Action Guide

NATIONAL ASSOCIATION OF
Community Health Centers

Reducing Tobacco Use with Evidence-Based 6l18 Interventions

BACKGROUND

Collaboration between public health, primary care, purchasers, and payers is integral to achieving health system changes that can ultimately improve population health. To realize this potential, the Centers for Disease Control and Prevention (CDC) is partnering with 15 state Medicaid programs and their counterpart state public health departments, as well as the District of Columbia Health Department and Los Angeles County Health Department, to improve and accelerate implementation of the 6l18 interventions to achieve better care, better health outcomes, and lower costs. The CDC is working with these organizations to understand best practices in implementing 6l18 interventions and to help disseminate best practices to other states.

The National Association of Community Health Centers, Inc. (NACHC) is working with the CDC in support of the 6l18 Initiative. Given the critical role health centers can play in improving population health, and their reach within communities across the nation, health centers are natural partners to work with the CDC. They can build and leverage collaborations with state Medicaid agencies, payers and other entities in an effort to better manage the common and costly health conditions that are the focus of the 6|18 Initiative.

Implementation of the 6l18 interventions can be viewed through the lens of the Value Transformation Framework developed by NACHC's Quality Center. The Value Transformation Framework translates research and proven solutions in three domains (infrastructure, care delivery, and people/human capital) to support improved population health, improved patient and staff experience, and reduced costs (the Quadruple Aim[1]). This Action Guide organizes the evidence base around reducing tobacco use and translates recommendations into actionable steps that can be undertaken by health centers in the areas of infrastructure, people, and delivery systems.

CDC 6l18 Initiative

CDC is partnering with health care purchasers, payers, and providers to improve health and control health care costs. CDC provides these partners with rigorous evidence about high-burden health conditions and associated interventions to inform their decisions to have the greatest health and cost impact. This initiative offers proven interventions that prevent chronic and infectious diseases by increasing their coverage, access, utilization and quality.

The 6l18 Initiative targets six common and costly health conditions—tobacco use, high blood pressure, healthcare-associated infections, asthma, unintended pregnancies, and type 2 diabetes prevention – and, initially, eighteen proven specific interventions.

WHY THIS ACTION GUIDE?

This Action Guide was developed to bridge evidence to operations – addressing evidence-based interventions for tobacco control in the context of larger organizational changes and transformation efforts. This work identifies ways to enhance care delivery, infrastructure, and people (human capital) in support of reaching 6|18's tobacco control goals and the Quadruple Aim goals of improved health outcomes, improved patient and staff experience, and reduced costs. This translational work is guided by the Value Transformation Framework developed by the NACHC's Quality Center.

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REDUCE TOBACCO USE
Smoking is the leading cause of preventable disease, disability, and death in the United States. An estimated 42.1 million adults (nearly 18% of Americans) smoke cigarettes.[2] Smoking results in about 480,000 premature deaths and nearly $300 billion in direct health care costs and lost productivity each year.[2] The prevalence of cigarette smoking is higher among adults who are male, younger, multiracial or American Indian/Alaska Native, have less education, live below the federal poverty line, live in the South or Midwest, have a disability/limitation, or are lesbian/gay/bisexual.[3] Reducing tobacco use is one of the most important, and yet challenging, preventive health measures to address. As seven out of every ten individuals in the U.S. see a physician each year, health care providers have a vital role to play in helping smokers quit.[4] Research indicates that 69% of people who currently smoke would like to quit smoking, and 52% try to quit at some point in the course of a year.[5]

Common to all of the 6|18 Initiative conditions, tobacco use: (1) affects a large population, (2) is associated with high health care costs, (3) has evidence-based interventions known to prevent and manage the condition in less than 5 years, and (4) has evidence-based interventions that can be implemented by health care purchasers, payers, and providers.

