Low-Burden Tobacco Cessation Strategies and Strategic Community Partnerships

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Conflicts of Interest Disclosure

The presenter has no conflicts of interest, financial or otherwise, to disclose concerning the contents of the following presentation.
Session Objectives

• Define “low-burden”
• Provide several concrete actions that can be taken to provide effective and efficient tobacco cessation services
• Provide resources to support rapid improvement planning
Low-Burden

1. Benefits delivered (e.g., patient health outcome improvements) are worth the costs incurred.
2. Benefits are understood and appreciate by those who perform the services.
PLANNING 1: Where Are Going?
Some Back of the Envelope Calculations

- ~800,000 tobacco smokers in Arizona
- 75% want to quit within the year (600,000)
- 65% have tried to quit in the last year (520,000)
Misconception of BH Prevalence Rates

- Greater Need to Smoke
- Greater Need Depresses Desire to Quit
- Reduced desire to quit reduces success rates
- Higher Prevalence
- Stigma
- Low SES
- Discrimination
- Chronic Stress
- Psychological Distress
- Coping Skills
- Environmental Exposure
- Industry Targeting
- Biology
- Access to Treatment

- Addiction
- Incarceration
- Recidivism
- Relapse
- Poor Health
Tobacco Industry Targeting

- In 2011, tobacco companies spent $8.8 billion on advertising and promotional materials
- Tobacco companies sought out individuals with limited resources to cessation services
- Promoted smoking in treatment settings
- Monitored or directly funded research supporting the idea that people with schizophrenia need to smoke to manage symptoms

For every $1 the state spends to reduce tobacco use, $18 is spent by tobacco companies to promote their products.
Neighborhood Level Effects

- Higher density of tobacco retail outlets
- More aggressive POS marketing
- Neighborhoods targeted for direct mail of coupons
- Higher prevalence of heart disease
- Higher incidence of tobacco-related self-deprivation
Quitting: It Can Be Done

Persons with behavioral health conditions:

• Are able to quit using
• 75% want to quit using
• 65% tried to quit in the last 12-months
Lack of access to services including psychiatric medications

Increased targeting by tobacco industry

Increases both numbers who smoke and the quantity smoked (higher prevalence rates and higher dependence)

Which financial and physical toll and increases the need for additional quit support

Increases the desire to quit
Interest in Quitting Drug Court Participants, Florida--2015
Some BoE Calculations

- 800,000 tobacco users in Arizona
- 75% want to quit within the year (600,000)
- 65% have tried to quit in the last year (520,000)
- 60% (312,000) did so unaided
- 7% were successful (21,840)

Group A = ~80,000
24,000

Group B = ~312,000
56,000
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>
Ask → Advise → Assess → Assist → Arrange

- Telephonic Counseling
- Group Support
- Individual Counseling
- Peer Support
- M.A.T.
PLANNING 2: Where are We?
Convene a Wellness Committee

• One of four essential characteristics of effective, long-lasting tobacco free policies
• Not a “tobacco-free committee”
• Identify, recruit, train, deploy, & maintain Wellness Champions
Wellness Committee Composition

- Neighbors
- Compliance
- Security
- Public Affairs
- Facilities Management
- Key Client Groups
- Health Education
- Human Resources
- Opponents
Analyze Your Workflow

1. Get rid of "stupid stuff"
2. Look for alignment opportunities

Getting Rid of Stupid Stuff
Melinda Ashton, M.D.

Many health care organizations are searching for ways to engage employees and protect against burnout, and involvement in meaningful work has been reported to serve both functions. According to Bailey and Madden, it is easy to damage employees’ sense of meaningfulness by presenting them with pointless tasks that lead them to wonder, “Why am I bothering to do this?” A decrease in administrative my colleagues and I had reason to believe that there might be some documentation tasks that could be eliminated. Our EHR was adopted more than 10 years ago, and since then we have made a number of additions and changes of the beholder. Everything that we might now call stupid was thought to be a good idea at some point.”

