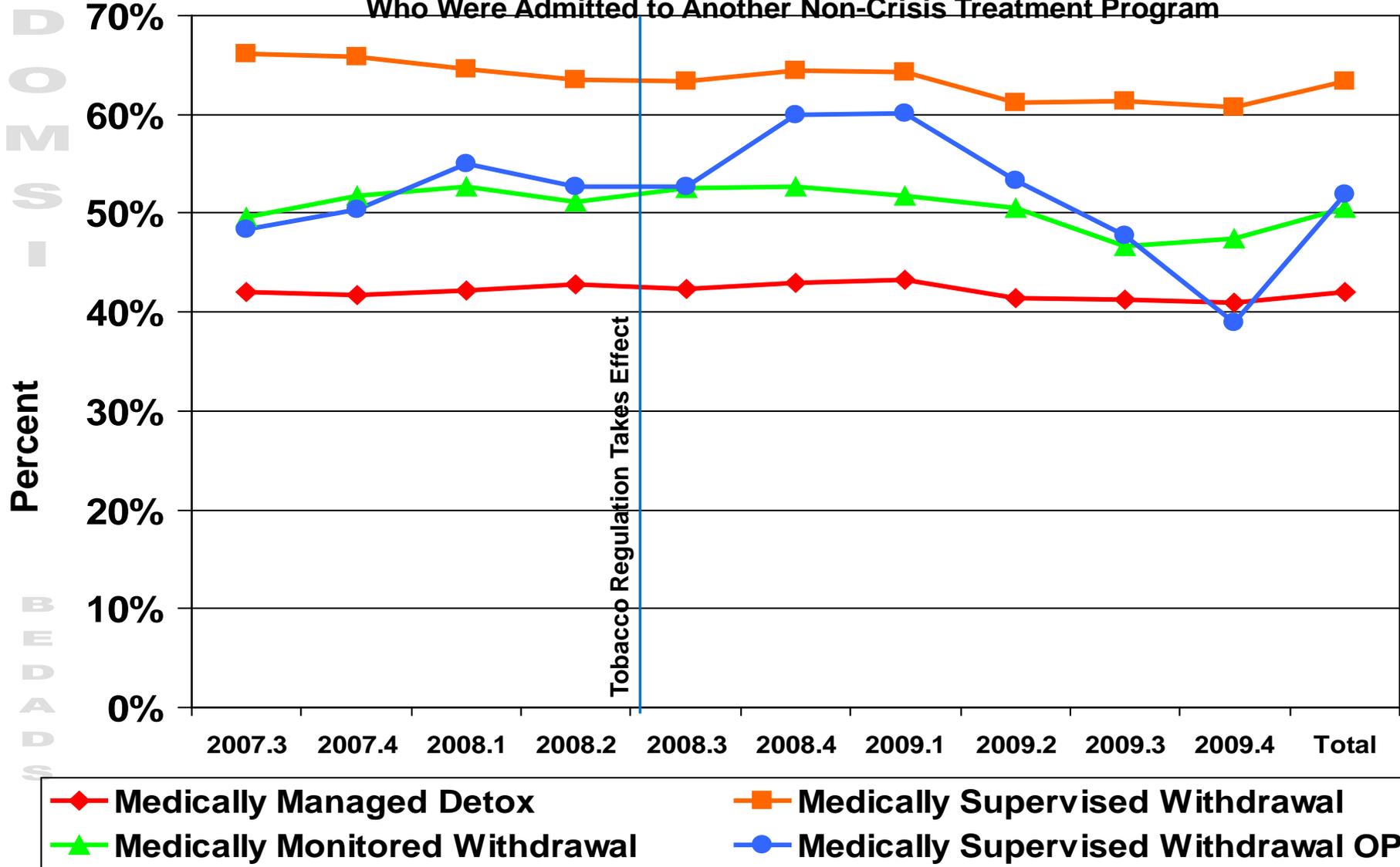
IPMES Indices - Percent of Clients Discharged Who Completed Treatment or Completed Treatment or Were Referred



