Guidelines for Systems and Professionals

Presentation time: 3 hours (minus 15 minute break)

Trainers are encouraged to add any appropriate local resources during the discussion of resources in this module

Activity: This module will include a small group discussion about systems issues. Plan a process of your choice to assemble groups according to type of work settings. For example – prior to the session post sign up sheets according to settings that are represented such as hospitals, out-patient clinics, community health centers, behavioral health etc.

Key Points: This module will cover guidelines beginning with a systems perspective, to the program level and finally the individual TTS.
Objectives of the Module

- List the Public Health Service recommendations for optimal structure and intensity of effective tobacco treatment interventions
- Describe the range of established and innovative treatment modalities
- Discuss systems and program implementation
- Define the role of the TTS: Professional development, resources and responsibilities

Key Points: Briefly review each of the objectives for this module
Objective

Describe the PHS recommendations for optimal structure and intensity of effective tobacco treatment interventions

Key Points:
- The Public Health Service Clinical Guideline: Treating Tobacco Use and Dependence, 2008 update, is still considered a valuable reference for the work of TTS. As of August there were no plans to update the guideline.
- The PHS guideline was developed using meta-analysis
- TTS Trainers and TTS should be very familiar with the PHS guideline, how it was developed and the major recommendations
- Remind participants that the link to the PHS guideline was included in Basic Skills

Effective Strategies in a Clinical Setting

The PHS Guideline provides evidence for three major strategies for intervening with patients in the clinical setting:

1. Counseling
   - Routine, brief interventions with all patients
   - More intensive behavioral counseling, including telephone counseling
2. Pharmacological support
3. Systems support

Fiore et al, 2008

This slide is animated with each numbered item showing after mouse click

Key Points:
- The PHS guideline provides evidence for numerous interventions to treat tobacco dependence. They can be grouped into these 3 major strategies.
  - Counseling: brief interventions, intensive (telephone, face to face group or individual)
  - Pharmacotherapy (7 first line meds) to be discussed in Module 4
  - Systems support, including processes used to identify tobacco users and offer treatment, documentation of tobacco use and treatment provided, clinician training
- This information is on the exam and is important for participants to understand that all three components contribute to effective treatment
The 5A Model of (Brief) Tobacco Treatment Intervention

- **Ask** about tobacco use every visit
- **Advise** to quit
- **Assess** willingness to make a quit attempt
- **Assist** in quit attempt
- **Arrange** follow-up

Fiore et al, 2008

This slide is animated. The entire text will appear with mouse click. This helps to provide time to elicit the 5As from participants

**Key Points:**
- Remind participants that the 5As were introduced in Basic Skills – ask them to list the 5As (no looking at the manual)
- This model is recommended for use mainly by primary care providers or other people who come into contact with smokers but whose main job is something other than tobacco treatment.
- TTS have responsibility to help train personnel within the agency to perform this brief intervention, or to help facilitate the delivery and documentation of the brief intervention.
Objective

Describe the range of established and innovative treatment modalities

Key Points:

- There are a range of methods for delivering treatment that will be briefly reviewed
Many Treatment Modalities are Available

- In-person: individual, group
- Telephone
- Internet
- Mobile Apps
- Harm Reduction

Key Points:
- Each of these modalities will be discussed briefly
### Key Points:
- Note that the reference group with no treatment has a relatively high abstinence rate. This is likely due to the fact that studies included in the meta-analysis include participants who join the study because of motivation to quit. Overall, quit rates for self-quitters with no support are 3-5% annually.
- **Efficacy of treatment increases with duration** of person-to-person treatment. The more time you can spend with them, the more successful, UP TO A POINT of diminishing returns (>300 minutes).

Reference:
PHS Guideline, 2008 update: Table 6.9 Meta-analysis (2000): Effectiveness of and estimated abstinence rates for total amount of contact time (n = 35 studies)
### Treatment Efficacy Improves with Number of Sessions

<table>
<thead>
<tr>
<th>Number of Sessions</th>
<th>Estimated Abstinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 1 session</td>
<td>12.4% est. abstinence</td>
</tr>
<tr>
<td>2 – 3 sessions</td>
<td>16.3%</td>
</tr>
<tr>
<td>4 – 8 sessions</td>
<td>20.9%</td>
</tr>
<tr>
<td>&gt; 8 sessions</td>
<td>24.7%</td>
</tr>
</tbody>
</table>

**Fiore et al, 2008**

**Key Points:**
- There is a strong dose-response relationship between *number of treatment sessions* and treatment efficacy, with treatments lasting more than 8 sessions significantly more effective than interventions lasting either zero to one or two to three sessions.

**Reference:**
PHS Guideline, 2008 update: Table 6.10
Meta-analysis (2000): Effectiveness of and estimated abstinence rates for number of person-to-person treatment sessions (n = 46 studies)
### Treatment Efficacy Improves with Clinician Involvement

<table>
<thead>
<tr>
<th>No clinician</th>
<th>10.8% est. abstinence rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>One clinician type</td>
<td>18.3%</td>
</tr>
<tr>
<td>Two clinician types</td>
<td>23.6%</td>
</tr>
<tr>
<td>Three or more</td>
<td>23%</td>
</tr>
</tbody>
</table>

Suggests that a variety of clinicians can (and should) play a role in promoting smoking cessation

Fiore et al, 2008

### Key Points:
- Treatments delivered by multiple types and a variety of clinicians are more effective than interventions delivered by a single type of clinician. Therefore, if feasible, the delivery of interventions by more than one type of clinician is encouraged – key to adopting a Systems Approach.
- This suggests that a variety of clinicians, including physicians, nurses, dentists, dental hygienists, pharmacists, psychologists, respiratory therapists and health educators can play an important role in promoting smoking cessation.
- Physician’s advice has been shown to be an important component.

