Medicaid and the Expanded Smoking Cessation Counseling Benefit

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Disclosure Statement

I have no real or perceived vested interests that relate to this presentation nor do I have any relationships with pharmaceutical companies, and/or other corporations whose products or services are related to pertinent therapeutic areas.
Learning Objectives

• Discuss key components for intermediate and intensive inpatient smoking cessation counseling
• Describe how this smoking cessation counseling information can meet the requirements for implementing the new Joint Commission Tobacco Treatment Measures
• Describe the role of the New York State Quitline in meeting the Joint Commission Treatment Measures
Recommendations for Treating Tobacco Use

- 2008 Public Health Service Clinical Practice Guideline Update
  - Treat tobacco use as a chronic disease
  - Deliver brief clinical interventions and tailored assistance at each visit
  - Use the 5 A’s as a framework to discussing tobacco use
  - Offer approved smoking cessation medications
  - For patients unwilling to quit, increase motivation to quit by using the 5 R’s
The 5 As: Treating Tobacco as a Chronic Disease

**ASK**
Do you currently use tobacco?

**YES**
**ADVISE**
to quit

**ASSESS**
Are you willing to quit now?

**YES**
**ASSIST**
Provide appropriate tobacco dependence treatment

**NO**
**ASSIST**
Intervene to increase motivation to quit

**ASK**
Have you ever used tobacco?

**YES**
**ASSESS**
Have you recently quit? Any challenges?

**YES**
**ASSIST**
Provide relapse prevention

**NO**
**ASSIST**
Encourage continued abstinence

**ASK**
Have you ever used tobacco?

**NO**

**ARRANGE FOLLOW UP**
Counseling to Treat Tobacco Use

Brief interventions have been proved effective in increasing a patient’s motivation to quit

<table>
<thead>
<tr>
<th>Level of contact</th>
<th>Number of arms</th>
<th>Estimated odds ratio (95% C.I.)</th>
<th>Estimated abstinence rate (95% C.I.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No contact</td>
<td>30</td>
<td>1.0</td>
<td>10.9</td>
</tr>
<tr>
<td>Minimal counseling (&lt; 3 minutes)</td>
<td>19</td>
<td>1.3 (1.01, 1.6)</td>
<td>13.4 (10.9, 16.1)</td>
</tr>
<tr>
<td>Low intensity counseling (3-10 minutes)</td>
<td>16</td>
<td>1.6 (1.2, 2.0)</td>
<td>16.0 (12.8, 19.2)</td>
</tr>
<tr>
<td>Higher intensity counseling (&gt; 10 minutes)</td>
<td>55</td>
<td>2.3 (2.0, 2.7)</td>
<td>22.1 (19.4, 24.7)</td>
</tr>
</tbody>
</table>

Meta-analysis (2000): Effectiveness of and estimated abstinence rates for various intensity levels of session length (n = 43 studies)

Smoking cessation interventions for hospitalized patients: Rationale for Joint Commission Recommendations
(Rigotti Arch Int Med 2008)

• Intensity 1: contact in hospital of 15 minutes or less and no post discharge support
• Intensity 2: contact in hospital of more than 15 minutes and no post discharge support
• Intensity 3: any hospital contact plus post discharge support lasting 1 month or less
• Intensity 4: any hospital contact plus post discharge support lasting more than 1 month
APPLYING THE 5As to the Hospital Setting

• 3 minutes
• 3-10
• >10
• Opt to Quitline program
• Steps to Implement Joint Commission measures
What Can You Do in 3 Minutes?
ASK, ADVISE, REFER

ASK
about tobacco USE

ADVISE
tobacco users to QUIT

REFER
to other resources

Patient receives assistance, with follow-up counseling arranged, from other resources such as the tobacco quitline

ASSIST

ARRANGE
3 minute counseling strategy

STEP 1:  ASK

- ASK about tobacco use
  
  - “Do you, or does anyone in your household, ever smoke or use any type of tobacco?”
  
  - We like to ask our patients about tobacco use, because it contributes to many medical conditions.”
STEP 2: ADVISE

- ADVISE tobacco users to quit (clear, strong, personalized)
  - “It’s important that you quit as soon as possible, and I can help you.”
  - “Occasional or light smoking is still harmful.”
  - “I realize that quitting is difficult. It is the most important thing you can do to protect your health now and in the future. We can help you now while you are in the hospital and will help set up a treatment plan when you are ready to leave.”
STEP 3: REFER

- REFER tobacco users to other resources

Referral options:
- A doctor, nurse, pharmacist, or other clinician, for additional counseling
- A local group program
- Outside NY toll-free quit line: **1-800-QUIT-NOW**
- IN NEW YORK **1-866-NYQUITS**
Intermediate Smoking Cessation Counseling

- 3-10 minutes

- Goals of brief counseling
  - Assess patient’s readiness to quit
  - Enhance motivation to quit
  - Increase confidence that they will have support

- Reach all smokers including those who:
  - Are willing to quit (5 A’s)
  - Are unwilling to quit (5 R’s)
Intermediate Smoking Cessation Counseling: 3-10 Minutes

- **Ask: Introduce the topic of smoking (1 minute)**
  - Use general, non-threatening statement to open the discussion
  - “Are you currently smoking cigarettes or use other tobacco products?”
  - “We are now asking everyone who is admitted this question”

