



A Collaboration of Legacy & Partnership for Prevention

HELP YOUR PATIENTS QUIT TOBACCO USE

An Implementation Guide for
Community Health Centers

HELP YOUR PATIENTS QUIT TOBACCO USE:

AN IMPLEMENTATION GUIDE FOR COMMUNITY HEALTH CENTERS



SEPTEMBER 2013



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FOR LONGER HEALTHIER LIVES

LEGACY[®] HELPS PEOPLE LIVE LONGER, HEALTHIER LIVES BY BUILDING A WORLD WHERE YOUNG PEOPLE REJECT TOBACCO AND ANYONE CAN QUIT. Legacy's proven-effective and nationally recognized public education programs include **truth[®]**, the national youth smoking prevention campaign that has been cited as contributing to significant declines in youth smoking; **EX[®]**, an innovative public health program designed to speak to smokers in their own language and change the way they approach quitting; and research initiatives exploring the causes, consequences, and approaches to reducing tobacco use. Located in Washington, D.C., the foundation was created as a result of the November 1998 Master Settlement Agreement (MSA) reached between attorneys general from 46 states, five U.S. territories, and the tobacco industry. To learn more about Legacy's life-saving programs, visit LegacyForHealth.org. Follow us on Twitter @legacyforhealth and Facebook www.facebook.com/Legacy.



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PARTNERSHIP FOR PREVENTION WAS FOUNDED IN 1991 BY LEADERS DEDICATED TO MAKING DISEASE PREVENTION AND HEALTH PROMOTION NATIONAL PRIORITIES AND AMERICA A HEALTHIER NATION. Partnership seeks to increase understanding and use of clinical preventive services and population-based prevention to improve health. Its mission is to create a prevention culture in America where disease prevention and health promotion, based on the best scientific evidence, are the first priorities for policy makers, business leaders, and practitioners.

ActionToQuit is Partnership's tobacco control policy program dedicated to reducing tobacco-related death, disease, and cost through communication, education, and advocacy.

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INTRODUCTION

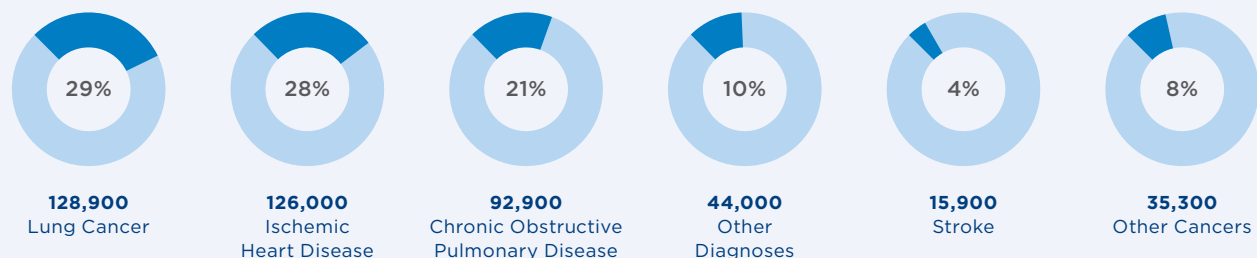
Tobacco use is the leading preventable cause of death in the United States today.¹ Cigarettes are by far the most widely used form of tobacco, and smoking accounts for approximately 443,000 deaths—or one of every five deaths—each year.^{2,3} The economic costs of smoking are also enormous. Cigarette smoking has been estimated to cost the United States nearly \$96 billion in direct medical costs and \$97 billion in lost productivity annually.⁴

The good news is that smoking rates have been cut nearly in half since the 1960s.⁶ Even so, nearly 20 percent of U.S. adults—about 43.8 million people—still smoke.^{7,8,9} Rates of tobacco use vary by state and across demographic characteristics, including age, gender, socioeconomic status, education, and sexual orientation.¹⁰ Every day, nearly 3,500 youth younger than 18 smoke their first cigarette, and about 900 become daily smokers.¹¹ One in three youth smokers will eventually die from a tobacco-related disease.¹²

THE CHANGING LANDSCAPE OF TOBACCO PRODUCTS

Tobacco users now have an array of products to choose from, including cigarettes, pipes, cigars, little cigars, cigarillos, smokeless tobacco and snus, dissolvables (nicotine strips, orbs, and sticks), and e-cigarettes. In many cases, the tobacco industry has introduced these products as replacements for cigarettes, given the overall decrease in smoking, smoke-free air laws, and federal regulation of cigarettes. Little data exists on the use and health effects of these new products, though one concern about them is their use in addition to cigarettes, which could keep smokers addicted to nicotine and make it even more difficult to quit.

CHART 1⁵
ABOUT 443,000 U.S. DEATHS ATTRIBUTABLE EACH YEAR TO CIGARETTE SMOKING



Epidemiologic data suggest that almost 70 percent of smokers want to quit and about 52 percent try to quit every year.¹³ Many of those who make a quit attempt do so without help, and they are often unsuccessful.¹⁴ In 2010, only 6.2 percent of the 23.7 million people who tried to quit succeeded.^{15,16} Tobacco dependence is a chronic disease, and people may need to make multiple quit attempts before they are successful.¹⁷

Community health centers (health centers) are a critically important player in efforts to reduce tobacco use because they provide a high-quality, patient-centered medical home. This model, which emphasizes team-based care, strong relationships

with patients and their families, and prevention and wellness, can provide the ongoing support and tools that people need to successfully quit tobacco. Health centers provide comprehensive primary and preventive care to 20 million people annually, a number expected to double as the Patient Protection and Affordable Care Act (ACA) takes effect.¹⁸ By instituting tobacco cessation services and integrating them with existing clinical services, health centers are in a position to improve the standard of care and make a significant positive impact on tobacco use and the health consequences of smoking.



WHAT ARE COMMUNITY HEALTH CENTERS?

Community health centers are community-based and patient-directed organizations that serve populations with limited access to health care. Health centers include Federally Qualified Health Centers (FQHCs), which receive funding from the Health Resources and Services Administration (HRSA), and FQHC-look-alikes, which meet all the Health Center Program requirements but do not receive Health Center Program grants. For more information, visit the [About Health Centers^A](#) page on HRSA's website.

HELP YOUR PATIENTS QUIT TOBACCO USE: AN IMPLEMENTATION GUIDE

Help Your Patients Quit Tobacco Use: An Implementation Guide for Community Health Centers is intended to help health centers integrate tobacco cessation into their clinical services. It will help health centers to:

- **Begin and sustain efforts to integrate tobacco cessation services into their work** by making the case for this service as essential to the mission of providing high-quality, comprehensive care. The direct and continuing involvement and support from administrative and clinical leadership is critical to the success of these efforts.
- **Think through some of the concrete, day-to-day issues involved in instituting and maintaining tobacco cessation services.** These challenges include making tobacco cessation a priority for staff who have limited time and multiple existing responsibilities, beginning and sustaining a conversation about tobacco cessation with patients, and devising ways to embed the services so efficiently and consistently that they become the standard of care. The experience and suggestions of centers that have successfully integrated tobacco cessation services are incorporated throughout this guide.

ORGANIZATION OF THE GUIDE

This guide has several major sections. The first, “The Burden of Tobacco Use for Low Socioeconomic Status Populations,” describes the health effects of tobacco use and **why tobacco use is a particular problem for the populations** served by health centers. The second section, “Making the Case for Tobacco Cessation Services in Health Centers,” **sets out the rationale** for establishing and maintaining tobacco cessation services and integrating them into a health center’s overall clinical services. The third section, “Integrating Tobacco Cessation into Your Center’s Clinical Services,” lays out **steps health centers may want to consider** in beginning to offer tobacco cessation services. It also provides tips on planning and carrying out these efforts and **handling the challenges** that inevitably arise. Throughout these sections, you’ll see these helpful tools:

LEARN MORE! refers you to useful resources with additional information. The URLs for websites mentioned in these sections can be found in **Resource F**.

EXPERIENCE FROM THE FIELD provides real-world examples of issues discussed in the text.

The final section of the guide, “Case Studies,” showcases in greater detail examples of successful tobacco cessation initiatives in health centers across the country. The **case studies** highlight several state initiatives and efforts in individual health centers. Finally, the guide has several appendices that provide useful additional resources.



2

THE BURDEN OF TOBACCO USE FOR LOW SOCIOECONOMIC STATUS POPULATIONS

Any exposure to tobacco smoke—even the occasional cigarette or contact with secondhand smoke—is harmful.¹⁹ Cigarette smoke contains more than 7,000 chemicals and compounds.²⁰ Hundreds of these are toxic, and at least 69 cause cancer.²¹

Compared with nonsmokers, smoking is estimated to increase the risk of:²²

- coronary heart disease by two to four times;
- stroke by two to four times;
- men developing lung cancer by 23 times;
- women developing lung cancer by 13 times; and
- dying from chronic obstructive lung disease (such as chronic bronchitis and emphysema) by 12 to 13 times.

The harmful effects of tobacco extend beyond those caused by inhaling smoke from a cigarette.

LEARN MORE!

Visit these websites to learn more about the health effects of tobacco use.

CDC: Smoking and Tobacco Use^B

Campaign for Tobacco-Free Kids: Smoking Harms^C

Secondhand smoke (the combination of smoke from the burning end of a cigarette and the smoke breathed out by smokers) also has numerous deleterious health effects. According to the U.S. Centers for Disease Control and Prevention (CDC), nonsmokers who are exposed to secondhand smoke at home or work increase their risk for heart disease by 25 to 30 percent and their risk for lung cancer by 20 to 30 percent.²³ In the United States, secondhand smoke kills about 50,000 people each year, with the majority of those deaths being from heart disease.^{24,25} The home is now the predominant location for secondhand smoke exposure for children and adults, making smoke-free homes an important way to protect children and family members.²⁶

Even when secondhand smoke clears, deleterious effects remain. Thirdhand smoke, a relatively new term, refers to the contaminants and toxins left on clothing and other surfaces after secondhand smoke is no longer visible. Children are particularly susceptible to thirdhand smoke exposure.²⁷

Low socioeconomic status (SES) populations, the primary community served by health centers, are hit especially hard by tobacco use. For the purpose of this report, low-SES populations are defined as sociodemographic groups of individuals with low income (less than “livable income” based on geographic considerations), people with fewer than 12 years of education, individuals with no or limited medical insurance, the unemployed or underemployed, and the working poor. Low-SES

populations have a higher prevalence of smoking than do other population groups; almost 29 percent of adults with incomes below the poverty line smoke, compared to 18 percent at or above the poverty line.²⁸ Smoking prevalence also is high among unemployed adults, adults with blue-collar jobs, and those with less education.

A second reason for tobacco's disproportionate impact on the low-SES populations served by health centers is that these populations are also disproportionately affected by many of the diseases and conditions that are caused or exacerbated by tobacco use, such as lung disease, heart disease, and asthma.²⁹ In reporting on diseases and conditions among more than 20 million health center patients, the 2011 Uniform Data System (UDS) National Report shows that diseases caused by or worsened by tobacco are a significant burden for these patients. The data reveals that:³⁰

- **2,101,506** patients have hypertension;
- **1,366,643** patients have diabetes;
- **562,121** patients have asthma;
- **276,202** patients have heart disease; and
- **193,911** patients have chronic bronchitis and emphysema.

LEARN MORE!

For details, see HRSA's **2011 UDS National Report**.^D

A third reason for tobacco's effect on these populations is that the tobacco industry advertises heavily and makes its products readily available in particular communities, including those of low-SES; communities of color; youth and young adults; the homeless; and Lesbian, Gay, Bisexual, and Transgender (LGBT) communities.^{31,32,33,34,35} This higher level of commercial exposure can increase the likelihood that tobacco use is seen as acceptable in communities.³⁶ The industry



also provides financial contributions and support to groups that represent low-SES communities.^{37,38,38,40,41} These targeted marketing tactics further contribute to health inequities.⁴²

LOOKING AHEAD TO “MAKING THE CASE”

Clearly, tobacco use is a particular problem for low-SES communities. By why should tobacco cessation services be a priority for health centers? Health centers already have a full plate of responsibilities. The next section of this guide provides several compelling arguments that demonstrate how tobacco cessation services can improve the quality of health center services as well as the health of the populations they serve.

