Tobacco Cessation: Strategies for Creating Policy to Improve Outcomes

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## Change Package

| Family and Patient-Centered Care Design | 1.2 Team-based relationships  
1.3 Population management  
1.6 Organized, evidence based care |
|----------------------------------------|---------------------------------------------------------------------|
| Continuous, Data-Driven Quality Improvement | 2.1 Engaged and committed leadership  
2.2 Quality improvement strategy supporting a culture of quality and safety  
2.3 Transparent measurement and monitoring |
| Sustainable Business Operations |                                                                         |
About 36% of people with mental illnesses and 77-93% with addictions smoke, as compared to 16.8% of the general population. Smoking-related illnesses cause half of all deaths among people with behavioral health disorders. Practices are collecting data on tobacco cessation as a part of meaningful use, but are practices intentionally using this data to drive clinical practice? Mental health administrators will gain an understanding of why they should take aim at tobacco use. Administrators will learn strategies to use the data that they are collecting on tobacco use to drive clinical practice and target tobacco reduction for their client population.
Learning Objectives

- At the end of this session, enrolled organizations will be able to:
  - Identify a goal for their practice to reduce tobacco use
  - Implement strategies to reduce tobacco use
  - Create a clinic culture targeting a reduction of tobacco use
  - Develop policy to reduce tobacco use
As a matter of fact...

• Approximately **1 in 5** (~57.7m) Americans suffer from mental illness every year
• On average, persons diagnosed with mental illnesses and addictions die **10-25 years earlier** than the general population
• ~**50%** of people with behavioral health conditions smoke.
• People with mental illnesses and addictions smoke more than **40%** of all cigarettes produced.
• Anti-smoking efforts have **not been directed toward people with mental illnesses** as they have toward the general population.
• Up to **90%** of people with mental illnesses and addictions being treated recover.
FQHC Tobacco Requirements

- Uniformed Data System - Quality Care Indicators
- 14a: Tobacco Use Screening & Cessation Intervention

**Performance Measure:** Percentage of patients aged 18 or older who were screened for tobacco at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

- Numerator: # of patients in denominator that were queried about their tobacco use one or more times during their most recent visit or within 24 pharmacotherapy if identified as a tobacco user.

- Denominator: # of patients who were 18 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the reporting year, and with at least two medical visits ever

- Exceptions: None


<table>
<thead>
<tr>
<th>Line</th>
<th>Tobacco Use Screening &amp; Cessation Intervention</th>
<th>Total patient aged 18 and older</th>
<th># Charts sampled or EHR total</th>
<th># Patients assessed for tobacco use &amp; provided intervention if a Tobacco user</th>
</tr>
</thead>
<tbody>
<tr>
<td>14a</td>
<td>Performance Measure</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CCBHC Tobacco Requirements

- **National Quality Forum Measure #28: Care & Screening: Tobacco Use**

- **Performance Measure:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

- **Numerator:** # of patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

- **Denominator:** All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.

- **Exception:** Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason).

- [www.qualityforum.org/Measure.../Behavioral_Health_Specs_Table.aspx](http://www.qualityforum.org/Measure.../Behavioral_Health_Specs_Table.aspx)

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**SAMHSA CCBHC Data Standard:**

<table>
<thead>
<tr>
<th>Potential Source of Data</th>
<th>Measure or Other Reporting Requirement</th>
<th>National Quality Forum Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR, Encounter data</td>
<td>Preventative Care &amp; Screening: Tobacco Use: Screening &amp; Cessation Intervention</td>
<td>NQF #28: Care &amp; Screening: Tobacco Use</td>
</tr>
</tbody>
</table>

Making the Financial Case for Tobacco Cessation
<table>
<thead>
<tr>
<th>Diagnosis and Treatment</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Use Disorder</td>
<td>305.1</td>
</tr>
<tr>
<td>Personal History of Tobacco Use</td>
<td>V15.82</td>
</tr>
<tr>
<td>Symptomatic Tobacco Use Council 3-10 min</td>
<td>99406</td>
</tr>
<tr>
<td>Symptomatic Tobacco Use Counsel &gt;10 min</td>
<td>99407</td>
</tr>
<tr>
<td>Asymptomatic Tobacco Use Counsel 3-10 min</td>
<td>G0436</td>
</tr>
<tr>
<td>Asymptomatic Tobacco Use Counsel &gt;10 min</td>
<td>G0437</td>
</tr>
</tbody>
</table>
Essential Health Benefit

• Under the healthcare exchange the essential benefit must include
  • MH/SA including meds
  • Preventive and wellness services for tobacco
    • At least 2 attempts per year
    • 4 counseling sessions (individual, group, telephonic)
    • 90 days of FDA medication
    • No cost sharing
    • No Prior authorization

• This also applies to Medicaid expansion and third-party insurance
Medicare Providers

• Medicare Part B covers tobacco use treatment multiple times each year
  • 8 visits per year (4 sessions per attempt)
  • At intermediate (3 to 10 min) or intensive (>10 min) levels
• Medicare Part D covers cessation medications
What We Know About Coverage?