- **Advice: Provide advice to quit (1 minute)**
  - “I think quitting smoking is one of the best ways to strengthen and improve one’s (your) health.” (Make it relevant to current illness if appropriate)
Intermediate Smoking Cessation Counseling: 3-10 Minutes for patient not ready to quit

- **Assess** readiness
  - Are you ready to quit? If no:
  - Explore ambivalence and enhance motivation
    - Provide information (available resources)
    - Ask noninvasive questions to identify reasons for tobacco use and concerns about quitting
    - Raise relevance (health concerns, consequences)
    - Demonstrate empathy and foster communication
    - Leave decision to the patient
    - DO NOT provide a treatment plan
Intermediate Smoking Cessation Counseling: 3-10 Minutes for *patient ready to quit*

**Assess readiness**

- Are you ready to quit in the next month? If yes:
  - Assess tobacco use history (2 minutes)
    - Current use
    - Past quit attempts (What led to relapse in the past?)
  - Facilitate quitting process (6 minutes)
    - Discuss triggers
    - Explore potential coping strategies
    - Discuss withdrawal symptoms
    - Discuss methods for quitting (counseling and pharmacotherapy)
    - Provide quit smoking educational material, local quit resources, and information on the NY State Quitline.
**Intensive Smoking Cessation Counseling**

- 10 or more minutes

- **Goals of intensive counseling**
  - Assess patient’s readiness to quit
  - Increase patients’ motivation and confidence in quitting
  - Explore smoking history and behavioral aspects
  - Educate and discuss treatment options

- **Reach all smokers who:**
  - Are willing to quit (5 A’s)
  - Are unwilling to quit (5 R’s)
Topics to be Discussed in Intensive Counseling

• Not Ready to Quit
  - Use the 5 R’s and open-ended questions
  - Education on health risks of smoking and benefits of quitting
  - Decisional balance
### Intensive Counseling: 5 R’s for patients not ready to quit

| **Relevance** | Encourage the patient to indicate why quitting is personally relevant. Motivational information has the greatest impact if it is relevant to patient:  
- Disease risk, family/social situation, health concerns, age, gender, etc. |
|-----------------|--------------------------------------------------------------------------------------------------|
| **Risks** | Clinician should ask patient to identify potential negative consequences of tobacco use. Clinician should highlight the risks associated with tobacco use.  
*Acute Risks:* Shortness in breath, exacerbation of asthma or bronchitis, increased risk of respiratory infections, harm to pregnancy, impotence, infertility.  
*Long-term Risks:* Heart attacks and strokes, lung and other cancers, chronic obstructive pulmonary disease, osteoporosis, and long-term disability.  
*Environmental Risks:* Increased risk of lung cancer and heart disease in spouses, increased risk for low birth weight, sudden infant death syndrome (SIDS), asthma, middle ear disease, and respiratory infections in children of smokers. |
| **Rewards** | Clinician should ask patient to identify potential benefits of quitting tobacco.  
Examples of rewards:  
- Improved health  
- Saving money  
- Setting a good example for children  
- Feeling better physically  
- Improved appearance including reduced wrinkles/aging of skin and whiter teeth.  
- Food will taste better, improved sense of smell  
- Home, car, clothing, breath will smell better  
- Having healthier babies and children |
| **Roadblocks** | Clinician should ask patients to identify barriers or impediments to quitting and provide treatment that could address barriers.  
Examples of barriers:  
- Withdrawal symptoms  
- Fear of failure  
- Being around other tobacco users  
- Enjoyment of tobacco  
- Lack of support  
- Depression  
- Limited knowledge of effective treatment options |
| **Repetition** | The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful and that you will continue to talk about their tobacco use with them. |
Topics to be Discussed in Intensive Counseling

- **Preparing to Quit**
  - Prepare environment for being smoke-free
  - Review past quit attempts-what led to relapse in past
  - Social support
  - Set a quit date (may not be relevant for hospitalized patient)

- **Dealing with Withdrawal**
  - Review withdrawal symptoms and rationale for use of pharmacotherapy
  - Plan coping strategies for withdrawal

- **Dealing with Triggers**
  - Review sources of triggers: physical, thoughts, feelings, behaviors
  - Plan coping strategies for each type of trigger
CHALLENGES

1. Patients may be discharged before being approached (30-40%)
2. Patients may be unable or unwilling to speak to the counselor /nurse/MD about their tobacco use (e.g. too ill)
3. Timing of intervention may not be quite right (e.g., Psych)
Steps to Translating Joint Commission Policy into Practice

1. Implement clinical reminder system
2. Ensure that staff (clinical and administrative) receive training on 2008 Update on Tobacco Use Treatment Guidelines
3. Implement system to ensure routine Quitline referral on discharge
Steps to Translating Joint Commission Policy into Practice

4. Identify tasks for key personnel
   - Who is screening patient on admission?
   - Where does the information get documented?
   - How does this information get transmitted to the person who will provide counseling?
   - Who will provide counseling?
   - Who will discuss referral process and make referral?
   - When and who will make follow-up contact and how will this be accomplished in the most efficient (and least costly) manner?
Steps to Translating Joint Commission Policy into Practice

5. Other questions
   - What systems do you have in place to receive feedback from the Quitline and to document that patient was reached?
   - How will you address the one day stay?

Reach out to Cessation Centers
Thank you