1 – Completed Treatment or Referred; 2 – Completed Treatment

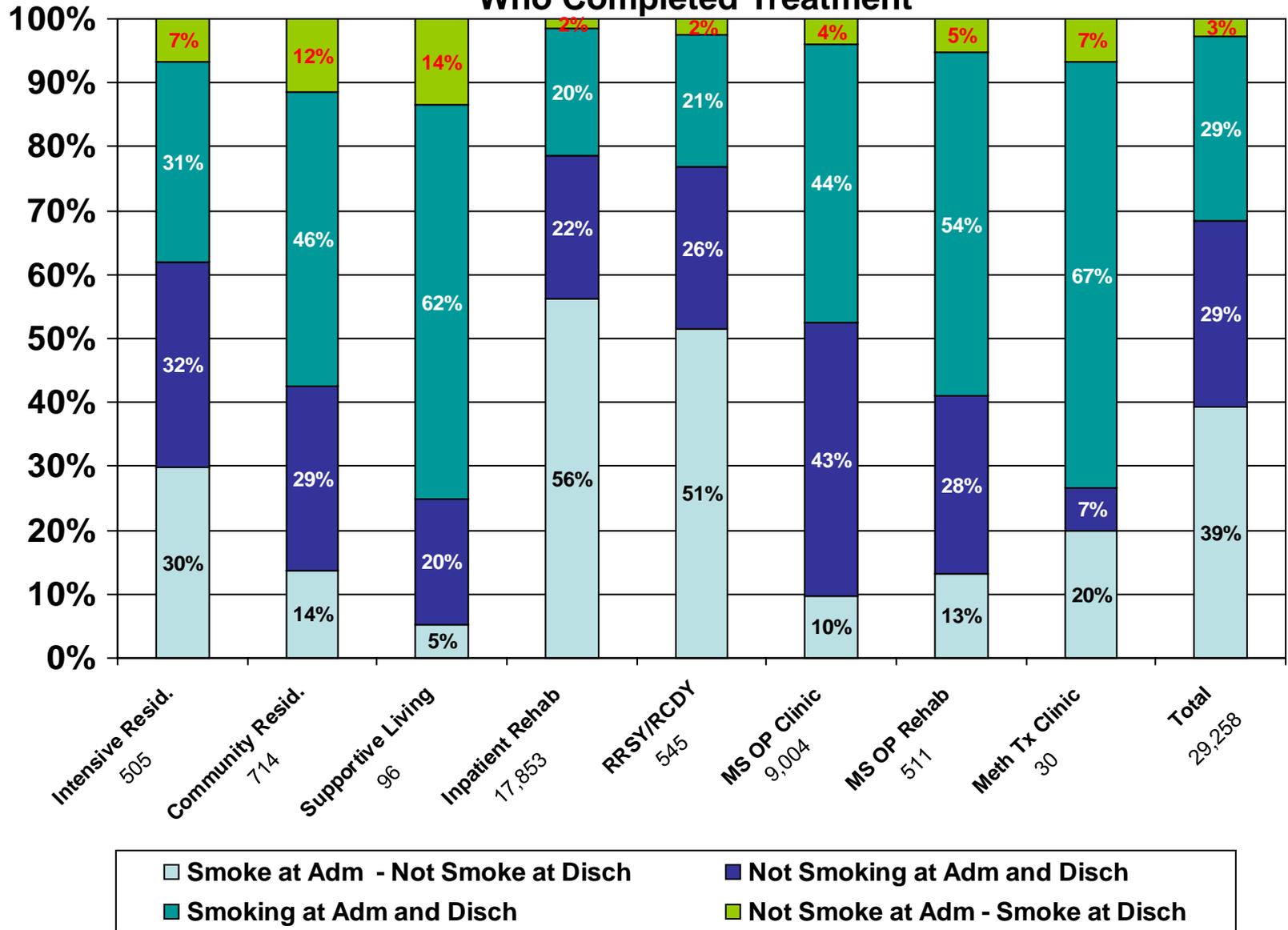
Graph 16

IPMES – Indices: Percent of Clients Who Completed Treatment in Crisis Programs Who Were Admitted to Another Non-Crisis Treatment Program



Graph 17

**Smoking Status of Patients at Admission and Discharge
Who Completed Treatment**



Source: CDS 29,258 Discharges from 4/2009 to 12/2009

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M
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I