Reference:
PHS Guideline, 2008 update: Table 6.12 Meta-analysis (2000): Effectiveness of and estimated abstinence rates for interventions delivered by various numbers of clinician types (n = 37 studies)
In-Person Counseling: Individual

- Includes brief interventions through intensive treatment
- Can tailor to client’s specific needs
- Different providers (TTS, physician, respiratory therapist, etc.) can all play a role in delivering interventions
- May be covered by insurance

Key Points:

- Counseling given outside of routine clinical care helps smokers quit.
- PHS Guideline found practical counseling (problem-solving/skills training) and social support to be particularly effective
- The PHS guideline also found that when separately analyzing the “effect of different providers of care the estimates suggest that non-physician clinicians (a category including psychologists, social workers and counsellors) are similarly effective compared to a no-provider reference group (OR 1.7, 95% CI 1.3 to 2.1) as physicians (OR 2.2, 95% CI 1.5 to 3.2)” (Fiore 2008 Table 6.11).

References: Fiore, 2008; Lancaster and Stead, 2016.
In-Person Counseling: Groups

Why use a group model?

- **Effective**
  - Quit rates are similar
- **Efficient**
  - Capacity to service greater number of clients with limited treatment resources
- **Enhanced Experience for Participants**
  - Social support
  - Group cohesion

Stead et al, 2017

Key Points:

- A quit smoking group has a clear behavioral change agenda targeting tobacco use.
- The focus is on helping individuals develop specific behavioral changes which are supported and reinforced by other group members.
- Groups can be very effective and efficient.
- Especially in mental health and substance use treatment settings, clients are familiar and comfortable with this format.
- For those in MA, note that you can bill MassHealth for groups (if members are covered by MassHealth).
Things to Consider When Planning a Treatment Group

- How many sessions will be held?
  - 4-8 standard
- Recruitment and referral
- Screening
- Triage and referral of inappropriate participants

Key Points:

- There are many similar but different formats available for quit smoking groups.
- Checking in with other agencies or programs in your area may also be helpful in determining the right structure for your group.
- The group setting is not ideal for all participants. Planning ahead of time and having a process for screening will help you guide clients into the appropriate treatment modality.
- See the Members section (online) for a sample Telephone Screening Questionnaire. Suggested screening questions include smoking history, level of motivation, social support, medical and mental health history and current concerns, and current medications.
- Issues that may impact a member’s success within the group structure include severe and active mental health concerns, substance abuse beyond nicotine, and difficulty with group participation.
- There is no right or wrong way to run a quit smoking group! Take into account your population and its culture, your organization, the resources available to you and your own particular skills.
Telephone Counseling

- Provides wide access to evidence-based counseling
- Both proactive (call initiated by quitline counselor) and reactive (call initiated by tobacco user) increase quit rates compared to control
- Health care sites can implement systems to regularly refer patients to state-funded quitlines
- Commercial health care entities provide services to employers, health plans etc.

Get to Know the Quitline Services in Your Area!

Key Points:
- By implementing systems to refer patients to quitlines, facilities can provide referrals to evidence-based treatment even if they do not have access to resources for in-person treatment.
- Quit rates for proactive calls include calls to smokers who may not be thinking of quitting when recruited. 20-36% increase translates to 2-3% actual higher quit rate compared to a 10% control. (Stead, 2013)
- Reactive (call initiated by tobacco user) 20-50% increase in quitting compared to control (Stead, 2013)
- Actual number of smokers served by quitlines is small, about 1%.
- Most quitlines in US offer services in English and Spanish. There is an Asian Quitline based in California that offers counseling in several languages.
- Specific services and hours of operation will vary by state/type of service.
- Get to know your state quitline and services offered

Telephone Counseling: Quitline survey

North American Quitline Consortium’s 2017 survey of quitlines found that:

- Close to 1 million direct calls were made/received – dropping over past few years.
- Treatment reach has also decreased slightly since 2009 (from 1.19% to 0.87% of total U.S. tobacco users)
- Almost all offer free NRT (mostly patch) with multi-session counseling services (varies by state/payer)

www.naquitline.org

Key Points:
- Demographic highlights from NAQC’s report on surveys of quitlines in the U.S. (including Asian Quitline) and territories:
  - Nearly 60% of quitline callers are female
  - Median age of quitline callers is 48 years old.
  - Nearly 60% of callers have a GED/HS diploma or less for educational attainment.
  - Nearly 4% of quitline callers identified as American Indian/Alaskan Native.
  - Nearly 5% of quitline callers identified as LGBT
  - 8% of quitline callers identified as Hispanic/Latino.
  - 42.8% of unique tobacco users who received evidence-based services (counseling and/or medications) reported a behavioral health condition
  - 50% of quitline callers stated they were either uninsured or enrolled in Medicaid.
- For more information about quitlines, visit the North American Quitline Consortium’s website at www.naquitline.org

Quitlines: Not just Telephone Counseling

The 2017 survey found:
- 94.3% offer proactive telephone counseling
- 93.9% offer web-based self-help
- 63.3% offer interactive web-based counseling
- 55.1% offer interactive test messaging
- 10.2% offer a mobile app

www.naquitline.org

Key Points:

## Treatment Efficacy by Modality

<table>
<thead>
<tr>
<th>No format/treatment</th>
<th>10.8% est. abstinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-help</td>
<td>12.3%</td>
</tr>
<tr>
<td>Proactive telephone counseling</td>
<td>13.1%</td>
</tr>
<tr>
<td>Group counseling</td>
<td>13.9%</td>
</tr>
<tr>
<td>Individual counseling</td>
<td>16.8%</td>
</tr>
</tbody>
</table>

- Proactive telephone counseling, group and individual counseling formats are effective (Strength of Evidence = A)
- Interventions delivered in multiple formats increase abstinence rates and should be encouraged (Strength of Evidence = A)