We thought we would probably receive nominations in three categories: documentation that was never meant to occur and would require little consideration to eliminate or fix; documentation that was needed but could be completed in a more efficient or effective way; and never tasks or processes...
Agency Alignment

Identify the Framing Context
- Mission & Values
- Co-Occurring/ Dual Disorders
- Chronic Care/ Integrated Care
- CCBHC PPS removes previous restrictions

Build a Clear Rationale
- Tobacco as a Bridge

Communicate
- Intentions
- Expectations

Demonstrate Leadership
Tobacco Cessation Workflow

Front Desk/ Admin
- Screening form
- Post/place tobacco cessation promotional materials in waiting area
- Fax quitline referral preauthorizations
- Billing

Clinician/ Medical Assistant (5A's Model)
- Verify screening form & complete tobacco use assessment
- Current or recent tobacco use
- No
- Discuss sustaining abstinence and healthy living strategies
- Yes
- Utilize Motivational Interventions to Address Use*
- Visual Prompt on Exam Room Door
- CO Reading
- Onsite cessation group and/or individual counseling
- Peer services/ Patient navigator
- Collaborative treatment planning
- Preauthorizations & referrals
- Enter interventions into EHR and/or chart

Physician (2A's & R Model)
- Review screening & tobacco use assessment
- Brief counseling*
- Rx meds**
- Follow up appointment set within 1 month

* 5As algorithm
** Cessation medications protocol
DOING: A Person-Centered Tobacco Cessation Workflow
The 5A’s Model

- Ask if patient uses tobacco
  “Have you smoked our used other tobacco/nicotine products in the past month”?

- Advise in a clear, personalized manner to seriously consider quitting

- Assess if patient wants to set a quit date
  “Would you like to quit in the next month?”

- Measure CO

- Assist with accessing treatment:
  • Medications,
  • Behavioral interventions,
  • Self-help materials,
  • Referrals

- Use motivational interventions and provide brief counseling to increase motivation
  Provide education and relevant materials

- Arrange follow-up

- Yes
  - Yes: Assess for recent or lifetime tobacco/nicotine use
  “Have you ever smoked or used other tobacco or nicotine products?”

  - Yes: Yes
    - Yes: Congratulate
    - No: Provide relapse prevention counseling and congratulate
    - No: Help patient avoid second-hand smoke exposure
    - No: Stop

  - No: Yes: Assess last quit
    “When was the last time you smoked or used other tobacco or nicotine products?”
    - <1 year ago: Yes
      - Yes: Stop
      - No: Congratulate
    - >1 year ago: No
      - No: Yes: Ask if anyone else smokes around the patient
          - Yes: Help patient avoid second-hand smoke exposure
          - No: Stop

- No: Yes: Yes
  - Yes: Stop
  - No: No

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Workflow Burden

- Ask: 100%
- Advise & Stages of Change: 83%
- Motivational Intervention & Dependency: 54%
- High: 29%
- Middle: 20%
- Low: 5%
Referrals

- Accessible to consumer
- Relevant to consumer’s goals as well as their capacity
- Adequate to address consumers dependency level
- Provider should set proper expectations
- “Warm hand off” when possible
- Tour referral facilities, meet referral staff
- Create in-reach opportunities
Six-State Quitline Study
National Jewish Health

- History of a MH condition ranged from 62% in MT to 89% in ID
- Quit rates ↑ for callers without MH issues, but a substantial number of callers reporting MH also sustained quits (40% vs. 29% at 6 months)
- Outcomes appear to be mediated by how smokers feel their conditions may influence quit attempts

Lukowski et al., 2015
Become a Connection

• Contact local AHEC to determine which services they provide
• Contact local and/or state public health for access to educational, informational, instructional materials
• Reach out to nearby community behavioral health organizations to find points of overlap and areas of collaboration/cooperation/integration
Add Wellness groups

- Not necessarily tobacco-specific groups
- Use evidenced-based programs
- Opportunity to leverage peer engagement

May 2018 presentation for the National Council for Behavioral Health
Available on our YouTube Channel: youtube.com/c/BhwellnessOrg
Train Staff in Motivational Interviewing

- Applicable across behavioral change goals
- Complementary to existing skills

Why don’t people want to change?
Leverage Biofeedback

- Examples: CO monitor, metabolite screens, spirometry
- Encourages treatment plan compliance
- Non-invasive
Organizational Policy

- Policy Templates
- Policy Review
- Best Practices
- Training and Technical Assistance
- Troubleshooting
STUDY & ACT: Tobacco Cessation Evaluation
Compared to What?