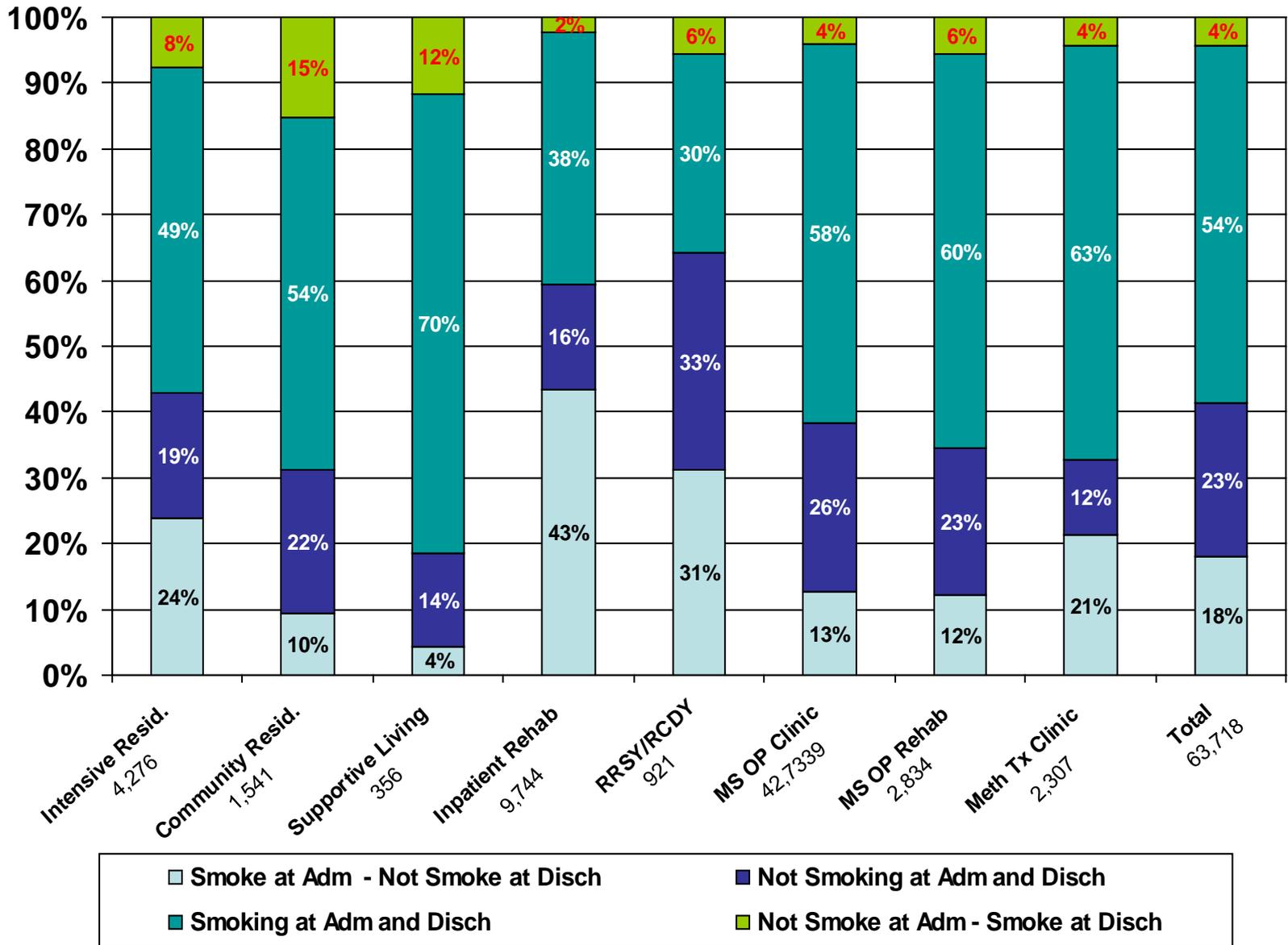
B
E
D
D
A
S
S

Graph 18

**Smoking Status of Patients at Admission and Discharge
Who Did Not Complete Treatment**