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**Key Points:**

- There is no evidence that one modality is best – individual needs and characteristics of the tobacco user must be considered
- Remember that these data are based upon clinical trials that typically include a high proportion of people motivated to quit. This accounts for the high (10.8%) abstinence rate with no treatment.
- 2016 Cochrane review of studies of individual counseling (at least 1 in-person visit of 10 minutes or more) efficacy found abstinence rates of 10-12% compared with a control rate of 7% at 6 months. These studies did not systematically provide pharmacotherapy. (Lancaster and Stead, 2016).
- 2017 Cochrane review of studies of group counseling compared individual face-to-face counselling found there was not enough evidence to evaluate whether groups are more effective, or cost-effective, than intensive individual counselling.
- A recent (2018) paper by Kotsen et al. offered a narrative review of group treatment outcomes from real world practice settings and concluded that group treatment is “feasible in various settings with good results” and “likely to be at least as effective as intensive individual treatment.” (Kosten C, et al., 2018).
All counseling types are effective

Studies comparing modalities have concluded:
- Each modality “plays a part in assisting populations of tobacco users in quitting”
- Different modalities may appeal to different tobacco users

Any counseling modality may be combined with pharmacotherapy to increase cessation rates

### Key Points:
- The PHS Guideline states that “Proactive telephone counseling, group counseling, and individual counseling formats are effective and should be used in smoking cessation interventions.” (Strength of Evidence = A). It goes on to note that cessation “interventions delivered in multiple formats increase abstinence rates and should be encouraged” (Strength of Evidence = A).
- Given that all types may be effective, it’s important to consider patient preferences.
- Preferences differ for tobacco users; for example, younger tobacco users may be more attracted to web or text-based programs, quitline is accessible to those who cannot attend in-person counseling.
- Costs: coverage varies, but group counseling is less likely to be covered by commercial payers.

### Background:
- Lawrence An and colleagues in MN reported on enrollment by current smokers, self-reported 30 day abstinence, and cost per quit. They also calculated reach per modality. Results: Enrollment was greatest for the website, followed by the helpline, treatment centers, and work sites. Helpline attracted more “socially disadvantaged smokers”. Web site attracted younger smokers. 30 day quit rates: helpline (29.3%), tx centers (25.8%), work sites (19.6%), web (12.5%)
- Hughes article: Comparison of in-person counseling, phone and web-based treatment programs in Vermont. Conclusion: reach, outcomes similar for all modalities. Clinics
serve more dependent smokers.

References:
Lawrence An et al (2010), Hughes, Suiter & Marcy (2010)
Internet-Based Treatment

- Include self-directed cessation materials, interactive counseling or coaching, chat rooms, automated email messages
- Social media sites (Facebook, Twitter)
- Can complement other evidence-based interventions

Can be effective – but not all are evidence-based. Check them out before referring.

Key Points:
- Research on web-based treatment programs has increased over the past few years.
Internet Programs: Do They Work?

- Recent meta-analysis found that interactive and tailored programs led to higher quit rates than usual care.
- Offering treatment via the internet may:
  - Increase accessibility of treatment
  - Allow for tailoring of materials
  - Be disseminated at low cost
  - Offer anonymity to users
- Limitations - Not all are evidence-based; less likely to be used by certain populations

Key Points:
- In a meta-analysis, Taylor et al. reported that “In combined results, Internet programs that were interactive and tailored to individual responses led to higher quit rates than usual care or written self-help at six months or longer.” They did not find that they were more effective than counseling.
- Some of the strengths of using the internet to provide treatment may include accessibility, low cost, option for tailoring, anonymity.
- May be particularly helpful with populations that are frequent internet users, like youth or college students.
- Limitations include the fact that not all are evidence-based, and it may be difficult for tobacco users to discriminate among the available sites.
- Randomized trial comparing internet with internet + pro-active telephone counseling found higher quit rates in the internet and telephone intervention.
Mobile apps may be effective

- Cochrane Review: Smokers using apps/texting programs were 1.7 times more likely to have quit at 6 months compared to no program

Not all apps are evidence-based

- Many providers are unsure of apps to recommend

Key Points:
- Mobile phone applications are increasing. There are hundreds available on iPhone and Android platforms.
- In 2017, 95% of adults owned a mobile phone. The proportion of mobile phone ownership is greater than 85% in every age, racial/ethnic, education, income, and geographic subgroup surveyed.
- Over 60% of these have used it to look up a health condition (Smith, 2015).
- Many providers are unsure of apps to recommend due to concerns about quality and validity (Boudreaux et al, 2014)
- Mention of medications is often missing from apps.
- Whittaker et al’s Cochrane review analyzed 12 studies with 6 month smoking cessation outcomes, 6 of which were biochemically verified. 9.3% of smokers quit with programs compared with 5.6% quit with no programs. While the overall relative risk was 1.67 (95% CI=1.46-1.90), the relative risk of those which were biochemically verified was higher: 1.83, CI=1.54-2.19. Caveat is that most studies of message interventions were implemented in high-income countries with good tobacco control policies.

References,
Mobile phone – Text Programs

Smokefree.gov: SmokefreeTXT
- Text “QUIT” to 47848
- Specialized text programs for teens, moms, veterans; also in Spanish
- Text message library is available for download: [http://www.smokefree.gov/hp.aspx](http://www.smokefree.gov/hp.aspx)

The Truth Initiative:
- E-cigarette program: Text “QUIT” to (202) 804-9884
- “This is Quitting”: Text “Quitnow” to (202) 759-6436

Key Points:
- Here are some examples of text programs
Mobile-phone Applications

7 strategies for evaluating and selecting apps:
1. Review the scientific literature
2. Search app clearinghouse websites
3. Search app stores
4. Review app descriptions, ratings, reviews
5. Conduct a social media query within professional and patient networks
6. Pilot the apps
7. Elicit feedback from patients

Boudreaux et al, 2014

Key Points:
- If you are interested in recommending an app review it for evidence-based components, as suggested in the slide:

1. Review the scientific literature: Search the scientific literature for papers reviewing apps in a content domain or strong clinical trials
2. Search app clearinghouse websites: Clearinghouses that review apps can help with identifying strengths and weaknesses
3. Search app stores: App stores are challenging to navigate, so it is important to fine-tune and filter app searches with the most relevant and targeted key words, including words keyed to the pathological state or target behavior
4. Review app descriptions, user ratings, and reviews: Publicized ratings and user reviews can offer evidence of app usability, functionality, and efficacy, which can help to narrow the pool of candidate apps
5. Conduct a social media query within professional and, if available, patient networks: Social networks may reveal new app trends, likability by certain user groups, and other substantive data
6. Pilot test the app: Apps may be piloted by the healthcare provider or a designee,
including examinations of functionality, accuracy of content, and usability