A FEW QUICK FACTS ON TOBACCO USE AND SOCIOECONOMIC STATUS

- Among adults age 25 and older, those with a General Education Development (GED) diploma have the highest smoking rates (45 percent), followed by adults with nine to 11 years of education (34 percent). Smoking rates are much lower among those with more years of formal education (10 percent for those with undergraduate degrees and six percent for those with graduate degrees).ⁱ
- Nearly 45 percent of unemployed adults smoke, compared to 28 percent of those working full time and 25 percent of those working part time.ⁱⁱ
- The highest smoking rates are found among those working as manual laborers or in blue-collar jobs, such as construction work (31 percent), mining (30 percent), and food preparation and service (30 percent).ⁱⁱⁱ
- Among adults younger than age 65, 15.6 percent with private health insurance smoke, compared to 33.5 percent of Medicaid enrollees, and 31.7 percent of the uninsured.^{iv}
- The percentage of nonsmokers exposed to secondhand smoke is higher among those below the poverty level (61 percent) compared to those at or above the poverty level (37 percent).^v
- Death from lung cancer and chronic obstructive pulmonary disease (COPD) is associated with low socioeconomic status.^{vii} Cigarette smoking is the leading cause of lung cancer and COPD.^{viii}
- Smokers below the poverty level are more likely to try to quit than smokers at or above the poverty level, but are less likely to quit smoking successfully.^{ix}

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iv Schiller, J. S., Lucas, J. W., & Peregoy, J. A. (2012). Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2011. *Vital and Health Statistics*, 256.

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viii U.S. Department of Health and Human Services. (2004). The Health Consequences of Smoking: A Report of the Surgeon General: Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Retrieved from http://www.cdc.gov/tobacco/data_statistics/sgr/2004/complete_report/index.htm

ix Centers for Disease Control and Prevention. (2011). Quitting Smoking among Adults—United States, 2001–2010. *Morbidity and Mortality Weekly Report*, 60(44), 1513-1519. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6044a2.htm?s_cid=mm6044a2.htm_w

3



MAKING THE CASE FOR TOBACCO CESSATION SERVICES IN HEALTH CENTERS

This section is designed to strengthen the rationale to health center administrative and clinical leadership that these services can help centers improve the quality of the care they provide to individuals, families, and communities. Following are five compelling reasons for including tobacco cessation services among health center offerings.

1. REDUCE THE IMPACT OF DISEASE IN YOUR PATIENT POPULATION

Tobacco use causes many diseases and makes other diseases and conditions worse.⁴³ As a result, patients' use of tobacco affects a health center's clinical services across the board, making the integration of tobacco cessation into all clinical services a priority.

Reducing tobacco use can be a powerful weapon in a health center's efforts to reduce the impact of chronic diseases among its patient population. Type 2 diabetes is a good example. Smoking increases the risks of cardiovascular disease, a potential burden already carried by people with diabetes.⁴⁴ In addition, many studies demonstrate that smoking negatively affects the metabolism of glucose and lipids in people with diabetes, making it harder to achieve metabolic control.⁴⁵ Smoking is also associated with an increased risk of microvascular and macrovascular complications.⁴⁶ By helping patients quit smoking, health centers can also help patients manage chronic conditions, such as diabetes, and improve their overall health.⁴⁷

Reducing tobacco use also can significantly improve the health and quality of life of specific groups of patients, including pregnant women and infants and children.

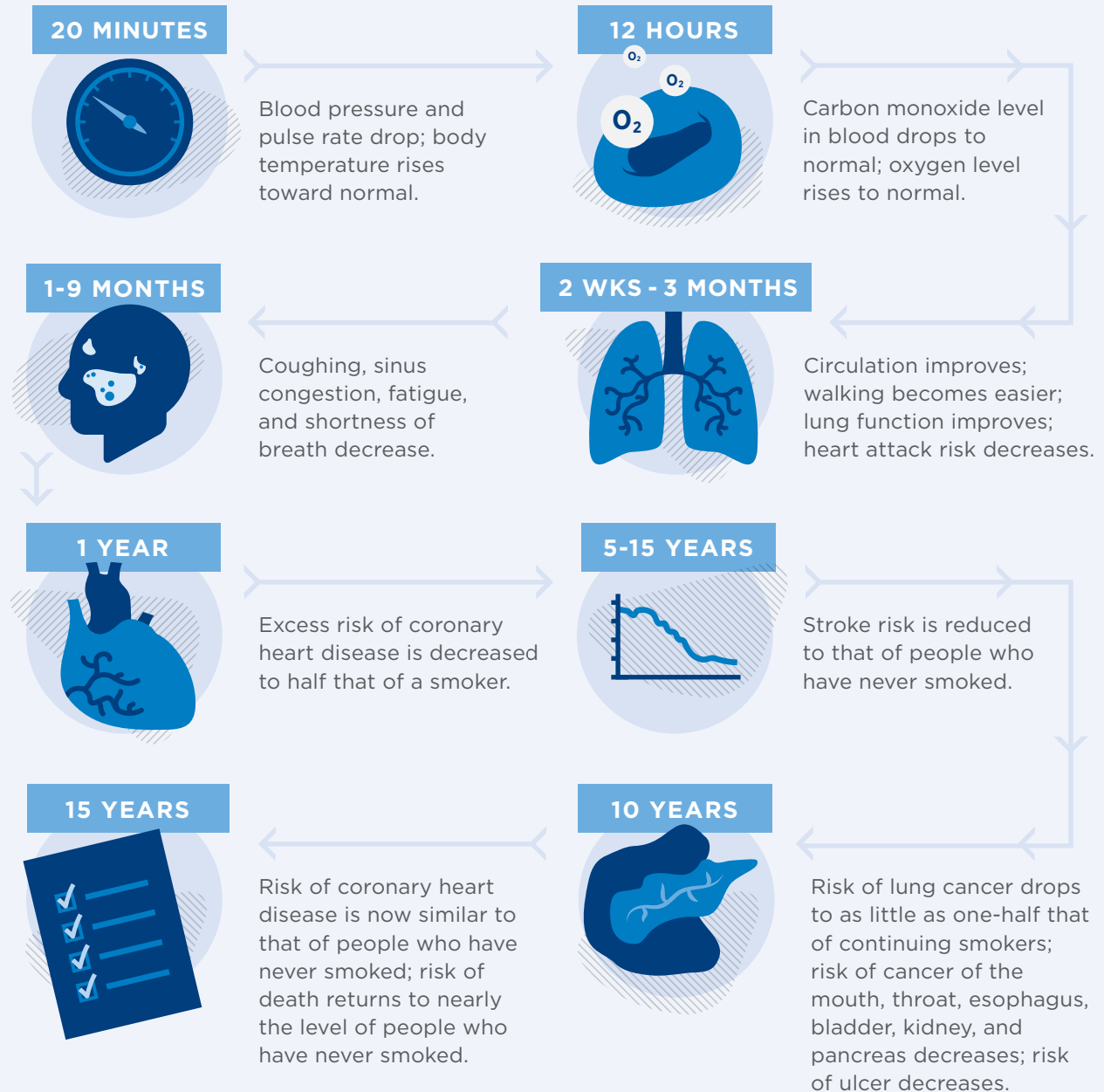
- About one out of every six pregnant women smokes, and many more may be exposed to secondhand smoke.⁴⁸ This exposure to tobacco among pregnant women is associated with spontaneous abortions; premature births; stillbirths; and many complications of pregnancy, including ectopic pregnancy, placenta previa, and placental abruption.⁴⁹
- Slightly more than half (54 percent) of children ages three to 11 in the United States are exposed to secondhand smoke.⁵⁰ In children, secondhand smoke can trigger asthma attacks.⁵¹ It also causes respiratory problems—such as wheezing, bronchitis, and pneumonia—and ear infections,⁵² and increases the risk for sudden infant death syndrome (SIDS).⁵³

LEARN MORE!

Read these factsheets to learn more about the health effects of tobacco use and secondhand smoke among children and pregnant women.

- **CDC: Secondhand Smoke**^E
- **CDC: Smoking During Pregnancy**^F
- **Legacy: Secondhand Smoke**^G

QUIT SMOKING, IMPROVE HEALTH—AFTER...



QUIT SMOKING, SAVE MONEY

Depending on where he or she lives, the average one-pack-a-day smoker who quits will save, on average, \$1,430 to \$3,320 every year.

Source: Campaign for Tobacco-Free Kids, *Benefits from Quitting Tobacco Use*, 2007¹¹

Source: Campaign for Tobacco-Free Kids, *Immediate Smoker Savings from Quitting in Each State*, 2011¹

2. MEET FEDERAL HEALTH PRIORITIES

Beginning in Fiscal Year 2012, the Health Resources and Services Administration (HRSA) requires two new clinical measures on tobacco use assessment and counseling in the Uniform Data Systems (UDS):

- The percentage of patients age 18 years and older who were queried [asked] about any and all forms of tobacco at least once within 24 months
- The percentage of patients age 18 and over who were identified as users of any and all forms of tobacco during the program year or the prior year who received tobacco use intervention [cessation counseling and/or pharmacological intervention]

LEARN MORE!

For more information about these measures, visit **HRSA's Clinical and Financial Performance Measures^J** web page.

These services are now becoming the standard of care for health centers nationwide. According to the 2011 *UDS National Report*, 80 percent of health center patients were asked about tobacco use and 53 percent of patients received cessation advice or medication.⁵⁴ These are encouraging statistics, but asking about tobacco use is only the first step in the recommended tobacco cessation intervention outlined in the U.S. Public Health Service Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update*. Health centers still have much further to go in screening, providing advice to quit, and providing evidence-based treatment through brief counseling and medication. Suggestions for how health centers can carry out this more comprehensive approach are described in Part 4 of this guide.

Tobacco cessation also is one of seven priorities for the National Prevention Strategy, a blueprint for coordinated federal action and leadership to foster prevention, wellness, and health promotion practices so as to increase the number of Americans who are healthy at every stage of life. By integrating tobacco cessation services, health centers can encourage clinicians to assess and treat tobacco use in adolescents and adults, a step in the National Prevention Strategy.⁵⁵

LEARN MORE!

Visit the **National Prevention Strategy^K** website and read the **National Prevention Council Action Plan^L**.

3. ALIGN WITH HEALTH CARE REFORM

Health centers are mainstays of care for low-SES populations across the country. Through their work—emphasizing primary and preventive care, reducing health disparities, managing chronic illnesses, improving birth outcomes, and providing enabling services—health centers not only provide care to individuals and families, they also help improve the health of the communities in which people live, learn, work, and play.

A major goal of the Affordable Care Act (P.L. 111-148) is to provide affordable coverage and primary care to a greater number of Americans. Health reform's focus on primary and preventive care is entirely consistent with the mission of health centers.

- Most tobacco cessation medications are included in the HRSA 340B Drug Pricing Program, which provides discounts on outpatient prescription drugs to select safety-net providers, including health centers.⁵⁶
- As of October 1, 2010, all state Medicaid programs must provide a comprehensive

cessation benefit for pregnant women with no cost sharing by the patient. A similar provision applies to some private group and individual plans as of September 23, 2010.⁵⁷

- As of June 2011, state Medicaid programs are allowed to reimburse quitlines for callers enrolled in Medicaid.⁵⁸
- As of January 1, 2013, state Medicaid programs that voluntarily cover all recommended preventive services, including tobacco cessation, receive increased federal reimbursements.⁵⁹
- Beginning January 1, 2014, state Medicaid programs will no longer be able to exclude tobacco cessation drugs from prescription drug coverage.⁶⁰

These HRSA and Medicaid provisions are important to health centers because about 39 percent of health center patients are enrolled in Medicaid, and numbers are expected to grow beginning in 2014 with the large expansion of eligibility under the Affordable Care Act.⁶¹ Smoking prevalence rates are much higher in Medicaid populations than in the general population (31 percent of Medicaid enrollees smoke, compared to about 19 percent of the overall adult population;⁶² 25 percent of pregnant women enrolled in Medicaid smoke, compared with 12 percent of pregnant women in the general population⁶³).