"The goal of these strategies is clear: to change clinical culture and practice patterns to ensure that every patient who uses tobacco is identified, advised to quit, and offered scientifically sound treatment."[8]

CDC 6|18 EVIDENCE-BASED INTERVENTIONS TO REDUCE TOBACCO USE
The CDC 6|18 Initiative's prioritized interventions for reducing tobacco use[5] are:
- Increase access to tobacco cessation treatments including individual, group, and telephone counseling, and all Food and Drug Administration (FDA)-approved cessation medications (in accordance with the 2008 Public Health Service Clinical Practice Guideline and the 2015 U.S. Preventive Services Task Force (USPSTF) cessation recommendations).
- Remove barriers that impede access to covered cessation treatments, such as cost sharing and prior authorization.
- Promote increased utilization of covered treatment benefits by tobacco users.

This Action Guide outlines provider-driven steps for operationalizing 6l18 tobacco cessation interventions. Treating tobacco dependence can be considered one of the most important treatments a provider can offer. It is estimated that if physicians advised 90% of smokers to quit, and offered medication or other assistance, 42,000 lives could be saved each year.[7] Tobacco dependence is a chronic health condition that often requires multiple, discrete interventions and quit attempts. Treatment approaches for tobacco dependence should consider relapses and remissions similar to treatment for other chronic conditions.[8]

The majority of smokers who try to quit do so on their own without using evidence-based tobacco cessation medications and/or counseling, with more than 95% experiencing a relapse.[5] The use of evidence-based interventions more than doubles success rates.[8]

PUTTING 6|18 EVIDENCE-BASED INTERVENTIONS INTO ACTION
The CDC's 6l18 tobacco interventions include increasing access to tobacco cessation treatments and Food and Drug Administration-approved cessation medications (in accordance with the 2008 Public Health Service Clinical Practice Guidelines and the 2015 US Preventive Services Task Force Recommendations), removing barriers that impede access to covered treatments, and promoting increased use of covered treatment benefits by tobacco users. Organizations have the opportunity to operationalize the interventions as part of a larger systems approach. The Value Transformation Framework, developed by NACHC's Quality Center, allows health centers to do just that.

NACHC QUALITY CENTER - VALUE TRANSFORMATION FRAMEWORK
The Value Transformation Framework supports transformation toward value-driven care and the ability of health centers to achieve Quadruple Aim goals. The Quadruple Aim goals are: improved health outcomes, improved patient experiences, improved staff experiences, and reduced costs. The Framework organizes action steps into three domains: care delivery, infrastructure, and people.

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Value Transformation Framework

HEALTH CENTER

Care Delivery
Population Health Management
Patient-Centered Medical Home
Evidence-Based Care
Care Management
Social Determinants of Health

Infrastructure
Improvement Strategy
Health Information Technology
Policy
Payment
Cost

People
Patients
Care Teams
Leadership
Workforce
Partnerships
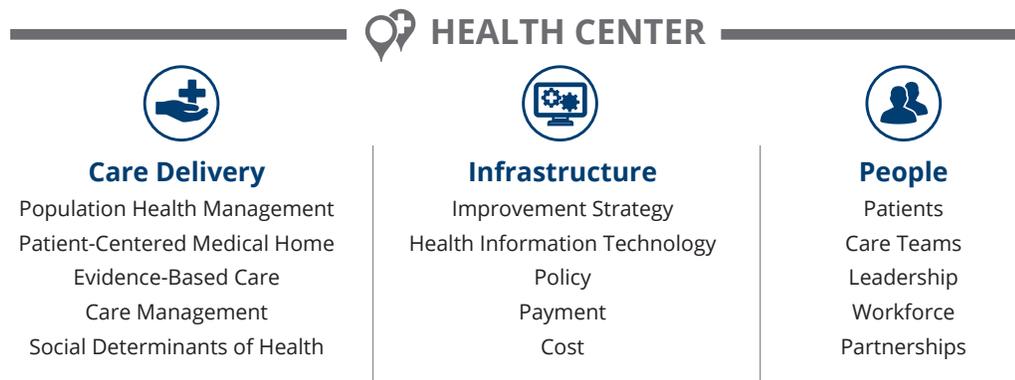
The 6|18 Initiative's evidence-based recommendations for controlling tobacco use, similar to the 6|18 Initiative's other conditions, then become part of an overarching strategy for transforming a health care delivery system to achieve improved health outcomes (tobacco control and cessation), enhanced patient and provider experience, and reduced costs. This approach recognizes that while tobacco-specific recommendations are critical to outcomes, they are just one part of a more comprehensive strategy.