7. Elicit feedback from patients: Patients may be able to provide valuable insights after they have used the app. A provider recommends

Recommends
Harm Reduction

“A set of practical strategies with the goal of meeting drug users 'where they're at' to help them reduce any harms associated with their drug use" (Marlatt, 1998)

Key Points:

1. Another type of intervention strategy:
   - not all smokers will embrace the goal of total abstinence from nicotine. For this reason, policy makers and clinicians alike have debated the relative merits of a harm reduction model although it remains somewhat controversial.
   - The concept of harm reduction has been around for quite a long time in the fields of substance abuse and HIV/AIDS prevention, in the form of needle exchange programs, methadone maintenance or safe sex campaigns. It hasn’t been until fairly recently that this concept has been discussed in relationship to tobacco use.

2. What is the concern about harm reduction?
   - Harm reduction strategies may actually compete with abstinence as a goal of treatment.
   - For certain people of populations of smokers (e.g. schizophrenics) harm reduction may be the most viable course of action.

3. How can we apply harm reduction to tobacco? (Brainstorm ideas)
Applications of Harm Reduction of Smoking

- Change policy: limiting access
- Change tobacco use practices: controlled smoking
- Use NRT in places where smoking is not allowed or for long term use
- Change the nature of tobacco products (making a "less hazardous" cigarette)
- Switch tobacco/nicotine products (Snus, e-cigarettes)

Key Points:

1. **Policy changes**: By restricting or limiting access to tobacco: smoking bans at work and other public places, for instance. Reduces amount smoked.

2. **Changing tobacco use practices**: a smoker only allows himself to smoke in certain rooms of the house and at certain times of the day. Reduces amount smoked in a staged fashion.

3. **Using NRT to reduce risk**, e.g., chewing gum as a substitute for smoking, particularly in situations where smoking is not allowed, or staying on an NRT product for beyond the 3 month therapeutic period.

4. **Product changes**, such as using SNUS or e-cigarettes instead of combustible tobacco. There are opposing views on the using these products as reduced harm products.
What about e-cigarettes?

**Concerns**
- Unknown health effects
- Re-normalization of smoking
- Uptake by youth
- Lack of quality control
- Fire hazard

**Possible benefits**
- Reduction of exposure to CO and tobacco carcinogens
- Possible cessation tool, appealing to smokers
- Regulation by FDA

**Key Points:**
- Harm reduction implies long-term use of e-cigarettes in place of combustible tobacco products (cigarettes, cigars, pipes)
- Use as a cessation tool will be discussed in the Pharmacotherapy module
- There has been a great increase in use of e-cigarettes by youth since 2011: 11.7% of high school students reported using e-cigarettes in 2017 compared to 1.5% in 2011.
- FDA rule extends its regulatory authority to all tobacco products, including e-cigarettes, cigars, and hookah and pipe tobacco. It bans sales to youth under 18 and requires age verification. Manufacturers of newly regulated tobacco products not on the market as of February 15, 2007, will have to show that products meet the applicable public health standard set by the law. Those manufacturers will have to receive marketing authorization from the FDA, although they are expected to have up to 2 years (from 8/2016) to submit a new product application.
- TIP to Instructor: encourage discussion of this topic but limit the amount of time spent.

Objective

Discuss systems and program components of tobacco treatment

Key Points:

- Treatment occurs within the context of a larger system and requires appropriate support and a place within the system
System: Definition

System refers to formal and informal processes and procedures within an institution

Key Point:
- The term ‘system’ refers to institutional level issues, beyond an individual client or provider.
- This may include both formal and informal processes and procedures as well as attitudes that influence how tobacco treatment is perceived.
System: External Influences

<table>
<thead>
<tr>
<th>Quality Measures and Regulatory Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Commission - Hospitals</td>
</tr>
<tr>
<td>MACRA - Medicare Access and CHIP Reauthorization Act</td>
</tr>
<tr>
<td>Affordable Care Act - Insurance</td>
</tr>
<tr>
<td>Health Resources and Services Administration (HRSA) - Community Health Centers</td>
</tr>
<tr>
<td>National Commission for Quality Assurance - Patient-Centered Medical Home</td>
</tr>
<tr>
<td>Commission on Accreditation of Rehabilitation Facilities - Behavioral Health and Rehabilitation Services</td>
</tr>
<tr>
<td>Reimbursement</td>
</tr>
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</table>

**Key Points:**
- These are some examples of regulations and quality measures that may impact policies and procedures
- Understanding relevant regulations can help TTS recognize opportunities for implementing policies that support tobacco dependence treatment
- According to CMS, “quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.”
- Payment linked to quality can incentivize health systems and providers
Key Points:
- The Joint Commission (JC) requirements for hospitals are currently optional.
- The 4th tobacco measure: TOB 4 (assessing status after discharge), was retired as of 2018.
- According to Joint Commission staff, as of March 2016, 768 hospitals out of 3,705 are now reporting their performance on the tobacco cessation measure set (Fiore and Adsit, 2016).
- If hospitals are considering enhancing tobacco dependence interventions it may be wise to follow JC standards.
- The Joint Commission has issued a statement regarding use of electronic cigarettes in hospitals: “In accordance with standard EC.02.01.03, smoking, regardless of type of smoking, is prohibited. There are provisions for allowing smoking in specific circumstances, which may include a designated smoking room with appropriate exhaust and fire safety features. These locations are to be physically separated from care, treatment and service areas.”
**CMS: MACRA**

- Medicare Access and CHIP Reauthorization Act of 2015
- Impacts Medicare payments to providers (value-based care)
- May drive change in office systems by encouraging a team-based approach to care
- Tobacco use may factor into several quality measures