Coverage of evidence-based treatment leads to:
- increases in quit attempts,
- use of cessation treatments,
- successful smoking cessation

Coverage provisions that pose barriers:
- copayments,
- prior authorization,
- limitations on number/duration of treatments,
- requiring counseling to obtain medications,
- stepped or fail-first care
Identify Your Goal

• Our practice is going to reduce tobacco use by 50% in the next year for our client population!!

  • Where are we now?
  • Who do I need to engage to get us there?
  • What tools do they need to get there?
  • What action steps need to be taken?
  • Where do I start?
Barriers to reducing tobacco use

• Culture change
  • My staff smoke or I smoke
  • Smoking is primary health care issue not behavioral health

• Staff education
  • How does this relate to MH symptomology
  • My client has high risk behaviors, is tobacco use a priority?
  • My clients use tobacco as way a to reduce anxiety
  • Tobacco is safer than other substances
Create a tobacco free culture

Culture is the way you think, act, and interact.
# Cessation Rates Across Interventions

<table>
<thead>
<tr>
<th>Treatment Format</th>
<th>Abstinence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unaided</td>
<td>4-7%</td>
</tr>
<tr>
<td>Self-help</td>
<td>11-14%</td>
</tr>
<tr>
<td>Quitline</td>
<td>11-15%</td>
</tr>
<tr>
<td>Individual Counseling</td>
<td>15-19%</td>
</tr>
<tr>
<td>Group Counseling</td>
<td>12/16%</td>
</tr>
<tr>
<td>Medication Alone</td>
<td>22%</td>
</tr>
<tr>
<td>Medication/Counseling</td>
<td>25-30%</td>
</tr>
</tbody>
</table>
Culture Change: Challenging the Mythology
Cessation Concurrent with Psychiatric Treatment

Myth:
1. Smoking is primary health care issue not behavioral health
2. How does this relate to MH symptomology
3. My client has high risk behaviors, I can’t prioritize tobacco use
4. My clients use tobacco as way a to reduce anxiety

Reality:
Smoking cessation has no negative impact on psychiatric symptoms and smoking cessation generally leads to better mental health and overall functioning
Addressing tobacco dependence during treatment for other substances is associated with a 25% increase in long-term abstinence rates from alcohol and other substances

Baker et al., 2006; Lawn & Pols, 2005; Morris et al., 2011; Prochaska et al., 2008
Psychiatric Symptoms Are Not Exacerbated by Smoking Cessation
(26 Studies)

Smoking cessation is associated with:

↓ depression, anxiety, and stress

↑ positive mood and quality of life compared with continuing to smoke

The effect size seems as large for those with psychiatric disorders as those without

The effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders

Taylor et al, 2014
Implement strategies to reduce tobacco use
Tobacco & BH Messaging: What Resonates?

• Tobacco can be built into a whole health initiative and marketed to agencies’ advantage.
• Tobacco cessation and tobacco free environments are critical to recovery.
• If you are doing addictions, you can easily do tobacco.
• Integration is the new norm and tobacco services are a mandated component of integrated health services.
• You don’t have to re-invent anything; there are ample resources for training, etc.
• Workflow examples exist for integrating tobacco into screening, assessment, and daily practice.
• Even though there is anticipatory implementation anxiety, tobacco free policies lead to more attractive treatment environments for both clients and employees.
Develop action plan to reduce tobacco use

Objective: Clearly Communicate Intention
- Inform staff and clients of tobacco-free policy timeline as early as possible.
- Articulate the supports available to help those who want to set goal of quitting adjust and begin the process.
- Create announcements and written communication to staff, clients and other partners.
- Establish listening sessions to hear and respond to staff and client concerns.

Objective: Educate Staff and Clients
- Posting State Quit Line in all buildings.
- Informational Sessions (Health Benefits if quitting).
- Provide staff education and training around tobacco-cessation. Training should include:
  - The association between mental illness, substance abuse and tobacco dependence.
  - Evidence-based pharmacotherapy and counseling for tobacco cessation.
  - Brief screening and assessment tools.
  - Practical strategies for include of tobacco cessation into treatment planning.
  - Community referral resources.

Objective: Offer Tobacco-Cessation support
- Implementation of “Learning about Healthy Living” curriculum in all day programs by June 30, 2015.
- Identify other programs and groups to offer Tobacco-Cessation support, provide training and curriculum.
- Integrate tobacco screening, assessment, treatment and referral into policies and procedures.
- Tobacco Cessation Medications - Determine if Way Station will provide Nicotine Replacement Therapy on site by June 30, 2015.
- Tobacco Cessation Counseling Quitlines.
- Peer to Peer.
- Review Way Station Healthy Incentives for staff to ensure they provide supports for staff in Tobacco-Cessation by June 30, 2015.
- Add tobacco cessation materials to new hire materials.

Care Transitions Network
for People with Serious Mental Illness
Where do we go from here?
Thank you!

www.CareTransitionsNetwork.org
CareTransitions@TheNationalCouncil.org

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