• Use national, state, and county level data
• Tell stories with population data
• Set short-term and long-term goals
• Set reach goals
• Be critical, but congratulatory
Data to Action

• What should staff, directors, providers do with the numbers?
• Is this number too high? Too low?
• Compare across clinics and providers.
• Are successes replicable?
• Are low numbers the result of systemic or personal conditions?
• How does this year compare to last year? (Trend going the right way or wrong way?)
To Do List

1. Form a Wellness Committee
2. Analyze the workflow, looking for strategic alignment opportunities
3. Get rid of stupid stuff (optional)
4. Screen all clients & Advise all tobacco users to quit
5. Assess Stage of Change & dependency
6. Educate consumers on harm of tobacco use and benefits of quitting
7. Provide an NRT recommendation (not an Rx, necessarily)
8. Refer to USPSTF-recommended services
9. Follow-up with consumer about their success
10. Embed all new services into a comprehensive policy that explains the necessity and benefits of these services.
11. Use data to be responsive to consumer needs and assist staff in improving health outcomes for consumers
Resources
The Deming Cycle

PLANNING 1: Where Are Going?
PLANNING 2: Where are We?
DOING: A Patient-Centered Tobacco Cessation Workflow
STUDY & ACT: Tobacco Cessation Evaluation
Rapid Improvement Analysis

**Act**

Returning to the start, to plan how to amend the next cycle or, if it is ready, to roll out the change.

**Plan**

Planning the change that you want to put in place and predicting what will happen through the cycle. Detailed work here includes deciding what data will be collected, who will do what, when and where the change will be implemented.

**Study**

Analysing before-and-after data to see what can be learned. Compare results to the original predictions.

**Do**

Implementing the change, measuring and gathering data as planned.

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**DIMENSIONS Action Plan**

**Name:**

**DIMENSIONS Training attended:**

- Tobacco Free Policy – Fundamentals
- Tobacco Free Program – Fundamentals
- Tobacco Free Program – Advanced Techniques
- Wellness Program – Advanced Techniques
- Wellness Program – Fundamentals
- Other (specify): Build a Clinic

**Best Way to Contact You:**

- Email
- Phone

**Readiness for change (check one):**

- Ready
- We’ll need to talk

**Position (check all that apply):**

- Administrator
- Provider
- Peer Advocate

**Date:** 08-15-17

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**Goal 1:**

- Breakdown of the steps that will lead to your goal.

**Completion of Goal 1:**

- Record of the enumerated list above.

**Completion of Goal 2:**

- Filled out worksheets from Toolkit. Brief written description (or itemized list of services and supports to be put in place as a result of the long term goal).

**Signature:**

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Resources for Implementation:

http://www.bhwellness.org/resources/toolkits/

Planning for Change

Once you have assessed a person’s readiness to quit, you can start developing a plan of care. However, much of this planning involves continuing to assess individuals’ motivation and potential barriers to change. In addition, the plan needs to be individualized. Motivational interviewing techniques will be vital to assisting individuals to take the next step.

The 5 A’s: Ask, Advise, Assess, Assist and Arrange

The U.S. Public Health Service Clinical Practice Guidelines: Treating Tobacco Use and Dependence provides healthcare clinicians an online strategy for smoking cessation treatment that is built around the “5 A’s” (Ask, Advise, Assess, Assist and Arrange). Knowing that providers have many competing demands, the 5 A’s were created to keep things simple. Regardless of the patient’s stage of readiness for a cessation attempt, the 5 A’s are essential for every patient visit.

The guideline recommends that all people entering a healthcare setting should be asked about their tobacco use status and that this status should be documented. Providers should advise all tobacco users to quit and then assess their willingness to make a quit attempt. Persons who are ready to make a quit attempt should be assisted in the effort. Follow-up should then be arranged to determine the success of quit attempts. The full 5 A’s model is most appropriate for agencies and organizations that have tobacco cessation medications and/or counseling and behavioral interventions available. In particular, settings providing integrated care (primary care and behavioral health) services are ideal as they have the expertise necessary for combined cessation treatment approaches.

Regardless of the patient’s stage of readiness for a cessation attempt, the 5 A’s are essential for every patient visit.
Workflow Analysis

- Points of Contact
- Policies and Procedures
- Staff Capacity
- Staff Attitudes and Behavior
- Workflow integration
- Strategic alignment
Promotes evidence-based approaches and best practices to prevent tobacco use and cancer among behavioral health populations

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