LEARN MORE!

Visit HRSA's **340B Drug Pricing Program and Pharmacy Affairs**^M website.

4. ACHIEVE MEANINGFUL USE GOALS THROUGH ELECTRONIC HEALTH RECORDS

The *Treating Tobacco Use and Dependence: 2008 Update* clinical practice guidelines call for systems-level tobacco intervention efforts. Broadly defined, that means integrated and sustainable

change within health care organizations as well as changes in policy and financing to encourage and support universal, evidence-based tobacco interventions. Electronic Health Records (EHRs) are one way in which health centers can integrate these guidelines into the clinical workflow to facilitate systems-level change.

LEARN MORE!

For more information on health systems change and how it relates to tobacco cessation, visit the **Multi-State Collaborative for Health Systems Change**^N website.

EHRs have the capacity to do much more than record patient information electronically. The Center for Medicare and Medicaid Services (CMS) has developed the Medicare and Medicaid Electronic Health Records Incentive Programs to encourage health care professionals and organizations to use EHRs to achieve benchmarks that can lead to improved care for Medicare and Medicaid patients. The programs provide incentive payments to Eligible Professionals (EPs), hospitals, and critical-access hospitals that demonstrate "meaningful use" of certified EHR technology by meeting selected required and optional objectives. Health center providers are eligible for the health professional incentive payments.⁶⁴

The requirements of these incentive programs emphasize the importance of addressing patient tobacco use. Stages One and Two of the programs require tobacco identification and documentation in the health record as core objectives.

LEARN MORE!

For more information, visit CMS's **EHR Incentive Programs**^O web page.

TABLE 1:⁶⁵ MEANINGFUL USE STAGE 1 VS. STAGE 2 COMPARISON - ELIGIBLE PROFESSIONALS (EPS) OUTPATIENT AND INPATIENT TOBACCO CORE OBJECTIVE

Stage One Objective	Stage One Measure	Stage Two Objective	Stage Two Measure
Record smoking status for patients 13 years old or older.	More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	Record smoking status for patients 13 years old or older.	More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

All eligible providers also are required to report on Clinical Quality Measures (CQMs), tools that help measure and track the quality of health care services, in order to demonstrate meaningful use of electronic health records. This tobacco measure is strongly recommended. EPs must report on nine out of 64 total CQMs. Given the devastating impact of tobacco use on health, the benefits of cessation, and the strong return on investment that cessation interventions provide, health centers should strongly consider selecting this measure.⁶⁶

TABLE 2:⁶⁷ OUTPATIENT TOBACCO CLINICAL QUALITY MEASURE

Stage One Measure Number (Required)	Stage One Measure	Stage Two Measure Number (Recommended)	Stage Two Measure
National Quality Forum (NQF) 0028	The percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user	National Quality Forum (NQF) 0028	The percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

Permission to print from the University of Wisconsin Center for Tobacco Research and Intervention.

4

5. REALIZE A STRONG RETURN ON INVESTMENT

Treating Tobacco Use and Dependence: 2008 Update is just one of many publications that make a powerful case for the cost-effectiveness of tobacco dependence interventions. The report states that tobacco use treatments, such as brief interventions and intensive programs including medications, are not only clinically effective but also extremely cost-effective relative to other commonly used disease prevention interventions and preventive services.⁶⁸

Return on investment can be understood through another, broader, lens as well. In our evolving health care environment, the pressures are increasing on health care providers of all types, including health centers, to improve the quality of care and to make the most out of resources. The Institute for Healthcare Improvement has developed a framework called Triple Aim to help achieve the goal of a strong return on investment. Triple Aim encompasses three dimensions:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per-capita cost of health care.

Integrating tobacco cessation interventions and education across all clinical activities is one way in which health centers can address all three components of this societal return on investment.

These services provide an avenue for health centers to prevent the diseases and conditions directly caused by tobacco, reduce the severity of conditions that are exacerbated by tobacco, improve the overall health of patients, and reduce the costs of care.

LEARN MORE!

For more information, visit the Institute for Healthcare Improvement's **Triple Aim Initiative**^P web page.

LOOKING AHEAD TO “INTEGRATING TOBACCO CESSATION”

While it is one thing to agree that instituting tobacco cessation services is a good idea for your health center, actually carrying out that idea is another thing altogether. Many practical considerations and questions lie ahead. How should we build on existing tobacco-related services? How do we develop a tobacco cessation program from scratch? How do we ensure that staff support these services and can carry them out? The next section of the guide provides a framework, with practical advice, to help your clinical and education staff plan, execute, and monitor tobacco cessation services that can be efficiently integrated into your other clinical activities.

INTEGRATING TOBACCO CESSATION INTO YOUR CENTER'S CLINICAL SERVICES



There is a national movement to identify tobacco users in clinical settings. Many health care facilities, including hospitals, the Indian Health Service, and military treatment facilities, are going even further and treating tobacco users by providing cessation counseling, medication, and referrals. It is imperative that more health centers be able to effectively provide these services as well.

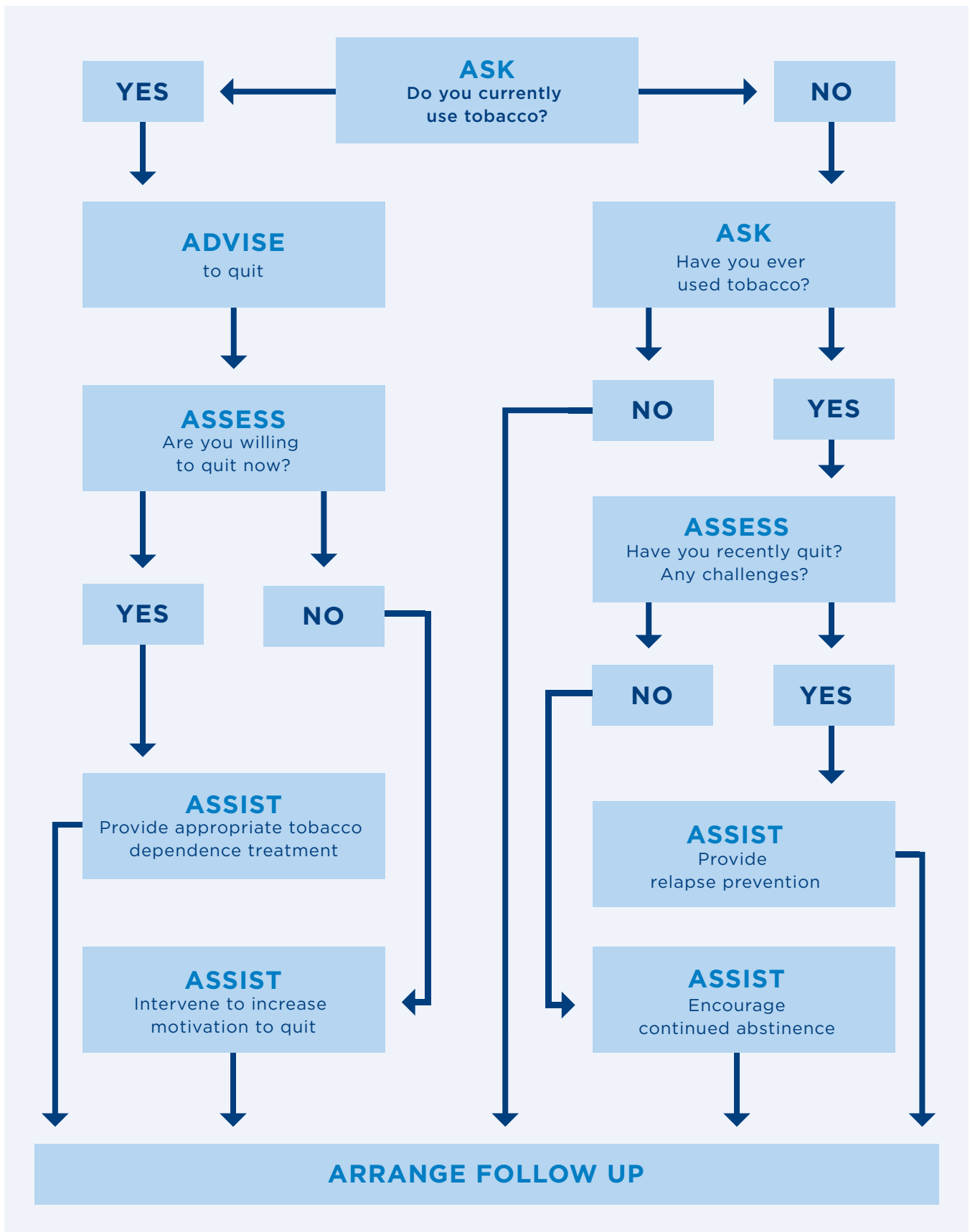
Health care organizations use different methods and carry out a variety of activities, but the overall goals are generally the same:

- Make sure that all tobacco users are identified, documented, and tracked at every medical encounter.
- Build tobacco cessation into the EHR and clinical staff workflow to treat tobacco users, with treatment defined as providing counseling, FDA-approved medication, and follow-up support.
- Embed the services successfully into the health center's systems and culture so that they become the standard of care.

The following sections describe the main activities involved in integrating tobacco cessation into your health center's clinical services. The information is designed for the clinical and education staff who may have this primary responsibility.

SELECT A TOBACCO CESSATION INTERVENTION MODEL

Treating Tobacco Use and Dependence: 2008 Update describes a brief tobacco intervention **5 A's model** (see the illustration on page 22 for a visual representation), which health centers can use to integrate tobacco cessation into their existing clinical services.⁶⁹ This evidence-based framework is a more comprehensive version of the activities encompassed by the two UDS performance measures described earlier in this guide (see page 17). In this model, providers:



Permission to print from the University of Wisconsin Center for Tobacco Research and Intervention.

- **ASK** about tobacco use;
- **ADVISE** to quit;
- **ASSESS** willingness to make a quit attempt;
- **ASSIST** in quit attempt; and
- **ARRANGE** follow-up.

If your health center has already integrated tobacco use identification and counseling to some extent into your clinical service offerings, you may feel you can move straight into the 5 A's model, which is the gold standard of cessation treatment.⁷⁰ If you're not ready for this comprehensive approach yet, you can still accomplish some of the same goals with a less expansive model, such as the **2 A's and R model**. In this model, providers:

- **ASK** patients whether they use tobacco;
- **ADVISE** those who use tobacco to quit; and
- **REFER** to evidence-based cessation services, such as a quitline or community cessation services.

Both of these evidence-based models are a flexible approach to counseling and treatment that can be carried out by one clinician in just a few minutes or by various staff over the course of an entire clinic visit. They can be used to help patients who will be successful on their first quit attempt as well as those who will need several attempts before they successfully quit. Tailor the model you choose to your health center's needs and the cessation services that are available in your community.

LEARN MORE!

The **American Academy of Pediatrics Julius B. Richmond Center of Excellence**⁹ has developed a number of downloadable PowerPoint presentations that can help your center's clinicians and educators learn more about the **5 A's**, the **2 A's and R**, and other counseling techniques, such as **motivational interviewing** and **role playing**. The presentations also provide valuable information about the effects of tobacco use and second-hand smoke on children and families, which may be especially useful for your staff when they counsel patients.

If you include these tobacco intervention steps in your patient records and work with your staff so that they are part of every patient visit, you can be confident that you always will be using an evidence-based approach to treating tobacco dependence. No matter which model you choose, your goal is the same: to make tobacco use identification and treatment an integral element of all your clinical services.

THE 5 A'S IN MORE DETAIL

This section describes the steps of the 5 A's model in greater detail. If you can, incorporate it into the Vital Signs and perhaps also the Medical History portion of your written patient record or EHR. Even if your center isn't quite ready to adopt the entire framework, knowing what is involved in each step can give you ideas for how to tailor the steps to your own center's capabilities and develop your tobacco cessation efforts over time.