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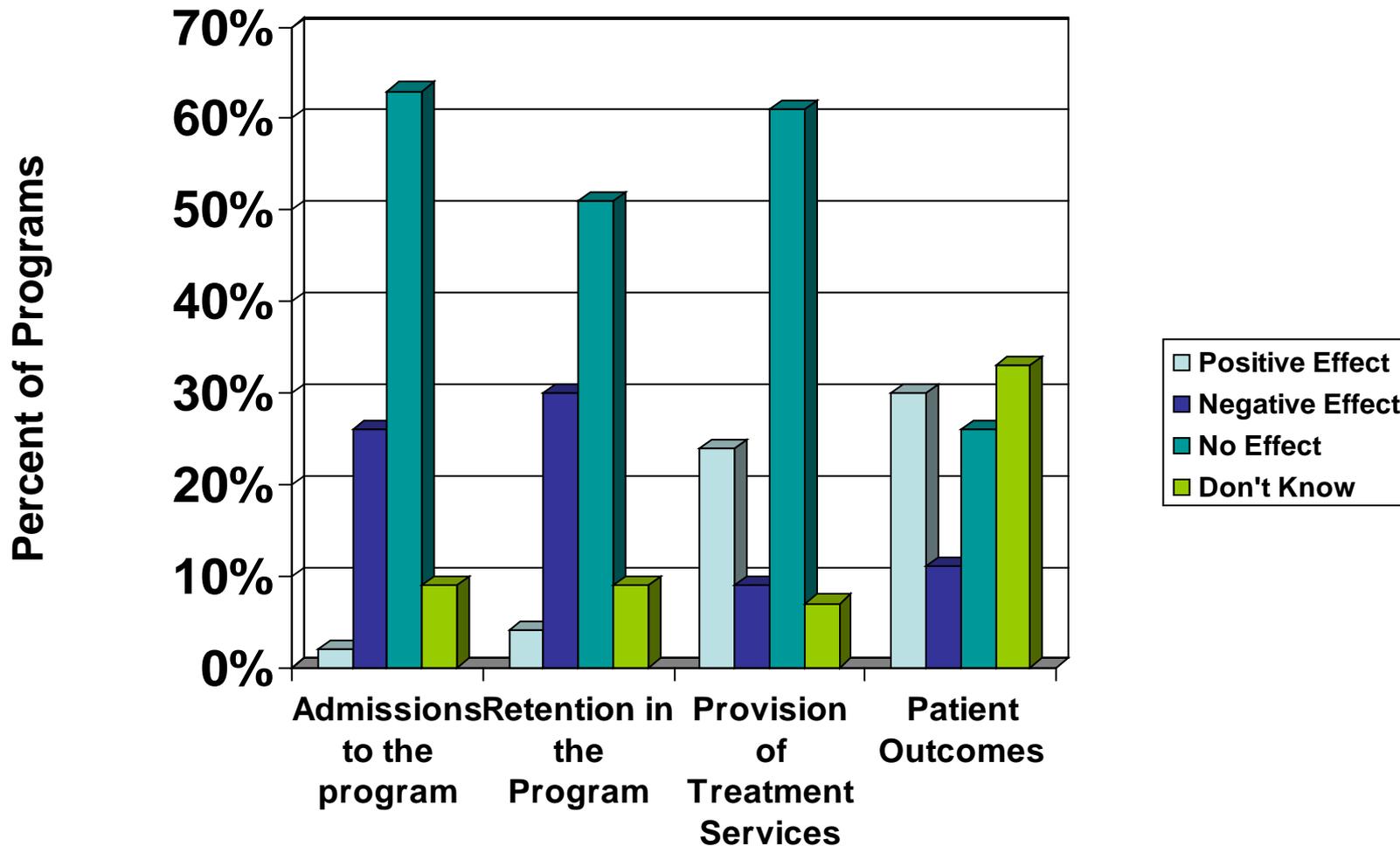
B
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Source: CDS 63,718 Discharges from 4/2009 to 12/2009