**Key Points:**

- Over the last five years, the Centers for Medicare and Medicaid Services (CMS) has implemented several payment programs that cut Medicare physician payment rates in response to lack of compliance with CMS definitions, measures and processes; commercial payers have followed suit.
- MACRA encourages value-based care: payments are partially linked to patients’ and/or... , unlike traditional fee-for-service care models.
- May encourage a team-based care approach, including the use of telehealth, integration of behavioral health in primary care, consideration of the patient’s trajectory across the continuum of care (e.g., coordination of those with chronic conditions, surgical continuum of care).
- Payment systems: Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APM).
- Providers select Quality metrics on which to report. Tobacco use may impact selected quality measures, such as control of IVD, preventing avoidable hospital readmissions and emergency department visits. MIPS has two tobacco-specific measures: Tobacco use screening and cessation intervention, and Tobacco use and help with quitting among adolescents.
- This was implemented in Jan 2017 -- and we will need to see how practices choose to implement quality measures.
Affordable Care Act: Benefits

Medicare:
- Prevention & wellness visits
- Closing Medicare Part D donut hole

Medicaid:
- Tobacco treatment for pregnant women (2010)
- Expanded coverage for adults, including medications (2014)

Exchanges & Employer-sponsored
- Required to cover all US Preventive Services Task Force ‘A’ & ‘B’ recommendations
- Recommendations issued May 2014

Key Points:
- The ACA has increased coverage for tobacco treatment for pregnant women in all states
- In states who have expanded Medicaid coverage there are also requirements to expand tobacco treatment coverage – implementation varies and participants will need to check with their own states for specifics.
- The recommendations issued in May 2014 for Exchanges and Employer sponsored plans are NOT requirements – they are just recommendations.
- It is recommended that all TTS view the recording of the webinar at Smoking Cessation Leadership Center to understand the current status of recommendations.
Key Points:
- Even with strong external motivators there need to be internal resources and support for implementing tobacco dependence interventions.

Ask: (large group) how do these internal influences impact the provision of nicotine dependence treatment?
Cochrane review found that implementation of EHRs typically showed positive effects on outcomes:
- documenting smoking status
- giving advice to quit
- assessing interest in quitting
- providing assistance including referral to quitline

Unable to conclude that EHR support has impact on cessation rates

Consider EHR functionality, workflow, roles of staff members

**Key Points:**

- EHRs can prompt provider to perform and document interventions, although other aspects of the system (staffing, workflow, priority of interventions) impact their use.
- Cochrane review studies “included six group randomized trials, one patient randomized study, and nine non-randomized observational studies of fair to good quality.”
Key Points:
- These are the areas to review when conducting an assessment of the existing system
- An assessment is the first step in making changes
- The Handout section of the module includes a template that can be used for assessing a system
- Trainers are encouraged to inform participants of any local/state resources that are available to help with system change
### Discussion: Challenges and Opportunities

1. What are the systems issues and barriers that complicate providing tobacco treatment to your clients?

2. List possible suggestions for addressing these issues to make the system more supportive of tobacco treatment for all clients

### Key Points:
- Remind participants that ‘system’ refers to policies and procedures - not client behaviors or motivations

### Activity:
- Group participants according to agency types that are represented in the group. Examples include:
  - In-patient medical setting
  - Out-patient medical
  - In-patient mental health
  - Out-patient mental health
  - In-patient substance abuse
  - Out-patient substance abuse
  - Insurance based wellness program
  - Disease management program
- Ask group to assign a recorder of the discussion
- Allow 10 minutes for initial discussion
- After 10 minutes notify groups that 5 minutes remain and remind them to list possible suggestions for addressing the issues identified
- Debrief with the large group – begin by asking each group to state one issue and suggested actions. Rotate among groups as time allows.
- As issues are identified ask for clarification, specifics on action items and offer relevant guidance and experience.
Key Points:
- This section will review some recommendations for the administrative components of a treatment program implementation
- These components are based upon expert opinion. Trainers are encouraged to integrate their own experience with these components
Documentation

Document client progress and counselor actions

- Include time spent on counseling
- Examples: SOAP notes, sample on Members Only web page
- EHR – include searchable fields to facilitate reporting
- Access to HIPAA compliant release of information forms and protocols

Key Points:
- Participants who are planning to pursue certification will find that thorough documentation will be helpful when writing the case study.
- Documentation of tobacco treatment services should be managed in a manner similar to all other clinical services provided.
- Determine a standard format that is easy to use and clearly/succinctly records treatment provided.
- See the sample provided in the Handout section. Information included:
  - Patient’s name and some descriptive information about that person.
  - Date, provider, duration and type of service.
  - Patient’s current smoking status.
  - Description of SPECIFIC treatment provided.
  - Description of treatment progress.
  - Current meds being used for tobacco treatment (Type(s) and dose given).
  - Follow-up plan. - All communication with other providers
### Example of Documentation

**Individual Session Clinical Note**

<table>
<thead>
<tr>
<th>Client Unique Id</th>
<th>Date of Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session #</td>
<td>Time In</td>
</tr>
<tr>
<td></td>
<td>Time Out</td>
</tr>
<tr>
<td>Client’s Quit Date</td>
<td>Type of tobacco</td>
</tr>
<tr>
<td></td>
<td>Amount used today</td>
</tr>
<tr>
<td></td>
<td>Tobacco-free for # weeks</td>
</tr>
</tbody>
</table>

**Clinical Note:**
- Patient’s name, descriptive information
- Patient’s current tobacco use status (including e-cigs)
- Description of SPECIFIC treatment provided
- Description of treatment progress
- Follow-up plan
- Communication with other providers

**Medication:**
- Type
- Dose
- Frequency

Clinician Signature

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Evaluation: Why Evaluate Your Program?

Scenario:
You are the only TTS at a busy behavioral health clinic. For the past 6 months you have offered both individual and group counseling to tobacco users. Clients are referred to you by other clinicians. Your supervisor asks you to report on your tobacco dependence treatment program.