EXPERIENCE FROM THE FIELD

Resource A provides a sample tobacco cessation clinical protocol from the Codman Square Health Center in Massachusetts and adapted screenshots showing how the protocol was incorporated into the center's EHR.

ASK

Tobacco Use Status

- Never Previous Current *some days* Current *every day*

For Tobacco Users

Type of tobacco:

- Cigarettes Smokeless

Level of use each day:

Exposure to Secondhand Smoke

- Never Previous Current *some days* Current *every day*

ADVISE

Advice to Quit Smoking or Using Other Forms of Tobacco

- Advice given (Date: _____) Advice not given

ASSESS

Readiness to Quit

- Not interested in quitting Thinking about quitting at some point Ready to quit

ASSIST

Counseling

- 3 Min or Less 3-10 Min 10+ Min
- Help patient set a specific date to stop smoking Refer patient to a smoking cessation class, program, or counseling Refer patient to a telephone quitline Provide patient with cessation educational materials

Pharmacotherapy (*Prescribe / Recommend*)

- nicotine gum nicotine lozenge nasal spray nicotine inhaler
- nicotine patch bupropion varenicline

ARRANGE

Follow-up Visit to Discuss Your Patient's Progress

- Follow-up visit in two weeks Address smoking at next visit

Adapted with permission from The Medical Society of the State of New York

At left is a template that covers all the essentials of the 5 A's in an easy shorthand version. A detailed explanation of each step follows.

THE 5 A's MODEL

ASK (medical assistant, nurse)

The UDS requires that all health center patients 18 years and older be asked about tobacco use. Meaningful use requires that all patients 13 years and older be asked about tobacco use. This action is the first step of the 5 A's model. ASK involves screening all patients for tobacco use at every visit and documenting the information in their health record. Find out whether your patient is a current or former smoker or has never smoked. For patients who do use tobacco, ask about the amount and the type(s) of tobacco product(s) they use.

Also ask about exposure to secondhand smoke. This is important whether your patient is a tobacco user or not. Find out whether your patient lives, works, or spends time in environments where other people smoke. Is it possible for your patient to avoid exposure to the secondhand smoke? Document this information in the health record.

ADVISE (doctor, physician assistant, nurse)

In the second step, ADVISE your patients who use tobacco to quit. Be clear, strong, and personal. Mention that quitting, or at least having a completely smoke-free home and car, is a good way to reduce children's and other family members' exposure to secondhand smoke. Congratulate those who have

quit successfully. Provide encouragement to those who have relapsed. Reassure them that it often takes several quit attempts to quit successfully, and state that you are there to help them succeed in quitting.

Consider giving your staff a script they can use after they screen for tobacco use. For example, *"As your clinician, I want you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you."* If you use EHRs, consider building in a sample script.

ASSESS (doctor, physician assistant, nurse)

The third step, ASSESS, involves determining the readiness to quit of patients who use tobacco. Ask, "Would you be willing to quit in the next 30 days?" Patients may be ready and eager to quit, thinking about quitting at some future time, or interested in cessation medications only to help with withdrawal symptoms. They also may not be willing to quit. Having a sense of your patient's state of mind about quitting will help you determine how to handle the next step in the framework.

ASSIST (doctor, physician assistant, nurse, health educator)

How you approach the fourth step, ASSIST, will differ depending on whether your client is willing or unwilling to quit.

If your patient is a current smoker who wants to quit, use the ASSIST step to provide or refer the



EXPERIENCE FROM THE FIELD

As a quality improvement measure, the Iowa Primary Care Association developed a screening tool to enroll only those patients most ready to quit into the association's intensive cessation programs. Initial data suggest this approach yielded an increase in the length of time spent in the program and a higher quit rate.

Permission to print provided by the Iowa Primary Care Association.



EXPERIENCE FROM THE FIELD

The Chronic Disease Health Educators at Myrtle Hilliard Davis Health Center in St. Louis Missouri incorporate tobacco cessation into the individual patient visit with their primary care provider. The health educators evaluate patient readiness to stop smoking, discuss quitline services, and with the patient permission, fax the referral to the quitline to enroll them in cessation services.

Permission to print provided by the Missouri Tobacco Control Program.

patient to treatment, which includes counseling and medications. This step includes five recommended elements (see **Resource B** for further details on each):

- Help your patient develop a quit plan.
- Recommend approved medications (except when contraindicated).
- Provide practical counseling and problem-solving skill training.
- Provide encouragement and social support.
- Provide supplementary materials, including information on quitlines.

Take advantage of existing evidence-based services. Quitlines (1-800-QUIT-NOW) are available in all states and provide free, confidential telephone counseling services. Tobacco users are offered support and a tailored quit plan from a trained health care professional. Some state quitlines also offer free or discounted pharmacotherapy. Many state quitlines offer fax-to-quit programs, where the provider faxes a referral form to the quitline and the quitline will call your patient. Some quitlines now accept electronic referrals as well as fax referrals. This provides a sustainable and seamless way to connect your patients to an evidence-based service. Often, the state quitline will provide an outcomes report, which can help you meet requirements for the patient-centered medical home model.

Give your patient a variety of referral options. Find out if any community organizations offer evidence-based, in-person cessation classes.

Patients who have access to the Internet may be interested in quit websites, such as **Smokefree.gov** or **BecomeAnEx.org**. The U.S. Department of Defense has **UCanQuit2.org**, a tobacco cessation website specifically designed for members of the military. Several new services, including **Text2Quit** and **SmokefreeTXT**, provide cessation support directly to mobile phones.

A more robust level of intensity for the ASSIST step is to offer on-site cessation counseling to all patients. Individual or group cessation counseling sessions can be managed by nurses, health educators, case managers, trained tobacco treatment

LEARN MORE!

Most smokers want to quit, but they don't know how. That's why Legacy developed **EX**[®], an evidence-based cessation plan that helps smokers "re-learn life without cigarettes." The centerpiece of **EX** is **BecomeAnEX.org**, a free website that prepares smokers for a quit attempt by helping them overcome smoking triggers, find medication, and enlist support from friends and family. The site also features a thriving online community where thousands of people share advice and encouragement. Research shows that the more times people visit **BecomeAnEX.org**, the more likely they are to abstain from smoking.

To learn more about EX,
visit **BecomeAnEX.org**.



specialists, medical students, or volunteers such as Community HealthCorps members. These individual or group cessation sessions can range from a single one-hour session to multiple sessions over several weeks. Research shows a strong relationship between the number of counseling sessions, when combined with medication, and successful quit attempts.⁷¹ If possible, offer the sessions in languages that represent your patient population for an even more comprehensive service.

LEARN MORE!

Founded by the National Association of Community Health Centers, **Community HealthCorps[®]** is the largest health-focused, national AmeriCorps program that promotes health care for America's underserved while developing tomorrow's health care workforce. These volunteers can be helpful in coordinating your tobacco cessation efforts.

If your patient is currently unwilling to quit, use Motivational Interviewing, a directive, patient-centered type of counseling that encourages

and strengthens motivation for change. It has been shown to be effective in increasing future quit attempts.⁷²

ARRANGE (doctor, physician assistant, nurse)

The fifth step, ARRANGE, involves actions that support your patients in their quit attempts. Providing follow-up support can easily fall by the wayside. It is important to set a time for a follow-up conversation, either in person or by telephone, within a week after a patient sets a quit date. These reminder systems can be built into EHRs. Some health centers have created cessation registries as a way to capture information about patients who are ready to quit. Such registries are often maintained by the health center health education department.

LEARN MORE!

For more information about Motivational Interviewing and help in learning this technique, visit the Substance Abuse and Mental Health Services Administration's **Motivational Interviewing[®]** website.

EXPERIENCE FROM THE FIELD

The Sea Mar Community Health Centers, in Seattle, Washington, created a cessation registry as part of their efforts to enhance ARRANGE activities and provide critical follow-up cessation support. The registry, an easy-to-use spreadsheet, tracks the number of patients served and their quit status. Staff members are able to easily record details about clients' tobacco use and treatment plans, such as frequency of current tobacco use and products used, past quit attempts, format of intervention (individual, group, or phone counseling), language of intervention, quit date, cessation medication plan, referral to the statewide quitline, and follow-up plan. Missed counseling appointments can be tracked as well. The information in the registry also allows the health center to provide continued support to clients through follow-up phone counseling, invitations to events and support groups, and tobacco program mailings. The registry is maintained by a Community HealthCorps member.

Source: Legacy Case Study "Creating a cessation registry and follow-up support"^T

During these supportive conversations, discuss your patients' progress in quitting. Congratulate abstinent patients on their success. Identify problems encountered, assess medication use and problems, devise practical solutions to current challenges, and anticipate future challenges. Remind patients about available support from quitlines and other community resources. Encourage patients who have relapsed to make a renewed commitment to quit, and help them identify strategies for staying quit.

PLAN AND PREPARE

Having chosen a tobacco cessation model, the next step—and an important key to ultimate success—is laying the groundwork to integrate the 5 A's model (or 2 A's and R) into your health center's existing clinical services. This planning and preparation involves several activities.

Find and Cultivate Champions

Securing buy-in from executive-level management, including governing board members and medical staff, is critical. Identify one or more champions among these groups who can build consensus around the value of tobacco cessation services, lead administrative or clinical activities to institute these services, coach and mentor other providers, serve as a cheerleader during the critical early period when the services are becoming fully embedded within the health center's systems, and assist in sustaining the services once they are established. At the same time, be careful not to become dependent on your champions. Focus on thoroughly integrating your tobacco cessation efforts into your clinical systems so that they can still thrive and be sustainable even if a champion is no longer involved.

Form a Tobacco Cessation Team

Well-coordinated teamwork is essential to the success of any clinical activity, and tobacco interventions are no different. To ensure that all service lines and locations of your health center

are represented and that you develop a cohesive plan for introducing and sustaining your tobacco cessation services over time, consider forming a team to plan and manage your activities. Identify a team leader who is passionate about tobacco cessation. Make sure your team includes members who represent administrative and clinical leadership as well as clinical and support staff. Have regular meetings, more frequently when your efforts are in the early stages.

Assess Your Patient Population

Make sure you have a good understanding of the populations your center serves and their tobacco use so that you can plan and organize the tobacco cessation services that best meet their needs. For example, if your center serves a multi-ethnic population, you may want to provide culturally tailored educational materials in several languages. If your center has a large and busy pediatric clinic, you may want to place a high priority on staff training sessions involving counseling about secondhand smoke exposure. You may already have a good sense of your patient population's use of tobacco from completing your HRSA funding application. Even if you can't collect and analyze data on your specific patient population, learn about the smoking rates of the demographics you serve.

The information you collect about your patient population will serve as a baseline against which to assess your progress in reducing tobacco use.

Assess Your External Environment

Learn about tobacco cessation services, programs, and materials that already exist in your community. As your program develops, you may find that partnerships with other community organizations that provide tobacco cessation services are useful in recruiting patients or as referral resources for more intensive counseling. Local public health departments, primary care associations, quitlines, and the local American Lung Association chapter often maintain lists of resources or programs that may be useful to you.

Assess Your Internal Environment

Learn about the attitudes and behaviors of your center’s clinical staff. How many of them are tobacco users? What do they need to effectively integrate tobacco cessation into their existing clinical practice and procedures? Being knowledgeable about and sensitive to your staff’s concerns and including them as part of a team will help you gain their support and participation when you plan and carry out your new tobacco cessation activities.



EXPERIENCE FROM THE FIELD

The North Carolina Community Health Center Association learned the value of assessing internal environment. Before jumping into physician training on the 5 A’s model, program planners revisited their project goals to ensure health centers were modeling healthy behaviors. They worked with health centers to institute tobacco-free facilities and help staff quit tobacco, resulting in a healthy, supportive environment for both patients and staff.

Permission to print provided by the North Carolina Community Health Center Association.

Set Goals and Objectives

Determine your overall goals, and within those, your specific objectives. These will depend on the tobacco-related activities you already conduct and whether your staff have the skills and training to deliver tobacco cessation services. Goals and objectives must be sensitive to staffing, time, and funding realities (See **Resource C: Implementing Tobacco Cessation Services in Community Health Centers—Sample Objectives, Goals, and Strategies**).