Care Delivery

It is estimated that in the volume-based system, a primary care physician would need to spend 21.7 hours per day to provide all recommended acute, chronic and preventive care to a panel of 2,500 patients.[9] Given this reality, how can providers assess tobacco use, and if needed, provide cessation counseling and treatment, all within the context of a primary care visit? The answer lies in changing who and how care is delivered, including hardwiring desired actions into visit processes. An effective tobacco cessation strategy requires multi-component system changes that incorporate tobacco assessment and cessation as part of routine care.[10] Leadership support and standardized workflows are among the changes that can yield great impact.

Clinical workflows can include the "5 A's" of treating tobacco dependence (Ask, Advise, Assess, Assist, and Arrange follow-up) to organize the clinical team around a tobacco cessation treatment strategy.[11] Implementation of the 5 A's in accordance with 6|18 evidence-based interventions includes:[5]

ASK about tobacco use:
- Identify and document tobacco use status for every patient at every visit.
- Incorporate tobacco use assessment and documentation into the routine vitals process.
- Have physicians and other clinicians advise patients to quit smoking, as this increases abstinence rates.

ADVISE to quit:
- Deliver a clear, strong, and personalized message urging every tobacco user to quit. 'As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The care team and I will help you'.
- Offer every tobacco user at least a minimal intervention (less than three minutes) when advising to quit.

ASSESS willingness to quit:
- Assess patients' willingness to quit. 'Are you willing to try quitting right now?'

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✅ **ASSIST** in quit attempt:
- Establish a Tobacco Cessation Brief Clinical Intervention Protocol.[8] A printable sample is available at: https://millionhearts.hhs.gov/files/Tobacco-Cessation-Protocol.pdf.
- Combine provider training and education in tobacco cessation strategies with system changes such as EHR prompts and reminder systems for maximum effect.
- Determine duration of each counseling intervention. Longer sessions are more effective, as there is a strong dose-response relation for person-to-person contact.

For patients willing to make a quit attempt:
- Help willing patients with a quit plan. Set a quit date and have patient prepare by informing family and friends and removing tobacco products from their environment; provide information on nicotine withdrawal symptoms. Review past quit attempts and discuss potential triggers and coping strategies (brief counseling).
- Combine medication and counseling, as this combination is more effective than either intervention alone.
- Use evidence-based medication for tobacco dependence treatment except where contraindicated or for specific populations (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).
- Prescribe one of seven first-line FDA-approved medications (bupropion SR, nicotine gum/inhaler/lozenge/nasal spray/patch, and varenicline). A resource guide to the FDA-approved medications can be found at: http://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/pharmacologic-guide.pdf. Certain combinations of first-line medications are also effective when used together. There may be occasion to use one of two second-line non-FDA approved medications (clonidine and nortriptyline).
- Offer or refer to one or both types of effective counseling and behavioral therapies: (1) practical counseling (problem solving skills/skills training) and (2) support and encouragement. Person-to-person treatment delivered in four or more sessions is highly effective in increasing abstinence rates.[6]
- Refer to quitline for supportive/additional counseling.

For patients unwilling to quit at the time:
- Use motivational interviewing. Effective motivational interviewing has been shown to increase a future quit attempt.
- Include attention to the 5 R's: relevance, risks, rewards, roadblocks and repetition.[9]
- Remind patients that use status will be assessed at the next patient visit.

For former tobacco users who recently quit:
- Congratulate on success and explore areas where support may be needed.
- Consider restarting medication and more intensive counseling (e.g., four or more sessions that are 10 minutes or more in length) for patients who report problems.