Graph 19

Local Government Unit Perceived Impact of Smoking Policy On Treatment programs

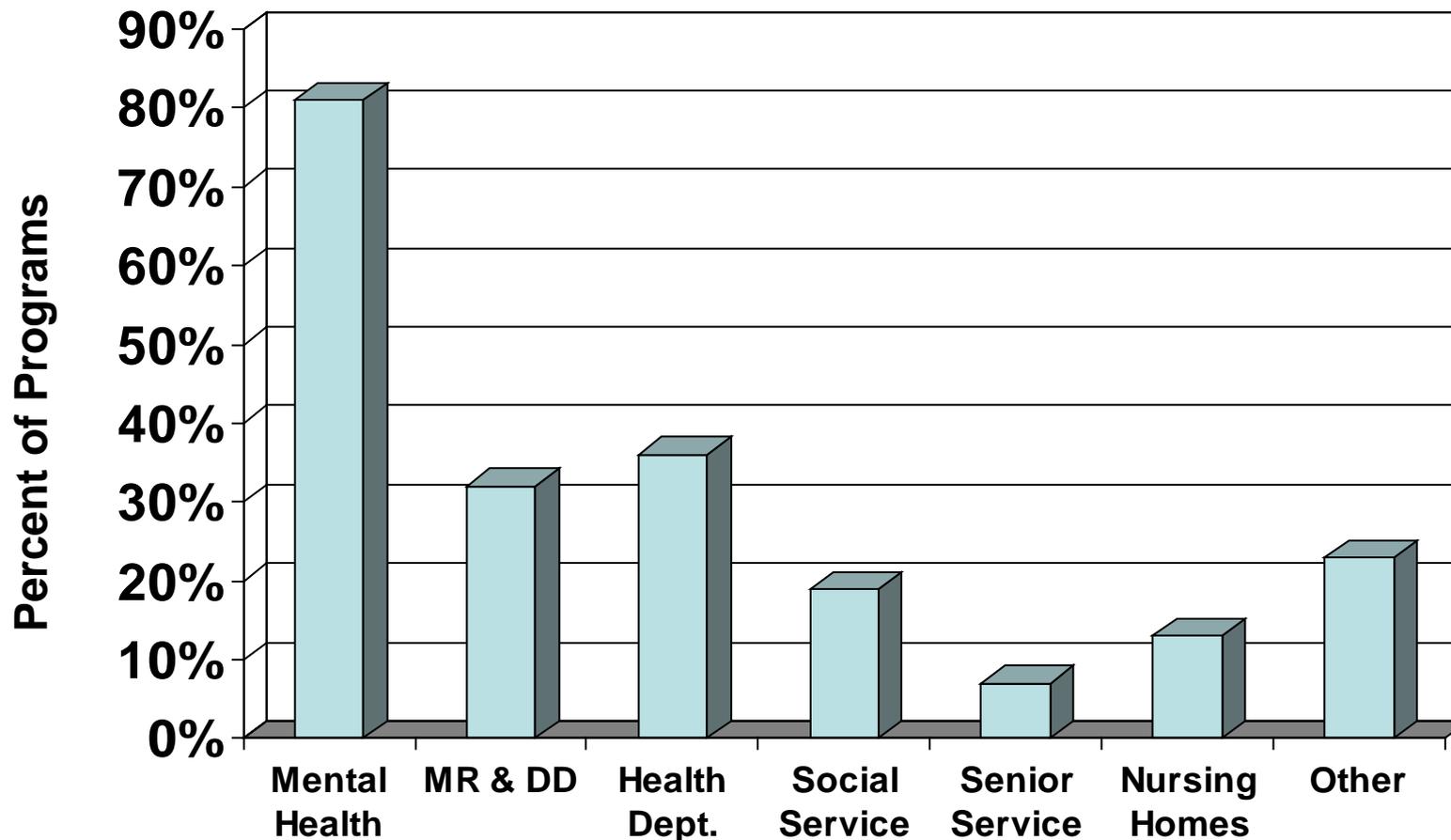


Source: 47 Counties Reporting on the County Planning System

S
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S
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Graph 20

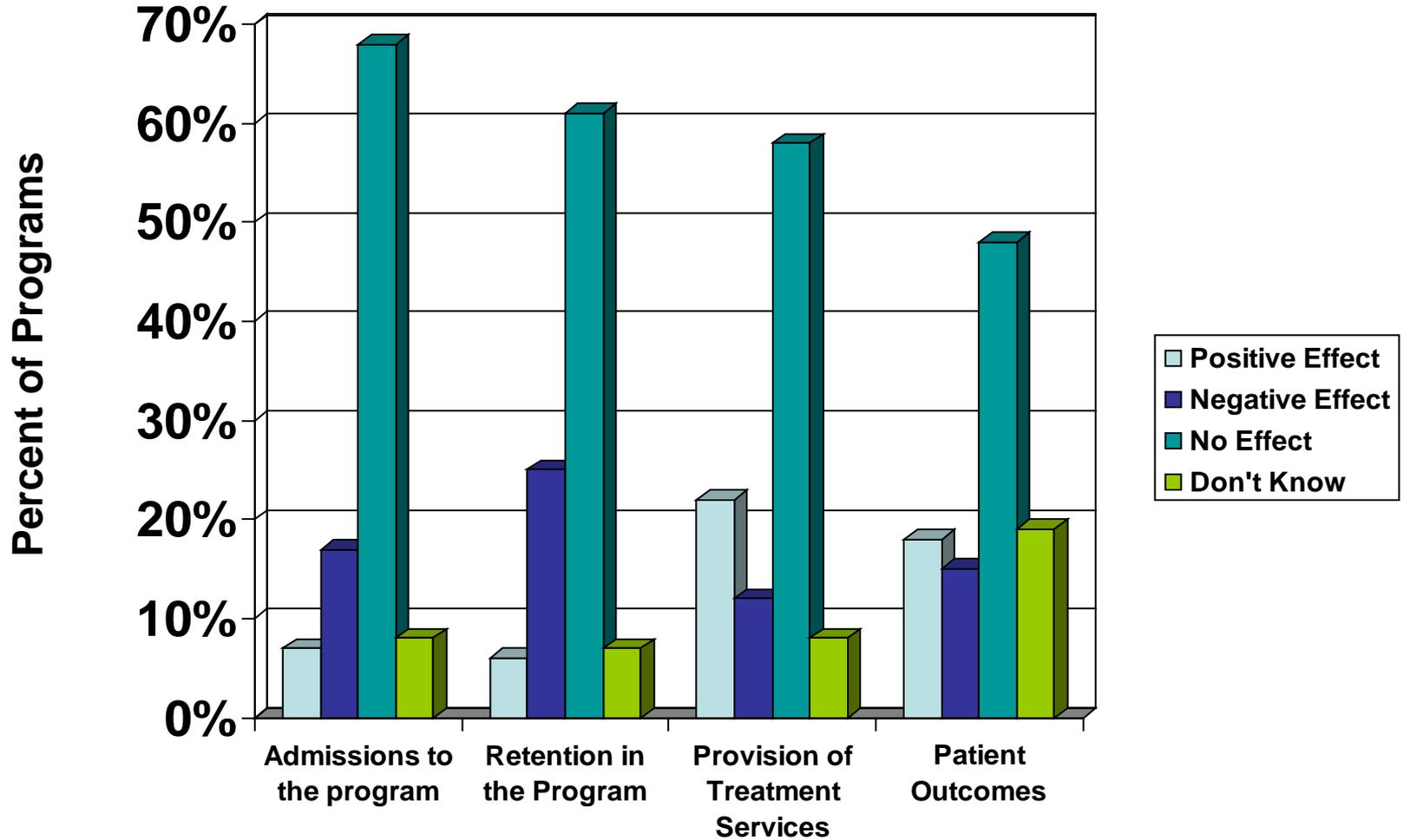
Other Programs Under the Jurisdiction of the LGU Which Have A Smoking Policy In Effect