Depending on the situation at your center, your primary goals and objectives may be building staff capacity and identifying ways to change existing clinical practices to make time for tobacco interventions. On the other hand, if you are already providing tobacco cessation services to some extent—for example, you already ask about tobacco use with your patients who have diabetes or asthma and incorporate counseling into their

medical care—your goals may be focused on how you can broaden your efforts and integrate these services into other clinical services. Items to consider in setting goals and objectives include:

- the percentage of patients asked about tobacco use status and documented in the health record;
- the percentage of patients asked about exposure to secondhand smoke and documented in the health record;
- the percentage of tobacco users given tobacco cessation counseling interventions documented in the health record;
- the percentage of tobacco users offered cessation medications during clinic visits and documented in the health record;
- the administrative and clinical positions that have defined responsibilities for cessation activities; and

- the percentage of staff trained in the tobacco cessation model you choose (5 A's or 2 A's and R) and the health center's clinical protocol.

Assign Clear Roles and Responsibilities for Tobacco Treatment Interventions

Once a tobacco use screening and treatment template is in place, establish a standard procedure for executing each tobacco treatment element. For example, it may be most efficient for the nurse or medical assistant to carry out the ASK step (tobacco use screening) when he or she is collecting vital signs. The clinician should handle the treatment portion (counseling and medication).

Train Health Center Staff

The best planned tobacco cessation services will not succeed unless staff are well trained in their delivery. Although no uniform training curriculum on tobacco cessation has been developed for health centers, several helpful resources do exist. Online trainings on the 5 A's model have been developed for health care professionals. These trainings offer Continuing Medical Education and Continuing Education Units. Depending on your staff's needs, these trainings can last anywhere from 60 minutes to a total of 12 hours. You also can consider creating your own training tailored to your center's clinical protocol and workflow process. Make sure your training closely follows *Treating Tobacco Use and Dependence: 2008 Update* recommendations. Your state or local

tobacco control program at the health department could be helpful in planning or even conducting the training.

Offer the training to all center staff and volunteers, including physicians, physician assistants, dentists, mental and behavioral health providers, nurses, medical and dental assistants, educators, and office staff—anyone who might identify and document tobacco users or provide tobacco cessation messages or treatment to patients. Training also is an important way to help change the social norm of your center to a tobacco-free stance and sends a message that the entire center speaks with one voice on this issue. You may want to designate one or more staff members to be responsible for staff trainings and briefings. You also may want to assign particular staff to be tobacco cessation specialists and ensure they get certified as tobacco cessation treatment counselors. Spanning several days, these trainings are comprehensive and intensive.

Once tobacco cessation interventions are instituted as a standard part of care delivery, consider providing regular briefings and updates for staff. These sessions can help maintain tobacco cessation as a high-priority issue for your center and give staff an opportunity to discuss successes and challenges in providing tobacco treatment as well as ways to improve the delivery of services.



EXPERIENCE FROM THE FIELD

Milwaukee's Sixteenth Street Community Health Center has many Latino patients. In addition, many patients have longstanding relationships with providers at the center and prefer to access support services there. As a result, the team at the center decided that a key component of its services would be in-house Spanish-language tobacco cessation counseling.

Source: Legacy Case Study "Systems Change: Integrating tobacco cessation into health education and chronic disease management"¹¹



EXPERIENCE FROM THE FIELD

Through the Iowa Primary Care Association's tobacco cessation project, participating health centers modified their clinical workflows in a manner that was not laborious or disruptive to the clinicians or patients. All adult patients were screened for tobacco use at each visit, most often by a medical assistant or nurse, and the information was documented under Vital Signs. Patients who were willing to quit were given a brief intervention by a physician, nurse, or case manager. Patients unwilling to quit were given advice by the physician. By the end of the project, the participating health centers had a screening rate of 90 percent.

Permission to print provided by the Iowa Primary Care Association.

CONSIDER A PLANNING MODEL

A number of models have been developed to help groups plan, carry out, and improve initiatives. One of these is the Plan-Do-Study-Act model. You may find this kind of model useful for your own purposes.

Plan-Do-Study-Act (PDSA)

Organizations use this quality improvement approach to test a change in a service or procedure. It has been used in programs to promote the chronic care model in clinical settings. PDSA entails:

- identifying a specific problem in clinical services and developing a plan to test a change in the service;
- briefly changing procedures to address the problem;
- observing and learning from the changes; and
- institutionalizing the changes or conducting additional cycles to test other changes.

Source: Langley, G. L., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers. Also visit the [Institute for Healthcare Improvement website](#)^v for information about PDSA and worksheets.

CARRY OUT TOBACCO TREATMENT INTERVENTIONS

Preparing tobacco interventions is the first step. Planning and executing them is the next. Here are some tips to make the process more efficient in your health center.

Build In Efficiencies

Consider screening tools that can be used in the waiting room to identify tobacco users, such as Tobacco Use Conversation Starters. Other options for making the tobacco cessation workflow efficient are to institute real-time reminder systems and protocols, such as automatic prompts and scripts in the EHR, stickers in the Vital Signs section of a paper health record, or stamps to prompt staff to identify users and deliver treatment.

Institute Protocols to Make Services as Consistent as Possible across Your Center

The delivery of interventions may differ across services lines and center locations, even within service types. For example, your dental clinic, pediatric or adult primary care service line, and behavioral health specialty care may all have somewhat different procedures and workflow processes. Gather representatives from the various service lines to discuss ways to ensure that all tobacco interventions are provided and documented in the most consistent way possible.

LEARN MORE!

Several reputable institutions, including the **Mayo Clinic**^W, **University of Massachusetts Medical School**^X, **University of Arizona**^Y, **University of New Jersey Medical School**^Z, and the **American Lung Association**^{AA} offer tobacco cessation treatment certification programs for health professionals. The **Association for the Treatment of Tobacco Use and Dependence**^{BB} supports the **Council for Tobacco Treatment Training Programs**^{CC}, the accrediting body for Tobacco Treatment Specialist Training Programs. Other organizations such as **University of Wisconsin's Center for Tobacco Research and Intervention**^{DD} and **Rx for Change**^{EE} offer online training for health care professionals.

Consistency will help you deliver these services efficiently, and it will be critical in tracking and monitoring progress over time.

Determine and Assist with Insurance Coverage for Tobacco Dependence Interventions

Coverage for tobacco cessation counseling and pharmacotherapy varies across both private

plans and publicly financed plans such as Medicaid, Medicare, and military plans.⁷³ Know how to appropriately bill and receive reimbursement for services. Also, be aware of Medicaid and Medicare coverage policies. Medicare provides coverage for both counseling and prescription medications. Most state Medicaid programs provide some coverage for counseling or medications, with only a handful of states offering comprehensive coverage. Commercial health plans vary from plan to plan. Diagnostic codes for cessation counseling include ICD-9 (International Classification of Diseases, 9th Revision, Clinical Modification) code 305.1 for tobacco use disorder or V15.82 for personal history of tobacco use.⁷⁴

Connect patients without coverage to prescription assistance plans, and investigate the 340B Drug Pricing Program as a way to provide low-cost pharmacotherapy.

LEARN MORE!

Visit the North Carolina Tobacco Prevention and Control Branch for suggested **Tobacco Use Conversation Starters**^{FF}.

EXPERIENCE FROM THE FIELD

The Medical Society of the State of New York worked with a network of 16 health centers in upstate New York to educate center physicians and their clinical staff on the 2008 *Treating Tobacco Use and Dependence* 5 A's model. This six-session training was paired with a commitment to integrate tobacco cessation services into the network's EHR system. The training, combined with leadership from nurse champions, had dramatic results, including jumps in the number of patients advised to quit; referrals to quitline; and providers giving educational materials, prescribing or recommending medications, referring patients to cessation counseling, and suggesting specific quit dates. The health center network has established a tracking mechanism with clear benchmarks for progress. These data are shared with staff to provide motivation and guide future efforts. The results of this staff education and EHR initiative: an increase in the number of quit attempts and a decrease in the prevalence of tobacco use among center patients.

Permission to print provided by the The Medical Society of the State of New York.

Consider the Special Needs of Patients with Complex Medical Circumstances

Many health center patients have complex medical or behavioral health conditions, such as multiple chronic conditions, mental health conditions, or substance abuse problems.⁷⁵ For example, smoking prevalence is extremely high among people with mental illnesses.⁷⁶ About 36 percent of adults with mental illness smoke, much higher than the 21 percent of the general population who smoke.⁷⁷ More than 30 percent of all the cigarettes smoked by U.S. adults are smoked by individuals with a mental illness.⁷⁸

These patients, and the staff who care for them, may consider tobacco cessation a secondary

LEARN MORE!

Visit the **Partnership for Prescription Assistance**^{GG} for ways to help qualifying patients without prescription drug coverage get free or low-cost medicines. Learn about the 340B Program from NACHC's *Understanding the 340B Program: A Primer for Health Centers*^{HH} and from HRSA's **340B Drug Pricing Program & Pharmacy Affairs**^{II} web page.

consideration compared with their other health issues. Educate your behavioral health staff to understand the importance of tobacco cessation

TOBACCO USE TREATMENT BILLING CODES

Commercial Health Plans

The following Current Procedural Terminology (CPT) codes are for face-to-face counseling by a physician or other qualified health care professional:ⁱ

- **99406** For intermediate visit of between three and 10 minutes;
- **99407** For an intensive visit lasting longer than 10 minutes.

Medicare

The following codes are to be used for Medicare fee-for-service schedule patients:ⁱⁱ

- **G0436** Smoking and tobacco use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes;
- **G0437** Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes.

Medicaid

Coverage for tobacco treatment varies from state to state. However, the 2010 Affordable Care Act made some changes that affect Medicaid coverage of tobacco cessation treatments. Among these are the requirement that states cover a comprehensive cessation benefit for pregnant women, and the removal of tobacco cessation medications from the list of excludable medications.

ⁱ U.S. Department of Health and Human Services. (2008, May). *Treating Tobacco Use and Dependence: 2008 Update* (Appendix C). Rockville, MD: U.S. Department of Health and Human Services. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK63955/>

ⁱⁱ Center for Medicare and Medicaid Services. Medicare Learning Network #MM713. Retrieved from <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7133.pdf>

for the overall health of their patients, and develop guidance to help them incorporate tobacco interventions into the ongoing care of patients with complex medical situations. A particular challenge for behavioral health and substance abuse providers is that they currently cannot bill health plans for tobacco cessation services, but you may be able to work out a mechanism for cross-referral to physical health providers, who can be reimbursed.

LEARN MORE!

Read about the toll of tobacco use on those with mental illness and the gaps in tobacco intervention services in behavioral health care in Legacy's 2011 report, ***A Hidden Epidemic: Tobacco Use and Mental Illness***^{JJ}.

Make the Most of the Electronic Health Record

If your health center uses an EHR system, it can be a valuable tool for building tobacco cessation services into your center's existing services. A center-wide EHR with this capability means that all staff use the same template, enabling them to more effectively coordinate care. Including tobacco use documentation and interventions in the EHR also provides an opportunity for the center to collect valuable data on provider performance and patient outcomes that can be tracked and measured over time. These data

LEARN MORE!

Learn more about billing and coding for tobacco dependence treatment with resources from ***Treating Tobacco Use and Dependence: 2008 Update***^{KK}, **The American Academy of Family Physicians**^{LL}, and **Center for Tobacco Research and Intervention, University of Wisconsin**^{MM}.

can be used for quality improvement initiatives as well as for HRSA requirements for reporting on tobacco use assessment and counseling performance measures (See **Resource D** for the American Academy of Family Physicians tobacco template for EHRs).