✅ **ARRANGE** follow-up:
- For patients with a quit plan, arrange for follow-up contacts, beginning within the first week after the quit date and a second follow-up within the first month. Frequency of contact is the major determinant of success.
- Use a variety of follow-up strategies including in-person, e-visits, secure email, telephone or group visits. Information on conducting group visits can be found at: "Guide to Tobacco Cessation Group Visit," available at www.aafp.org/tobacco-tools.
- Address any challenges a patient has encountered, including symptoms of withdrawal, as part of follow-up.
- Assess medication use and counseling support; remind patients of quitline support.

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Infrastructure

Leveraging and maximizing health information technology (HIT) is a critical component of the organizational infrastructure needed to maximize performance on tobacco cessation or other clinical measures. This includes improved data collection, better identification of patients in need of tobacco cessation intervention, and improved follow-up and tracking.

Incorporating data about tobacco use into reportable electronic health record (EHR) systems allows a health center to capture information on tobacco-use that can be used to assess performance across the patient population and track changes in tobacco status among users. Updating EHR templates to document tobacco status as part of vitals is a strategy that allows for the capture of tobacco status as a part of routine visit processes.

Tobacco use identification and intervention coding and documentation can be automated in a number of ways[14]:
- When a patient is identified and documented as a current tobacco user, the diagnostic code can be automatically populated.
- When brief tobacco cessation counseling is provided during the visit, a check box can appear for the clinician to select 1-3 minutes or 3-10 minutes of counseling, triggering the appropriate billing and reimbursement documentation.
- When a medication order is submitted, the appropriate coding for that order ensures that the order is placed, routed and billed, and that the medication is documented in the patient's EHR medication list.
- The EHR can be programmed so that the delivery and documentation of components of the tobacco cessation protocol will automatically populate the after-visit summary with the applicable text and resources (e.g., the quitline number) specific to each patient.

Other foundational interventions for tobacco control include the use of quitlines which have been shown to significantly increase abstinence rates compared to minimal or no counseling interventions[17] and should be considered an option for all patients, regardless of any counseling support provided by the organization. The addition of quitline counseling to medication treatment significantly improves abstinence rates compared to medication alone.[6] Quitlines are available in all 50 states free of charge. These lines are staffed by individuals trained in evidence-based smoking cessation strategies.

Patients can access their state's quitline by calling 1-800-QUIT-NOW (1-800-784-8669). Quitline services are available seven days a week, typically from early in the morning to late in the evening. In some states, callers to quitlines can have over-the-counter cessation medication mailed to their house. Many state quitlines provide follow-up calls to patients. A provider can fax or electronically submit a referral to the quitline and a quitline counselor calls the patient back and offers services. Information on quitline referral services by state is available at: http://map.naquitline.org/.

The American Academy of Family Physicians[15] recommends the following steps to refer a patient to a quitline:
- Provide a brief description of what services are available and address common misconceptions. For example, "This service has been shown to help people who smoke quit. It is staffed by people skilled at helping people quit. They will not try to make you feel guilty about smoking, and any information you supply will be kept confidential."
- Endorse the service and personalize it. For example, "I have referred many of my patients to the quitline, and they received assistance that helped them quit."
- Assess the patient's interest in getting help.
- If the patient is unsure, explore his or her ambivalence.
- If the patient is not interested, offer a quitline referral card and say, "If you ever change your mind, here is a number you can call to get support."
- If the patient is interested, provide a referral (fax referral, if available, or brochure or card with number).
- Inquire at follow-up visits to find out whether the patient has called the quitline or check feedback from the quitline, if available.

Telephone quitline counseling is effective with broad populations and has broad reach.[6] Quitlines are FREE, so they offer an accessible way to supplement any tobacco reduction efforts, regardless of other counseling that may be offered. In addition to state-supported quitlines, some health plans and employers offer telephone-based cessation support to their members or employees. Health care providers may also assemble lists of community resources that support tobacco cessation.