Source: 25 Counties Reporting on the County Planning System

Graph 21

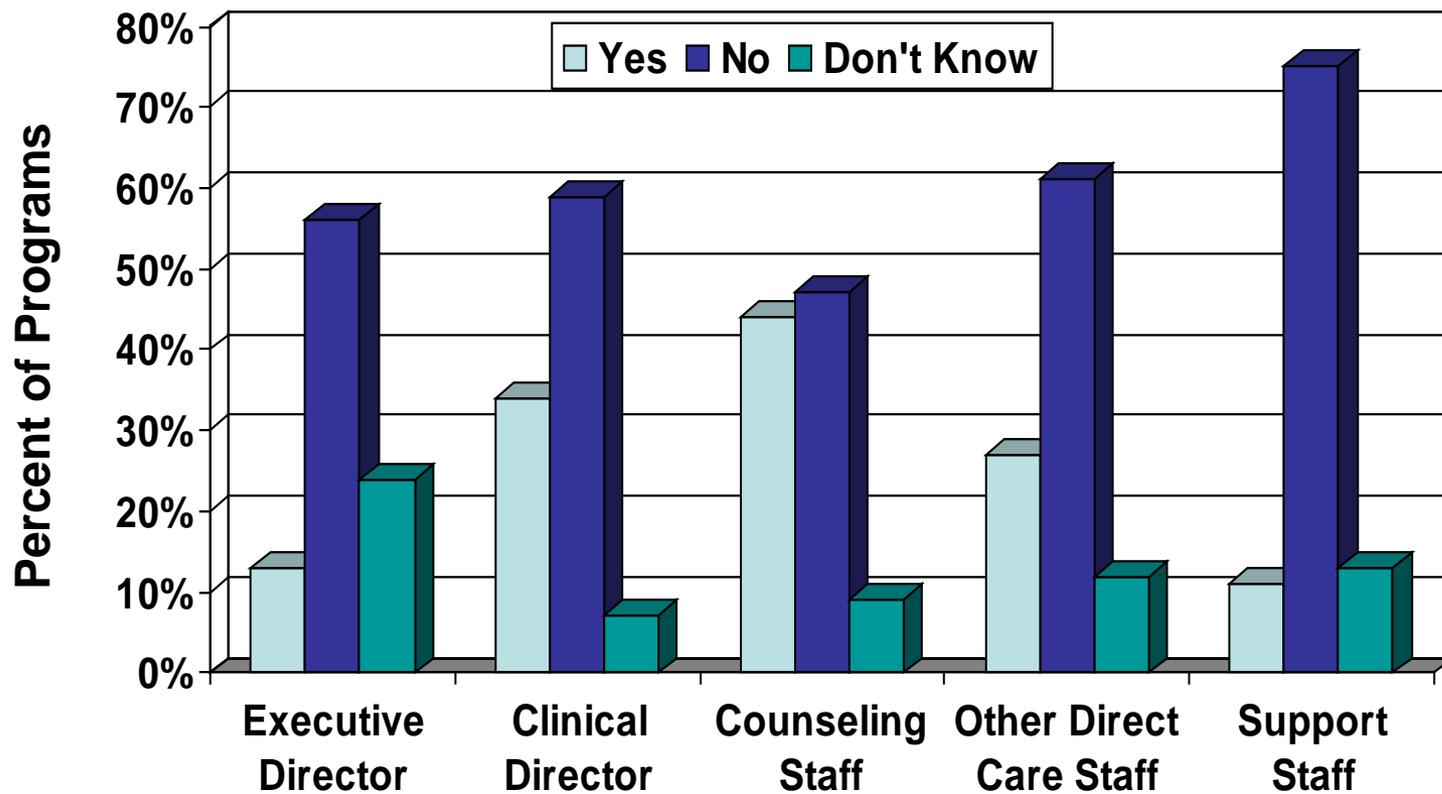
Perceived Impact of Smoking Policy As Reported by Treatment Programs