Include Tobacco Cessation in Health Education Programs

As part of their mission to provide comprehensive primary care, many centers have active health education programs, particularly for patients with chronic conditions such as asthma or diabetes. These programs provide information, guidance, and tools to help patients effectively manage their conditions. Effective management of chronic conditions can reduce hospitalizations, improve health, and enhance quality of life.⁷⁹

Integrating tobacco cessation education into existing health information programs can help patients understand how important quitting can be to managing their chronic conditions and improving their overall health. It provides a critical support and extension to the information and treatment already provided by clinical staff.

Many health centers are beginning to establish group visits for managing chronic diseases, such as diabetes. One model for group visits is the cooperative health care clinic. These are generally two-hour appointments co-led by a physician with nursing support. The visits are devoted to a specific disease or health topic, and patients struggling with the topic at hand are invited to attend. You may want to consider setting up a similar type of group visit program for tobacco cessation.

One key component to this effort is education about secondhand and thirdhand smoke and their effects on the health of children and family members, friends, and co-workers. Health educators can encourage parents and adults who are unable to quit not to smoke in the house or car (see page 27 for more details on the health effects of secondhand smoke).



LEARN MORE!

The American Academy of Family Physicians has several useful resources on establishing and managing group visits, such as **Group Visits 101^{NN}**.

DEAL WITH CHALLENGES

Challenges are bound to come up in the process of integrating tobacco cessation services with

EXPERIENCE FROM THE FIELD

The team at the Center for Tobacco Research and Intervention at the University of Wisconsin School of Medicine and Public Health worked for several years with the Dean Health System, a large integrated health care system in south central Wisconsin, to integrate the 5 A's model into their EHR. They learned two important lessons, which are likely to be relevant no matter what kind of tobacco cessation intervention you are able to implement in your center. First, merely building a new component into the EHR was not going to guarantee that it would be used. The project had to have buy-in from the clinicians and staff who were going to use it. Staff also needed training so that they would understand how to use the template and, more importantly, understand their role in the overall process of identifying, documenting, and treating patients who use tobacco. The second reality was that clinical staff are pressed for time. If they were going to carry out this one new task, they had to be able to do it quickly and efficiently, building it into what they were already doing. As a result, the development team spent considerable time:

- Writing brief scripts to guide providers through each step in the intervention. This information is also included in the after-visit written summaries given to patients.
- Creating drop-down menus and checkboxes so that staff had to do very little data entry.
- Establishing standards that clearly defined which staff would carry out which parts of the intervention. For example, medical assistants ASKed about and documented tobacco use while they collected vital signs information. This set up the ADVISE and ASSESS part of the intervention for the clinician.
- Pilot testing the workflow and language of the EHR.
- Providing in-person and online training to various departments across the Dean Health System, including family medicine, internal medicine, and obstetrics/gynecology.

Source: Legacy Robert Adsit, Center for Tobacco Research and Intervention at the University of Wisconsin School of Medicine and Public Health

EXPERIENCE FROM THE FIELD

At Sixteenth Street Health Center in Milwaukee, WI, tobacco cessation is not viewed as a stand-alone program. Rather, it is integrated into every aspect of health education. For example, tobacco smoke is reviewed as an asthma trigger during asthma education visits. Diabetes education includes awareness of how smoking can lead to impaired glycemic control and diabetes complications.

Source: Legacy Case Study “Systems Change: Integrating tobacco cessation into health education and chronic disease management”^{oo}

existing clinical services. Health centers have offered a number of suggestions for dealing with these challenges. Common challenges include the following.

Making and Sustaining Contact with Patients

It may be difficult to recruit populations within your community who have high rates of tobacco use. It may be hard to continue a conversation about tobacco cessation with certain patients you have seen in the office and provided with a brief tobacco intervention, especially if you have high turnover among your patient population or if patients do not come to scheduled counseling or treatment appointments. Patients may also have challenges with transportation, child care, and housing, which can make it difficult to sustain contact with them or impair their ability to connect with local programs if they are referred outside of the health center.

These realities should not be a deterrent to providing essential cessation services. Forming partnerships with other local organizations or agencies that have good relationships with

various community populations may be one way to solve this problem. Including staff of these agencies in tobacco cessation education and training efforts you provide for your own staff is another. You also may want to engage non-traditional health care workers, community health workers, and health navigators to help you with outreach, referrals, counseling, and support.



EXPERIENCE FROM THE FIELD

Recognizing the high prevalence of tobacco use among people with mental health conditions, the Sea Mar Community Health Centers in Seattle record any mental health diagnoses in their cessation registry so that cessation interventions can be coordinated across service lines at the centers (see page 27 for more about Sea Mar’s cessation registry).

Source: Legacy Case Study “Creating a cessation registry and follow-up support”^{pp}



EXPERIENCE FROM THE FIELD

To maintain knowledge of its tobacco cessation program in the face of staff turnover, the Association for Utah Community Health developed a “Tobacco Cessation Program” section for its health centers’ new-employee orientation handbook.

Permission to print provided by the Utah Tobacco Control Program.

Ensuring Continued Support and Interest from Center Leadership and Staff

Once you have integrated tobacco cessation into your clinical services, sustaining the commitment of staff to carry out these services will be critical. Finding a solid institutional home for the services and having enthusiastic champions to coordinate the program are essential. Consider the following:

- Keep tobacco cessation on the minds of clinical and administrative staff by including tobacco cessation on staff meeting agendas.
- Provide regular trainings for new staff and refresher trainings for other staff. Put up posters in the nurses’ stations and staff lounge.
- Ask patients to write “I quit tobacco!” testimonials for the health center newsletter.
- Share results from regular monitoring and evaluations of the service with staff members.

Let clinicians know the percentage of their patients who are identified as tobacco users and the percentage who are treated for tobacco dependence. Show them how they are doing compared to their colleagues. Results, both encouraging and discouraging, can be a powerful motivator for action.

Maintaining Institutional Knowledge in the Face of Staff Turnover

It may be hard to maintain knowledge about your tobacco cessation services and procedures if your clinic experiences substantial staff and clinician turnover. Developing a “Tobacco Cessation Services” section in the new-employee handbook and including tobacco cessation in new staff training and orientation is one way to address this challenge. Ask departing staff to write up any tobacco cessation tips or lessons learned for new staff coming in. Once the new staff have settled in, have your center’s tobacco champions meet with them to review procedures and answer questions.

Tracking Cessation Interventions

Instituting a new EHR system or making additions requires staff time, funding, and, at times, compromise on what measures to include or exclude. For example, you may experience resistance to adding tobacco use to the Vital Signs section of the record or to building in automatic prompts and referral pathways. One strategy is to ensure buy-in for tobacco cessation from both clinical leadership and health information technology leadership. Not only do tobacco use questions improve clinical care, but they also



EXPERIENCE FROM THE FIELD

Health centers in Oregon worked with their electronic health record providers to improve tobacco cessation referral tracking systems.

Permission to print provided by the Oregon Tobacco Prevention and Education Program.

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help health centers meet the requirements for meaningful use. If you already have an EHR and have successfully integrated tobacco cessation interventions into it, you may face additional challenges if you refer patients to a quitline that sends only paper reports back to you. For health centers without EHRs, tracking tobacco cessation activities requires chart review. Although these activities are time-consuming, they are worthwhile to ensure that patients are tracked and for quality improvement.

MONITOR, MEASURE, AND SUSTAIN PROGRESS

Instituting and maintaining an integrated tobacco cessation intervention program takes time and sustained commitment at all levels of your center. Building an extended timeframe into your thinking from the very start can help you cope with progress that may be slower than you would like. Developing ways to track and measure progress over the long term can help your center maintain enthusiasm for its tobacco cessation efforts and sustain and improve these efforts over time. You may want to revisit your initial goals and objectives to help you determine which to track and measure.

EXPERIENCE FROM THE FIELD

Through a tobacco cessation project of the Mississippi State Department of Health and the Mississippi Primary Health Care Association, health clinics administer patient surveys before and after cessation interventions to determine demographic information, prevalence of tobacco use, and willingness to quit tobacco. Patient chart reviews are also conducted to assess providers' implementation of clinical strategies to treat tobacco use and dependence. This data is used to provide trainings and support system changes within community health centers.

Permission to print provided by the The Mississippi Tobacco Control Program.

CONCLUSION



Tobacco use is the leading preventable cause of death and disease in the United States today, and it presents a particularly onerous burden for the patient populations served by community health centers. In our current health care environment, health centers are under increasing pressure to improve the efficiency and quality of health care and to reduce its costs. Because of tobacco's importance to so many aspects of health, integrating tobacco cessation services is one way that health centers can make major strides in achieving these goals.

Taking time to follow the suggestions in this guide can increase your potential success in integrating tobacco cessation into your existing clinical services. We hope these efforts will translate into reduced tobacco use and improved health among your patient population.

6



CASE STUDIES

Health centers around the country have begun to institute tobacco cessation programs, and their experience has informed the content of this guide. The case studies in this section describe the experience of health centers in four states—Massachusetts, North Carolina, Oregon, and Utah.* The case studies demonstrate the variety of routes that health centers can take to reach their goals and some of the innovative solutions that were used to overcome challenges along the way.

MASSACHUSETTS

TOBACCO CESSATION AND ORAL HEALTH



Background

In 2010, the Boston Public Health Commission contracted with the Massachusetts League of Community Health Centers for a two-year project to integrate tobacco use screening and referrals into oral health clinics. The project was funded at approximately \$244,000 and supported by Boston’s “Communities Putting Prevention to Work” grant, an American Recovery and Reinvestment Act (ARRA) funded initiative through the Centers for Disease Control and Prevention. The project goals were to:

- 1) Increase the number of oral health providers screening tobacco users and referring them to treatment;

* Case studies were printed with permission from the Massachusetts League of Community Health Centers, Davidson College, Oregon Tobacco Prevention and Education Program, and the Utah Tobacco Prevention and Control Program.



- 2) Integrate QuitWorks—a free tobacco cessation referral service developed by the Massachusetts Department of Public Health in collaboration with the major health plans in the state—into oral health clinics;
- 3) Increase quit attempts among patients; and
- 4) Promote policy changes for reimbursement.

The League recruited nine Federally Qualified Health Centers (FQHCs) for the project and provided training and technical assistance. During the recruitment period, MassHealth (the state’s Medicaid program) cut adult dental benefits. As a result, Massachusetts’s Health Safety Net started to cover medically necessary oral health services for adults who had been eligible for MassHealth dental benefits, but only at community health centers. This affected the number of clinics recruited, because patient numbers skyrocketed and resources were stretched even further.

Training

The League collaborated with the University of Massachusetts Medical School to provide full-day tobacco education sessions covering topics that addressed the project objectives. A total of 60 dentists, dental hygienists, dental assistants, and

office managers from the nine health centers were trained. Incentives were offered, such as continuing education credits through the Massachusetts Dental Society and compensation to the FQHCs for missed staff time (based on number and seniority of staff who completed the training). To ensure continuation of the project after funding ended, the League conducted a train-the-trainer course for senior dental staff.

Technical Assistance

Before the project, health centers had limited documentation of tobacco screenings and no standardized protocols for tracking screening and counseling. The League worked with each health center to redesign the workflow to accommodate implementation of a screening and intervention process. Four questions were used as a framework to guide the system changes.

1) Who will screen patients for tobacco use?

By the end of the project, some health centers chose to designate only dentists to conduct tobacco use screening, while others use a combination of dentists, hygienists, and assistants. In some centers, patients were asked about tobacco use

by both the hygienist and dentist, especially if the patient indicated he or she used tobacco.

2) When will screening patients for tobacco use take place?

All nine health centers elected to screen during the initial visit. Most screened during periodic exams, and some centers conducted additional screenings at hygiene visits and extraction services.

3) How will patients be screened?

Screening tools that could be integrated into dental charts and serve as a prompt for providers were created for the four centers with paper records. For example, one center created a carbon-copy tool, allowing the dentists to include one copy of the patient's tobacco history in the patient's file and another copy to a tobacco cessation counselor on site. Another center recorded tobacco use on the dental intake form and developed a Google account to store information about tobacco users and their referrals.