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While this capacity will likely take time to build, optimally, quitline referral information is also integrated into visit workflow and, where possible, EHR systems. An example is the QuitWorks model in Massachusetts, which links health care organizations, providers and patients to the state's tobacco cessation quitline and offers feedback reports.[16]

Among 6|18 Initiative strategies is the removal of barriers that impede access to covered cessation treatments, such as cost sharing and prior authorization. Improving health outcomes and patient and provider experience while reducing costs is central to the Quadruple Aim. In 2014, the Patient Protection and Affordable Care Act (ACA) began requiring insurance plans to cover many clinical preventive services, including tobacco use screening and cessation counseling. Where applicable, providers should bill Medicare, Medicaid or private insurance for these services.

For details on billing, and a list of CPT and ICD-10 codes related to tobacco cessation counseling, visit AAFP's Coding Reference for Tobacco Prevention and Cessation Counseling: https://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/codes-tobacco-cessation-counseling.pdf.

People (Human Capital)

How a leader and governing body use their leverage and knowledge to lead people and systems is essential to reaching improvement goals such as reducing tobacco use. Leaders must inspire organizational will, identify change ideas that can advance the organization, and then execute those ideas.[18] A key role in this process of Will-Ideas-Execution is providing the structure that allows for success.[19] Leadership creates the business case for high levels of performance on measures such as tobacco use and supports the organization's broader Quadruple Aim goals.

The work of transforming a health center's systems of people, care delivery and infrastructure requires an environment of clear direction based upon trust, dependability, and transparency. Leadership that supports staff training in methods and models of quality improvement can more easily execute evidence-based recommendations and other transformational changes. Strong leadership provides the foundation upon which the system-level strategies outlined in this Action Guide are built.

The effective deployment of tobacco control interventions also requires the effective deployment of care teams. A reinvention of the care team model, with more responsibility given to supportive members of the care team, has been proven to optimize the experience and outcomes of primary care for patients, providers and staff.[20]

"Sharing the care" involves a paradigm shift and a concrete strategy for increasing capacity. The paradigm (culture) shift transforms the practice from an "I" to a "we" mindset. Unlike the lone-doctor-with-helpers model, in which the physician assumes all responsibility, makes all decisions, and delegates tasks to team members (but cannot increase capacity), the "we" paradigm uses a team of clinicians and non-clinicians to provide care to a patient panel, with a reallocation of responsibilities, not only tasks, so that all team members contribute meaningfully to the health of their patient panel.[20]

To optimally implement a standardized workflow based on the Public Health Service Clinical Practice Guideline, care teams must be able to formalize a system to 'share the care' with job descriptions and accountability measures.[21] This requires delineating responsibilities for tobacco cessation services by staff role (e.g., physician, nurse, medical assistant) and standardizing patient visit workflows to include tobacco cessation activities. It is critical for organizations to outline where in the process and who among the care team will advise, assess, assist and arrange support for patients willing to quit. Discussion and training on these job responsibilities should be incorporated into new staff orientation. While each staff role should have clearly defined job tasks and accountability for tobacco cessation activities, the process

needs to allow for flexibility. Staff should be able to step in and assist with treatment where appropriate. Having multiple and different types of staff involved in the process, and reinforcing the quit message and supportive strategies, can enhance abstinence rates. Identifying a tobacco cessation champion – someone who can play a leadership role in tobacco cessation efforts at the health center – also helps support efforts. This should be someone who has the time, authority and resources to lead change.

Success for the 6l18 Initiative involves building stronger and more sustainable partnerships – collaborations across public health, providers, payers and purchasers – to 'move the needle' on tobacco control and the other 6l18 conditions.[22]
At the local and health center level, partnerships can increase the bandwidth of health centers to deliver tobacco cessation counseling and treatment.

CONCLUSION

The National Association of Community Health Centers, Inc. is working with the Centers for Disease Control and Prevention (CDC) in support of the 6l18 Initiative. Health centers are vital providers of health care, particularly for our nation's safety-net population, and play a pivotal role in applying the evidence base for reducing tobacco use to the patients they serve. Health centers have an opportunity to operationalize 6|18 interventions within a framework that is attentive to larger health systems transformation, including attention to care delivery, infrastructure and people. This Action Guide makes this connection by translating evidence for tobacco control into recommended action steps that can be implemented within health centers.

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