What do you want to know about your program?
What data do you need?

Large group Q & A (< 5 minutes)
• Discussion may include:
  • How many people have you see for one on one counseling? In group counseling?
  • How many total tobacco users are in your setting? What percentage are being referred to you?
  • Which departments/clinicians/programs are referring their clients for treatment?
  • Have you received reimbursement for counseling?
  • What % of referrals complete an intake? What % of those clients return for counseling?
  • How many clients make a quit attempt? How many are still quit at 6 months? 1 year?
Evaluation – What is Working? What Isn’t?

System level components
- How successful are your marketing efforts – internal and external?
- What are your average (monthly, weekly) enrollments/intakes?
- Where do most of your referrals come from – who are you missing?
- Reimbursement?

Client level components
- What can I learn from my clinical/supervision notes?
- Are my clients satisfied with the service they received?
- How successful are my clients at quitting smoking?

Key Points:
- Evaluation is critical to building a successful program
- Be sure to consider both system level components and clinical evaluation of client related issues
- Review any points not considered during discussion with prior slide
<table>
<thead>
<tr>
<th>Client Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who should I follow-up?</strong></td>
</tr>
<tr>
<td>All clients who complete enrollment/intake</td>
</tr>
<tr>
<td><strong>When should I follow-up?</strong></td>
</tr>
<tr>
<td>6 months after quit date? 12 months?</td>
</tr>
<tr>
<td><strong>How do I ask the right questions?</strong></td>
</tr>
<tr>
<td>Ex: NAQC – Minimal Data Set for Quitlines</td>
</tr>
<tr>
<td><strong>Who should collect the information?</strong></td>
</tr>
</tbody>
</table>

**Key Points:**
- These recommendations are adapted from standards for research protocols
- In this context follow-up refers to assessing outcomes, not additional clinical service
- Ex: NAQC – Minimal Data Set for Quitlines is available online and can be modified for in-person counseling
- Who should collect the information? If possible - someone other than the counselor. Include option to request follow-up by the counselor
- Trainers should include discussion of their own successful systems

**References:**
Hughes et al, 2003; Hughes et al, 2010; Star et al, 2005; West et al, 2005
Client Follow-Up (cont’d)

What do I need to know?
- 7-day point prevalence abstinence
- Prolonged abstinence
- Other nicotine use
- Self-report or biochemical validation (cotinine, CO)

How do I report the results?
- Clearly define the denominator
- How are those lost to follow up counted?

Notes:
- 7-day point prevalence abstinence = No smoking during the 7 days prior to the follow-up contact
- Prolonged abstinence = Sustained abstinence after an initial grace period
- Biochemical validation: cotinine testing (blood, saliva, urine) or CO monitor. Test strips can be used for urine or saliva cotinine testing in outpatient settings.
- Review each of these points briefly.
In the past year, 100 tobacco users registered for your “Quit Tobacco” groups
40 completed all 6 sessions
6 months after treatment you call those 40 participants and reach 30 of them.
15 report not using any tobacco within the last 7 days
Is quit rate 50% (15 out of 30), 37.5% (out of 40), or 15% (out of 100)?

Key Points:
• Make sure that denominator is clearly defined when reporting outcomes.
• “Intention to treat” – all clients enrolled are part of the denominator.
Billing – Medicare
“Counseling to Prevent Tobacco Use”

- Covers Medicare beneficiaries who use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
- 2 attempts per year (12 month period)
- Each attempt may include a maximum of 4 intermediate or intensive counseling visits
  - Intermediate smoking and tobacco-use cessation counseling visit = 3-10 min per session
  - CPT code 99406
  - Intensive counseling visit = >10 min per session
  - CPT code 99407

Key Points:
- Billing is especially challenging for tobacco dependence treatment
- Medicare billing is tightly controlled. Reimbursement rates are extremely low and utilization seems to be low.
- Medicare has helped to establish some criteria and CPT codes to be used. These codes may be useful as other insurance plans determine how best to meet the recommendations of ACA.
- Copayment/coinsurance and deductibles are waived with CPT codes listed on slide.
- Covered whether or not symptoms of tobacco-related disease are present.

Qualified providers may bill for cessation treatment services

- E.g.: Physicians, nurse practitioners, physician assistants, clinical social workers, clinical psychologists
- Services ‘incident to’ physician services may be covered

Tobacco Treatment Specialists are not considered “qualified providers” unless holding another license which would fall into this category

Key Points:

- Services provided by a non-qualified provider that are incident to services being provided by a qualified provider may possibly be covered under code 99211: “Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.” Talk to your organization’s billing department for more information.
Billing - Medicaid

Administered by individual states, using state and federal funding

Affordable Care Act mandates comprehensive coverage for pregnant women with no cost sharing

States may differ in eligibility requirements and covered services

American Lung Association's State Cessation Coverage Database lists Medicaid policy for each state: www.lungusa2.org/cession2/

Key Points:
- Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.
- States may implement barriers to treatment including: not covering all pharmacotherapies, requiring prior authorization for treatment, allowing cost-sharing, implementing treatment caps.
- Visit http://www.lungusa2.org/cession2/ to learn more about coverage in your state
Billing – Private Insurance

Many cover at least one medication and some behavioral intervention

Billing code categories:

- **Diagnosis codes (ICD-10)**
  - F17.2XX – Codes for specific tobacco dependence
  - Z codes – No current dependence

- **Procedure and Service codes (CPT)**
  - 99406 – Intermediate counseling
  - 99407 – Intensive counseling

- **CO testing – possible CPT Code:**
  - 94250 (expired gas determination)

**Key Points:**

- American Lung Association’s 2018 billing guide lists codes
- Consider billing for Carbon Monoxide testing.
- There may be co-pays/cost-sharing for some services.