One health center took the lead to develop a protocol for Dentrix, the software used by all four of the centers with electronic health records (EHRs), and to collaborate with the other health centers. This process involved developing dummy codes for screening and referrals that would allow providers to enter "charges" for the services and track referrals through the system. Because MassHealth and commercial dental insurance did not cover tobacco cessation screening and counseling by a dental provider, these services were provided at no charge for patients.

4) How will patients be connected to resources?

All participating centers provided a brief counseling intervention consistent with the 5 A's intervention model, which generally was conducted by the dentist. Additionally, all centers integrated QuitWorks into their oral health clinics.

The number of health clinics that provided on-site cessation services varied. One health center

employed a tobacco cessation counselor who provided individual counseling. Two centers offered group cessation classes, one of which was led by an AmeriCorps member. Two centers referred patients to a primary care provider for cessation and pharmacotherapy. Only one center prescribed nicotine replacement therapy.

Evaluation and Results

To evaluate the success of the project, the League created a customized data collection tool for the health centers and provided monthly reports. The number of patients who were screened and counseled about tobacco use increased significantly. They also were able to track the prevalence of tobacco use, the number of patients referred to services and where they were referred (QuitWorks, in-house cessation service, primary care, prescription, educational materials), the number of patients who were already attempting to quit and/or on medications, and the number of patients who reported tobacco use and refused additional services.

For more information, contact Shannon Wells, MSW, Oral Health Affairs Manager, Massachusetts League of Community Health Centers, at swells@massleague.org or 617-988-2203.

NORTH CAROLINA

TOBACCO CESSATION IN FREE CLINICS



Background

Six free clinics in North Carolina participated in a pilot study to evaluate the opportunities and challenges associated with implementing the U.S. Public Health Service (PHS) *Guidelines for Treating Tobacco Use and Dependence* in free clinics that treat the uninsured. With a grant from the National Institute of Drug Abuse, the study was conducted by researchers at Davidson College, Wake Forest School of Medicine, University of Kentucky, and the North Carolina Association of Free Clinics.⁸⁰ Five objectives were targeted:

- 1) Implement a tobacco user identification system.
- 2) Educate all clinic staff and volunteers.
- 3) Dedicate a program champion.
- 4) Use evidence-based treatment.
- 5) Create a supportive environment that reinforces provider behavior.

The six clinics each serve between 400 and 4,000 clients annually and employ between two and 11 full-time staff. What makes these free clinics unique compared to FQHCs is the heavy reliance on volunteer health care providers, the number of whom may fluctuate from day to day. They also serve exclusively uninsured clients.

Tobacco Cessation Champions

All clinics appointed a program champion to ensure that the PHS guidelines and strategies were implemented. In five of the clinics, the program champion was a paid staff member (four appointed executive directors; one appointed the breast/cervical cancer coordinator). One clinic dedicated a volunteer to this position. Researchers found value in having either paid staff or volunteers serve in the role. The paid staff champions were in a position to integrate the PHS guidelines without

needing to receive buy-in from upper-level administration; a downside was that attention to tobacco cessation could easily be diverted given competing administrative and clinical demands. The volunteer champion was both able to innovate and dedicate significant time to the project, meeting with patients one on one, following up by phone, and creating a tracking system. Researchers noted that it was unclear if the cessation work could be sustained were the volunteer to leave.

Staff and Volunteer Training

Before the intervention, the clinics had no systematic training for staff on the PHS guidelines for tobacco cessation. As part of the pilot study, all clinics received an on-site training that covered the five project objectives. Physicians were offered Continuing Medical Education credits. Clinics were also offered an online training, though the on-site training was better attended than the web-based training. Program champions were concerned over the lack of participation by volunteers, who are essential to the work accomplished in free clinics. In two of the six clinics, all paid staff attended the training. One clinic stressed the importance of training paid staff because they are the ones who consistently see patients in a clinic.

Several clinics suggested using a train-the-trainer model of provider education for program champions, who then train clinic staff and volunteers. Embedding cessation training into orientation was deemed both cost-effective and complementary with the existing structure of all clinics.

Clinic Innovation

Several clinics took innovative action to encourage their clients to quit tobacco. To address concerns about weight gain after quitting, one clinic offered applications to the local YMCA. Another clinic created follow-up forms for patients who expressed willingness to quit.

Opportunities and Challenges

The researchers identified common challenges to program fidelity across the clinics. One barrier unique to free clinics is access to pharmacotherapy for uninsured patients. Free clinics build the cost of over-the-counter and prescription drugs into their annual budgets in order to provide low- or no-cost medication to patients. Given limited resources and the need to prioritize, funding for medications such as nicotine replacement therapies is often not included in the budgets. Additionally, clinic staff were somewhat uncertain and unfamiliar with the use of tobacco cessation quitlines as a referral resource. Quitlines, the researchers determined, should be a key component of staff training.

Clinic leadership were overwhelmingly in favor of sustaining tobacco cessation strategies beyond the scope of the research project. As one clinic director commented, "...it is a part of our culture now."

This case study is an adaptation of "Integrating Evidence-Based Tobacco Cessation Interventions in Free Medical Clinics: Opportunities and Challenges," published in the September 2012 issue of *Health Promotion Practice*. For more information, please contact Kristie L. Foley, PhD, Medical Humanities Program, Davidson College, at krfoley@davidson.edu.

OREGON

TOBACCO CESSATION AND CHRONIC DISEASE SELF-MANAGEMENT

Background

In 2010, with funding from a CDC asthma-related grant, the Oregon Public Health Division began a partnership with the Oregon Primary Care Association to improve patient self-management among the state's low-income populations. A Patient Self-Management Collaborative was developed to improve participation in community self-management programs by patients of FQHCs. The CDC asthma grant is managed by the Oregon Public Health Division, and funding is distributed to the Oregon Primary Care Association. In the first year, the initiative received \$60,000 in funding, which was allocated to support staff time, technical assistance, and training for the FQHCs. The Patient Self-Management Collaborative, recognizing the importance of addressing tobacco use among its population, integrated tobacco cessation clinical services into the program.

Groundwork and Implementation

The Oregon Primary Care Association recruited seven FQHCs situated in various locations in the state. These clinics were tasked with assembling a team of staff and community partners, who were in turn charged with improving patient self-management through systematic referrals to community-based programs, such as the state quitline and the Stanford Chronic Disease Self-Management Program (CDSMP). CDSMP is a two-and-a-half-hour workshop offered once a week, for six weeks at a time, in various community settings. Workshops are available throughout the state of Oregon. Participants in CDSMP learn how to set self-management goals, develop action plans, and communicate effectively with their health care team. The skills participants gain through CDSMP workshops also assist them in their

tobacco cessation efforts. For more information on CDSMP, visit HealthOregon.org/LivingWell.

Training the team

Clinic staff receive training on achieving systems change and implementing tobacco cessation services. Each clinic team practices skills in patient-centered communications, develops an aim statement that answers the question, "What are we trying to accomplish?" as well as measurement plans, and conducts Plan-Do-Study-Act cycles. As a result, the clinic teams are able to describe their desired outcomes of the system change in a measurable and time-specific way, and they learn how to plan, implement, observe, and act on what they learn. Each clinic team also participates in regular coaching calls and motivational interviewing training. In addition, clinic staff are trained to ask patients about tobacco use, counsel tobacco users, and refer users to the state quitline. Clinic teams work with community partners to develop protocols for systematic referrals to the quitline using electronic health records.

Integrating and Evaluating Tobacco Cessation Services

At the clinic level, the Patient Self-Management Collaborative supports tobacco cessation services in FQHCs through systematic referrals to the state quitline. During the clinic visit, patients are screened for tobacco use, and identified tobacco users are counseled and referred to the state quitline. The tobacco use assessment, counseling, and quitline referral provided by trained clinic staff are documented in the EHR. Clinics use the fax referral reports from the quitlines to "close the loop" on

the referral and indicate the patient outcome in the EHR. Tobacco users with one or more chronic conditions are also referred to the CDSMP for additional support. Tobacco users can learn about the CDSMP not only through the clinics but also quitlines. Quitline callers seeking tobacco cessation support and having one or more chronic conditions are given the opportunity to participate in CDSMP and are mailed information about the program.

Tobacco cessation medication is provided during the visit, depending on the patient's insurance provider and the current quitline nicotine replacement therapy benefit. Most community health centers see primarily Medicaid or uninsured patients. In Oregon, each Medicaid plan establishes a unique tobacco cessation benefit package. The most recent assessment reported all plans covered patches, Wellbutrin, and Chantix. Medicaid plans do not require a co-pay for covered cessation medications, with the exception of the fee-for-service program, which charges a three dollar co-pay for Chantix. The quitline offers two weeks of the nicotine patch and gum to uninsured callers. Coverage and co-pays for patients with other insurance types vary by their individual plans.

Evaluation of the initiative is conducted from data each clinic reports twice per year on the following tobacco measures: tobacco use assessment, tobacco cessation counseling, closed-loop referrals to the quitline, and documentation of self-management goals in the patient chart. FQHCs also conduct a quarterly assessment of their progress using the **Assessment of Primary Care Resources and Supports for Chronic Disease Self Management**^{oq} quality improvement tool.

Challenges to Overcome

Oregon is facing some challenges in implementing its tobacco clinical services. EHRs often do not have sufficient functionality to track and report the data needed to successfully implement and monitor cessation services. This has led to challenges in collecting data to evaluate the results of implementing clinical services across participating FQHCs. The Oregon Primary Care Association is



working on this issue through continued conversation with clinics and the primary EHR provider in Oregon.

Achievements

By focusing on integrating tobacco cessation services into the clinic's daily practice, FQHCs were able to develop systematic protocols for closed-loop referrals to the quitline and CDSMP. A surprising but positive result developed from the initiative: Many clinics chose to maintain ownership of self-management programs like CDSMP rather than refer patients to community services. The FQHCs recognized that patients felt more comfortable attending workshops in a familiar environment such as the clinic. As a result, FQHCs are able to offer regular and successful CDSMP workshops to their patients in an accessible manner. Another unanticipated success was the seamless fit of these services into the Patient Centered Medical Home model, which enhances team-based care and develops strong relationships with patients and their families. Oregon plans to expand current efforts to additional clinics if additional funds become available.

For more information, contact Beth Sanders, MPH, Oregon's Tobacco Prevention and Education Program, Oregon Health Authority, at elizabeth.c.sanders@state.or.us.

UTAH

TOBACCO CESSATION AND STAFF TRAINING

Background

Although Utah's overall smoking rates are low, the prevalence of tobacco use varies widely among population groups.⁸¹ In 2002, the Utah Department of Health, Tobacco Prevention and Control Program (TPCP) set a goal to work with health centers to offer culturally sensitive, affordable, and effective tobacco cessation services to ethnically diverse and low-income patients. According to the 2011 UDS, Utah's health centers provided primary and preventive health care services to nearly 113,000 underinsured, uninsured, and underserved Utahns. Utah's health centers served a diverse population: Five percent identified themselves as migrant and seasonal farm workers, six percent were homeless, and 0.4 percent were veterans.

Additionally, Utah's health centers provided care to:

- One out of every six uninsured in Utah;
- One out of every five uninsured children in Utah;
- One out of every 15 Medicaid beneficiaries in Utah; and
- One out of every 17 rural residents in Utah.

The health centers involved in this initiative are all members of the Association of Utah Community Health (AUCH).

Leadership

The statewide tobacco cessation efforts described in this case study are led by the AUCH and the Utah TPCP. The collaboration between AUCH and the Utah TPCP began more than 10 years

ago, when staff from the Utah TPCP approached the executive director of AUCH with plans for assisting AUCH-affiliated low-income patients with overcoming tobacco addiction. The executive director was an enthusiastic supporter and played a key role in the execution of the initiative. Funding was granted by the Utah TPCP, and the program is managed by AUCH. The funds are used to provide tobacco cessation medications for patients and to support the training of health care providers within participating community health centers.