Source: 1004 Treatment Programs Reporting on the County Planning System

Graph 22

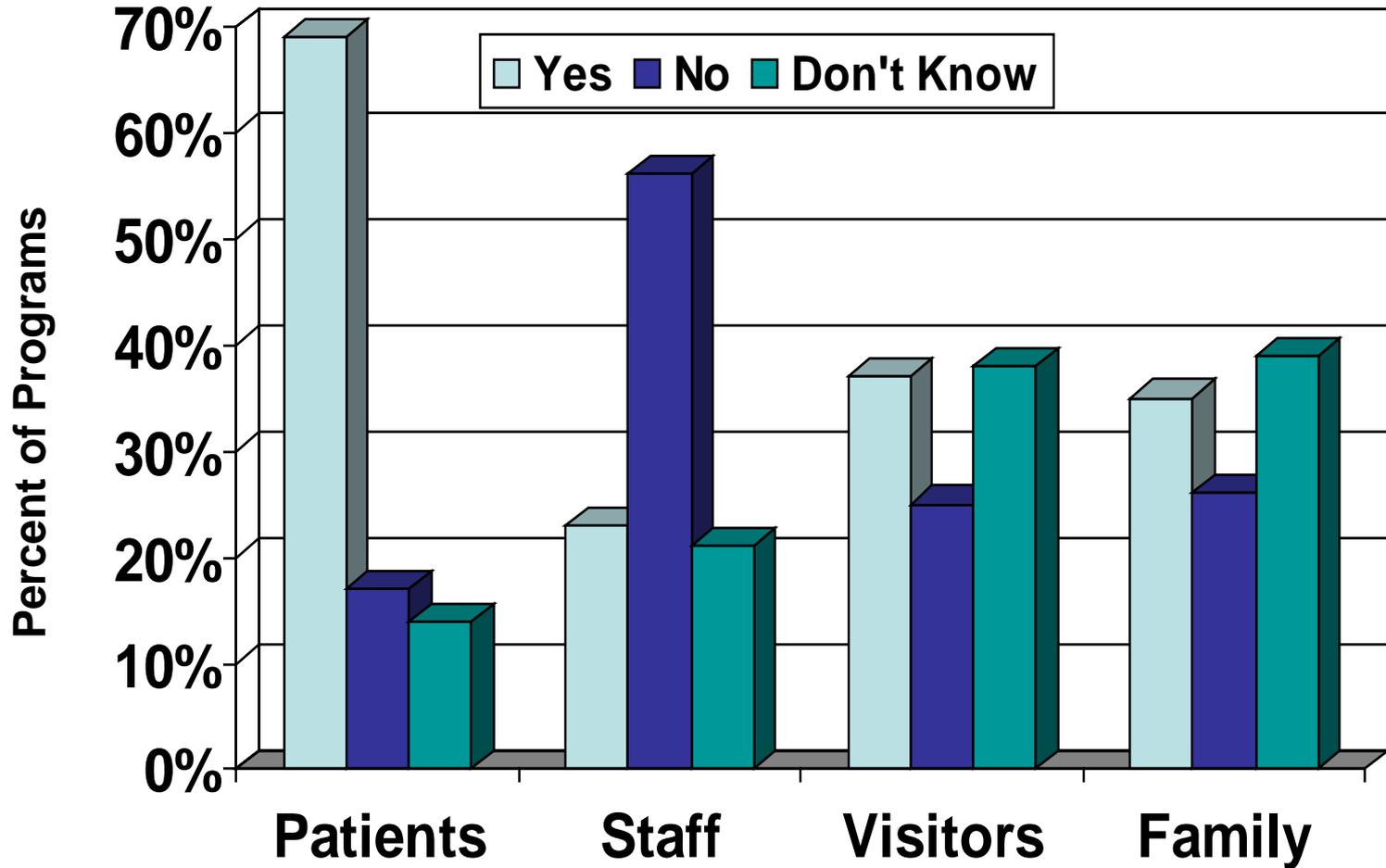
Treatment Program Staff Who Participated in Regional Tobacco Training Consortiums Sponsored by the University at Albany