Billing - Challenges

- Treatments may be limited (# of sessions, # of attempts/year)
- Medicaid coverage varies by state
- Private insurance plans required to provide tobacco cessation counseling; benefits may vary
- Possible co-payments for patients
- Low rates for reimbursement
- Defining qualified provider

Williams, 2016;
AAFP Coding Information webpage

Key Points:

- Rates for reimbursement of service may be low. Other substance use disorders have codes that allow for longer screening and higher reimbursement.
- Private insurers are required to provide evidence-based tobacco cessation counseling and interventions to all adults and pregnant women, but benefits are subject to specific plan policies. They are not required to cover all counseling modalities or pharmacotherapies.
- Be aware that even if service is covered there may be a co-payment. Clients may check with their insurer to determine any cost-sharing.
- If an agency is implementing new processes to bill for tobacco treatment there must be plans for how to handle billing to patients if cost is not covered.

Key Points:
- This section focuses on the tasks and responsibilities of the TTS as a professional
Role of the TTS

- Core Competencies
- Code of Ethics
- Professional development resources
- UMass TTS Training Final Exam
- TTS Credentialing

Key Points:
- Each of these topics will be covered

Background:
Trainers must become very familiar with all the forms and documents related to the ATTUD Competencies, training final exam protocol, and TTS credential.
**TTS: 11 Core Competencies**

1. Tobacco Dependence Knowledge and Education  
2. Counseling Skills  
3. Assessment Interview  
4. Treatment Planning  
5. Pharmacotherapy  
6. Relapse Prevention  
7. Diversity and Specific Health Issues  
8. Documentation and Evaluation  
9. Professional Resources  
10. Law and Ethics  
11. Professional Development  

*ATTUD. Standards of Practice for Tobacco Treatment Specialists, 2005  
http://www.attud.org/tts.php  
TTS – Guidelines for Systems and Professionals*

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**Key Points:**

- This training program has been designed to address all of these competencies.
- Details of each competency can be found on the ATTUD website listed on the slide and also in the handouts section.
- The competencies were first described by UMass and the Massachusetts Tobacco Control Program. ATTUD refined and endorsed these in 2005.
- Role as a TTS may include educating others in your organization about evidence-based interventions, including pharmacotherapy, and organizational systems to support those interventions.

**Note:** TTS in organizations may find resistance in using their knowledge and/or being seen as a resource about tobacco dependence treatment. For example, TTS have been met with resistance in suggesting pharmacotherapy to clients or advocating for changes in data collection and evaluation. If you have time, ask participants to reflect on challenges they may have had, and ask others how they have successfully overcome those challenges.
A tobacco treatment specialist will strive to maintain the highest level of professional competence and professional and personal conduct and will:

- Respect the privacy, dignity and culture of all individuals and ensure fair and equitable treatment of all individuals.
- Provide people with all relevant and accurate information and resources so they may make their choices freely and intelligently.
- Observe principles of informed consent and confidentiality of individuals.

**Key Points:**
- Review each point briefly. Will discuss all at end of section.
TTS Code of Ethics

- Be truthful in dealings with the public, never misrepresenting or exaggerating potential benefits or services.
- Avoid activities which may be or may be perceived to be a conflict of interest or unethical in nature.
- Maintain the highest level of competence through continued study and training.

Key Points:
- Review each point briefly.
TTS Code of Ethics

Accurately represent capabilities, education, training and experience, and act within the boundaries of professional competence, recognizing one’s limitations and seeking help or providing appropriate referrals when confronted with issues of mental illness or psychosocial problems that the TTS may not be trained to handle.

What ethical dilemmas have you or a colleague faced?
What are some ways you could handle them?

Key Points:
- After reviewing, ask if participants have any examples of ethical dilemmas they have faced and how they were handled.
- Suggestions for discussion:
  - Your client has begun to ask personal questions of you and asks to follow you on your personal social media accounts.
  - You disagree with the care given to your client by another provider, and you tell your client why the provider is wrong.
  - Your client tells you that she is being treated by a licensed therapist for a behavioral health disorder, but she would prefer to work with you on those issues because you "seem to understand." You do not have training as a counselor/therapist.
ATTUD is an organization of providers dedicated to the promotion of and increased access to evidence-based tobacco treatment for the tobacco user.

Free 6-month trial membership for new members completing an approved training

- Includes listserv access

www.attud.org

Key Points:

- Encourage participants to take advantage of the free trial membership in ATTUD – available only for first time members
- Trainers may wish to express the benefits they have experienced through ATTUD membership
Professional Development: Clinical Supervision

- Identify a clinical supervisor or peer support group
- Establish a regular meeting structure
- Use supervision time to:
  - review difficult cases
  - discuss limiting or terminating treatment
  - ensure attention to cultural issues
  - check in about professional boundaries as needed

Key Points:
- One key component of professional development
- Discuss briefly what resources participants have for clinical supervision or peer support. This is often challenging for TTS
- Encourage creative options to obtaining feedback. Some examples include: telephone-based review, peer supervision/case reviews.
- Review benefits of clinical supervision such as: objective look at the treatment, reviewing client progress, and self-care.
- The intensity/frequency of supervision will vary according to the setting TTS are working in.
Professional Development: Cultural Competence

- Acknowledge cultural differences
- Learn about your client’s culture
- Consult with community leaders, traditional/indigenous healers as appropriate
- Modify treatment to meet cultural needs

Sample resources:
- National Center for Cultural Competence: https://nccc.georgetown.edu/

Key Points:
- All modules will include reminders about the importance of adjusting tobacco treatment to the culture of the clients being served
- It is not possible to address all cultures specifically in this training
- The National Center for Cultural Competence has many resources
Professional Development: Working with Adolescents

- Research is limited
- PHS Guideline found counseling to be effective
- Adolescents are very interested in quitting but have low rates of success
- Best practices in counseling include:
  - 5A’s at health care encounters
  - Provide concrete and accessible support and resources
  - Tailor suggestions to client
  - Consider pharmacotherapy

Key Points:
- Many barriers to effective counseling exist. A survey of American Academy of Pediatrics members found that while most advised their adolescent patients who smoke to quit, only 1/3 discussed quitting strategies, 20% offered print or other materials, and 18% referred to a quitline.
- Many pediatricians felt they would be more likely to counsel if they felt it to be effective, if they felt confident, and if they believed that patients would not be fearful that their parents would be notified.
- There is a text program specifically designed with youth in mind: SmokefreeTXT. http://teen.smokefree.gov/smokefreetxt.aspx
- Pharmacotherapy may be considered for youth who want to quit, have moderate to high nicotine addiction and are interesting in trying it.