Source: 1004 Treatment Programs Reporting On the County Planning System

Graph 23

Treatment Programs Reporting That Individuals Brought Tobacco/Tobacco Products Into Treatment Programs

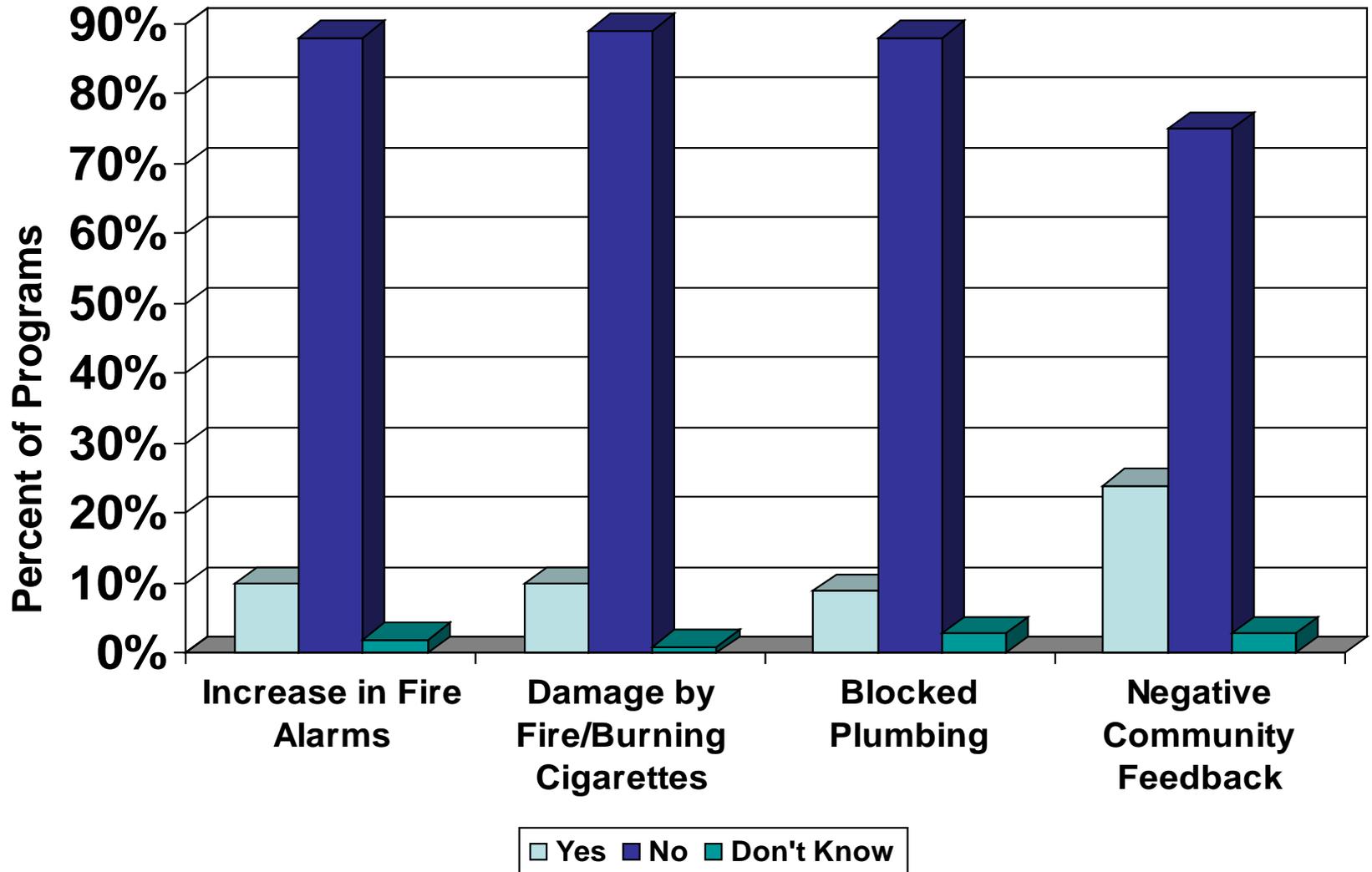


Source: 1004 Treatment Programs Reporting on the County Planning System

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Graph 24

Treatment Programs Reporting Negative Consequences Resulting From the Smoking Policy



Source: 1004 Treatment Programs Reporting on the County Planning System