Source: Pbert, 2015; Fiore, 2008
Key Points:
- Many professional associations have published statements supporting the importance of addressing tobacco use
- These statements may be helpful when working with leadership in various agencies

Background:

NAADAC – Position Statement on Nicotine Dependence
• All patients presenting for substance abuse services be screened and assessed for tobacco use and, where applicable, that a tobacco or nicotine diagnosis, using DSM-IV or ICD 9 criteria, be made in the patient’s chart.
• Tobacco dependence be included in the treatment plan for every patient to whom it applies
• NAADAC strongly supports and encourages the provision of tobacco education within the addictions treatment milieu.
• Staff not be identifiable as tobacco users during working hours or when representing the treatment facility

https://www.naadac.org/position-statement-nicotine-dependence

• The availability of tobacco products to the young should be controlled through the establishment of an enforced, national minimum age of 21 years for purchase
• All hospitals and medical schools should address nicotine addiction on a par with other chemical dependencies and establish completely tobacco-free buildings and tobacco-free grounds throughout their entire campuses.
• All clinicians should be trained to screen for nicotine addiction when they do medical evaluations, including assessments for other chemical dependencies.
• Treatment plans should address nicotine addiction as it would address any other addiction, and appropriate medication should be offered to address nicotine withdrawal while the patient is hospitalized.


APNA
• Failure to Act on Tobacco Dependence Equals Harm
• APNA has supported ANA resolutions dating from 1968 (Smokers and Health)
http://www.apna.org/i4a/pages/index.cfm?pageid=3827

NASMHPD
  www.nasmhpd.org
Resources: Treatment for Priority Populations

- Vulnerable populations: racial ethnic groups, LGBT communities, low SES
  - Smoking Cessation Leadership Center (SCLC)
  - Consortium of National Networks to Impact Populations Experiencing Tobacco-Related and Cancer Health Disparities (CDC)
- Behavioral health, Substance use
  - Smoking Cessation Leadership Center (SCLC)
  - Learning about Healthy Living (LAHL)
- Pregnancy
  - American College of OB/GYN’s Smoking Cessation Toolkit
- Armed Forces/Veterans
  - An Implementation Guide for the Armed Forces

Key Points:
- There are numerous resources available for delivering tailored, targeted tobacco treatment for priority populations.
- This slide lists a number of resources for providers and websites are provided in the Appendix.
- This list is not exhaustive, there are many other resources available.
- TTSs are encouraged seek our resources to learn about the population(s) served.
Key Points:
- In addition to ATTUD there are other professional resources
- SRNT requires membership
- Treatobacco.net is a free website
Resources: Clinical

Public Health Service Clinical Guideline: Treating Tobacco Use and Dependence (to order hard copy)
National Cancer Institute (NCI) 800-4-CANCER

Rx for Change: [http://rxforchange.ucsf.edu](http://rxforchange.ucsf.edu)
- Free (registration required) resource for training materials

Smoking Cessation Leadership Center:
[http://smokingcessationleadership.ucsf.edu/](http://smokingcessationleadership.ucsf.edu/)
- Webinars, publications, clinical protocols
- Behavioral health resources

Key Points:
- The PHS guideline can be downloaded from various websites. There are limited hard copies available now and the best resource is NCI
- Trainers and TTSs are encouraged to register with Rx for Change for free access to many training materials
- Smoking Cessation Leadership Center is especially helpful for TTS in behavioral health settings
UMass TTS Core Training
Final Step:
Exam
Online Course Exam

- Administered online
- Must be completed within 6 weeks to receive certificate of completion
- Detailed instructions on how to access the exam will be e-mailed on the first business day after the completion of the course
- Closed book test with two parts:
  - Part one: ~ 60 multiple choice (1 ½ hour time limit)
  - Part two: Short answers and one case study (1 hour time limit)

Key Points:
- The TTS Exam is administered online
- Participants will be e-mailed detailed instructions on how to access the course.
- It will be important for participants to complete the exam registration PRIOR to the time at which the plan to take the exam. We recommend registering for the exam as shortly after receiving the email with instructions.
- No books or resources should be used during the exam, and the exam must be taken independently.
- Passing grade is 75%. Exam may be re-taken after a 3 month waiting period.
- Advise participants requesting accommodations to speak with trainer.
- Upon successful completion of the training participants may use the term tobacco treatment specialist as a title but not as a credential for example:

  Joan Doe, RN
  Tobacco Treatment Specialist
Tobacco Treatment Specialist Credentialing:
National Certificate in Tobacco Treatment Practice (NCTTP)
National Certificate in Tobacco Treatment Practice—Exciting News!

The Association for Addiction Professionals (NAADAC) in collaboration with The Association for the Treatment of Tobacco Use and Dependence (ATTUD) has announced the establishment of a National Certificate in Tobacco Treatment Practice (NCTTP).

The NCTTP will replace the varied certification programs previously existed.

This is exciting news for our profession! This unified credentialing process is an important step to enhance the professionalization and recognition of tobacco treatment as a specialty.

We encourage you to apply! The application and listing of requirements is available at https://www.naadac.org/nctp

Key Points:
Tobacco Treatment Training Requirement

- Completion of a TTS training program that is accredited by the Council for Tobacco Treatment Training Programs (CTTTP) is one of the eligibility requirements.

- You will receive a Document of Completion by email with your exam score if you have successfully completed the UMass TTS Training Program:
  - Complete Basic Skills for Working with Smokers and score 75% or better on final quiz
  - AND Complete TTS Core Training and score 75% or better on the TTS Exam

- An application and listing of requirements is available at [www.naadac.org/ncttp](http://www.naadac.org/ncttp)