How It Works

As part of Meaningful Use and HRSA's Unified Data System measure requirement, all patients are screened for tobacco use. Patients who are identified as tobacco users at participating AUCH community health centers are offered up to 12 weeks of bupropion or 24 weeks of Chantix per year at no cost. Free tobacco cessation counseling is provided, in addition to the medications, through the health centers or a referral to the Utah Tobacco Quit Line (UTQL). Whenever possible, behavioral health providers see the patient initially and encourage them to use UTQL services. Patients also can be referred to the UTQL by their health educator, primary care provider, or in-house pharmacist. Follow-up generally occurs at the end of the counseling period or the patient's next visit. AUCH receives monthly and quarterly usage reports from its member clinics regarding the number of clients who received free tobacco cessation medication and how many prescriptions were provided. The Utah TPCP Quit Line report provides AUCH with the number of fax/electronic referrals to the Utah Tobacco Quit Line each month. Tobacco



intervention data were initially tracked by the AUCH pharmacy services coordinator through chart pulls; however, with the implementation of EHRs, health center staff are now being trained to enter patient data, including tobacco reduction/cessation information, into the EHR. The information entered by the health centers can be retrieved and reviewed in Uniform Data System reporting.

Challenges and Lessons Learned

One of the major challenges in implementing the tobacco cessation services is managing clinician turnover. In the current environment, it is difficult to retain staff members who are adequately knowledgeable about tobacco cessation services and procedures. To address this problem, AUCH pharmacy services coordinators developed a “Tobacco Cessation Program” section within the health center employee orientation guide to ensure that standard training is provided to all clinicians. The guide includes information on the vision and objectives of the program, the 5 A’s, the Utah Tobacco Quit Line, the Tobacco Cessation Program formulary, and prescribing guidelines.

One major lesson learned during the implementation of tobacco cessation services within Utah’s health centers is the importance of collaborating rather than competing with other important

clinical services. The health centers are very busy, and clinicians are often overwhelmed with project proposals for different clinical services. For example, AUCH is involved with two other programs with the Utah Department of Health Bureau of Health Promotion Programs: the Diabetes Prevention and Control Program and the Heart Disease and Stroke Prevention Program. Rather than have AUCH work separately on each initiative, Bureau of Health Promotion staff decided to move toward a unified and collaborative shared work plan, with tobacco cessation screening and treatment an integral part of treatment for tobacco users with other chronic conditions such as diabetes or high blood pressure.

An additional positive outcome of this initiative was that the health centers decided to implement tobacco-free campus policies. These policies protect clients from secondhand smoke exposure and assist those who have quit or want to quit by creating a health care environment that supports and encourages their efforts.

For more information, contact Marci Nelson, CHES, Health Program Specialist, Tobacco Prevention and Control Program, Utah Department of Health, at marcnelson@utah.gov or 801-538-7002.

7



RESOURCES

RESOURCE A:

Sample Tobacco Cessation Intervention Clinical Protocol and Electronic Health Record Tracking

RESOURCE B:

Five Recommended Elements of the ASSIST Step in the 5 A's Tobacco Brief Intervention

RESOURCE C:

Implementing Tobacco Cessation Services in Community Health Centers—Sample Objectives, Goals, and Strategies

RESOURCE D:

Integrating Tobacco Cessation Into Electronic Health Records, from the American Academy of Family Physicians

RESOURCE E:

ActionToQuit and Legacy Web Pages

RESOURCE F:

Web Links for Resources Cited in this Guide

RESOURCE A: SAMPLE TOBACCO CESSATION INTERVENTION PROTOCOL AND ELECTRONIC HEALTH RECORD TRACKING^{82,83}

Codman Square Health Center Protocol for Tobacco Screening for Providers

Updated February 7, 2008

Provider Protocol:

During a Visit with MD, PA, or NP:

1. At Intake, MA or Nurse performs Tobacco screening. The results (e.g., Current, Previous, or Never) are documented by the MA or the Nurse on the VS Form. The documentation is also displayed in the Tobacco section of the Histories Form for easy provider access.
2. Provider verifies Tobacco Status and updates it if a different history is obtained.

For Current Smokers:

1. Provider advises patient to quit smoking and documents this by checking the “Advised to Quit” radio button on the Histories tab.
2. Provider assesses patient readiness to quit (“Are you considering quitting in the next few months?”) and documents Yes or No using the radio buttons.

For Current Smokers Who Are Not Ready to Quit:

1. If Provider counsels patients on Reasons to Quit or Barriers to Quitting, these Brief Interventions are documented by checking appropriate boxes on the fifth tab of the Histories Form, labeled “Tobacco Interventions.”

For Current Smokers Who Are Ready to Quit:

1. Provider counsels patient on one or more of following: Reasons to Quit, Barriers to Quitting, Quit Date, Pharmacotherapy, QuitWorks, On-site Counseling.
2. Provider documents these Brief Interventions by checking appropriate boxes on the fifth tab of the Histories Form, labeled “Tobacco Interventions.”

Additional Information about Brief Interventions:

1. A patient handout on Smoking Cessation can be printed by clicking the “Tobacco Handout” button in the Tobacco section of the Histories Form.
2. A Referral to Quitworks can be printed by clicking the “QuitWorks Referral” button in the Tobacco section of the Histories Form or on the Tobacco Intervention tab of the Histories Form.
 - a. Fill out the required fields with the patient, and fax to QuitWorks.
 - b. QuitWorks is appropriate for patients at any stage of their process of behavioral change.
3. An appointment for In-House Counseling can be made by scheduling an appointment with a smoking cessation counselor (Tobacco Treatment Specialist) in MSI.
4. Pharmacotherapy options (see Quick Guide to Pharmacotherapy):
 - a. Nicotine replacement options—Patch, Gum, Lozenge, Nasal Spray, or Inhaler
 - b. Non-nicotine medications—Bupropion (Zyban) or Varenicline (Chantix)

Permission to print provided by Codman Square Health Center.

QUITWORKS

Quick Guide to Pharmacotherapy in Tobacco Treatment

NICOTINE REPLACEMENT (NRT)

Combining long-acting NRT (patch) with a short-acting NRT (gum, lozenge, or inhaler) is more effective than using a single type of NRT

LONG-ACTING PRODUCTS

PATCH

7 mg, 14 mg, 21 mg	Dose: 1 patch every 24 hrs. 21 mg patch if ≥ 10 cig/day 14 mg patch if < 10 cig/day	Duration: 6-14 wks
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SHORT-ACTING PRODUCTS

GUM

2mg, 4 mg	Dose: 1 piece every 1-2 hrs. Max: 24 pieces/day	Duration: 6-14 wks
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LOZENGE or MINI-LOZENGE

2mg, 4 mg	Dose: 1 lozenge every 1-2 hrs. Max: 20 pieces/day	Duration: 12 wks
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NASAL SPRAY (Nicotrol® NS)

10 mg/ml	Dose: 1-2 doses per hr. Max: 5 doses/hr or 40 doses/day	Duration: 3-6 mos
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INHALER (Nicotrol® Inhaler)

Dose: 6-16 cartridges/day Max: 16 cartridges/day	Duration: 3-6 mos
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BUPROPION SR (Zyban®/ Wellbutrin SR®)

May be combined with nicotine replacement

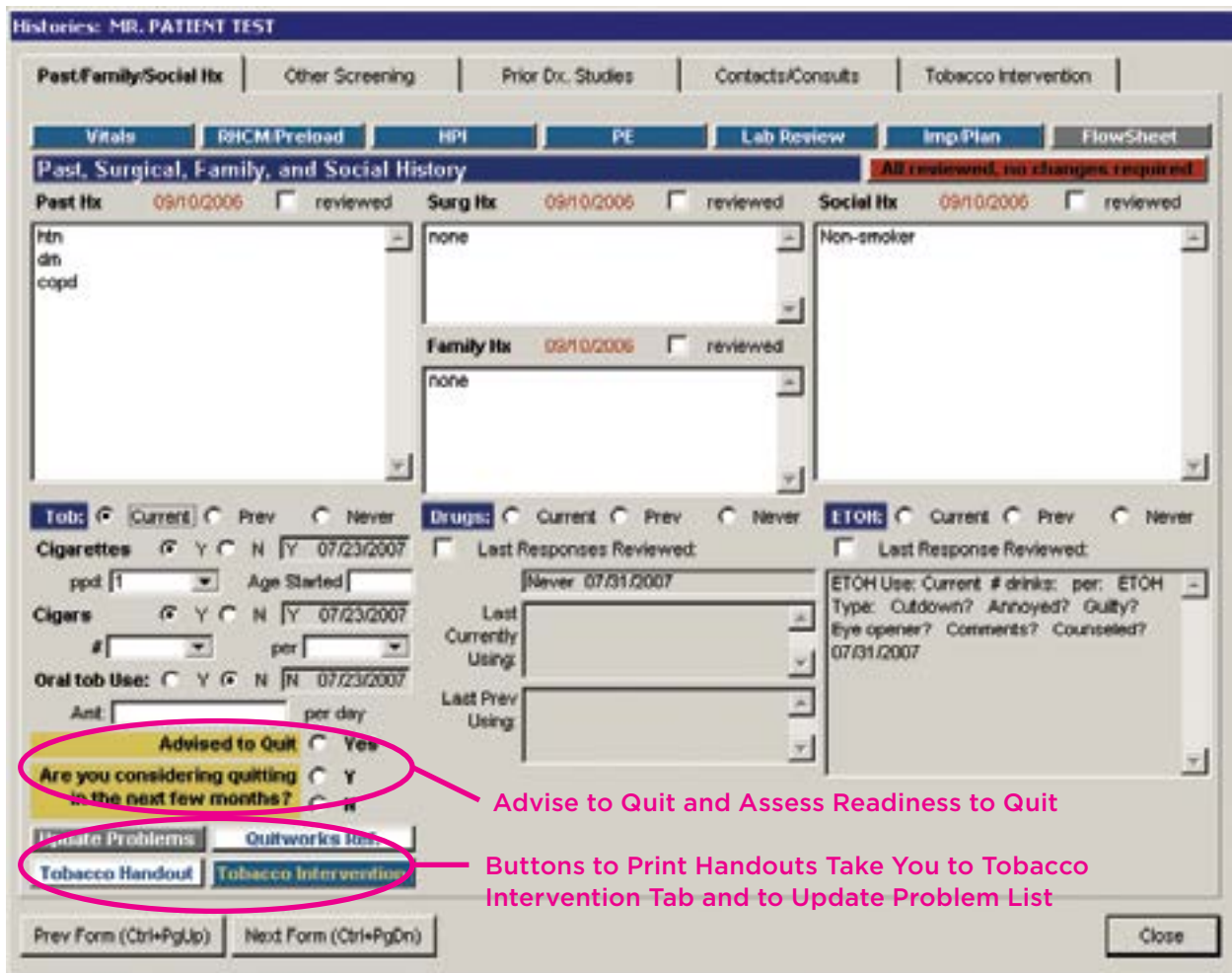
150 mg tablets	Dose: 150 mg once per day (days 1-3) 150 mg twice per day (day 4+) Max: 300 mg/day	Duration: 12 wks*
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VARENICLINE (Chantix®)

0.5 mg, 1 mg tablets	Dose: Starting Month Pack = 0.5 mg once per day (days 1-3) 0.5 mg twice per day (days 4-7) 1 mg twice per day (days 8+) Continuing Month Pack = 1 mg twice per day Max: 2 mg/day	Duration: 12 wks*
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* If quit at 12 wks, consider 12 more weeks of drug

Source: Fiore MC, Jaen CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update. Quick Reference Guide for Clinicians*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. April 2009. Inclusion of this adult dosage chart is strictly for the convenience of the prescribing provider. Please consult the Physicians' Desk Reference for complete product information and contraindications. This chart does not indicate or authorize insurance benefit coverage for any of these medications. This chart is provided by the Massachusetts Department of Public Health's Tobacco Cessation and Prevention Program.



RESOURCE B: FIVE RECOMMENDED ELEMENTS OF THE ASSIST STEP IN THE 5 A'S TOBACCO BRIEF INTERVENTION

ASSIST YOUR PATIENTS TO QUIT	
ACTION	Strategies for Implementation
<p>Help your patient develop a quit plan.</p>	<p>Together, work out a plan that includes the following key elements:</p> <ul style="list-style-type: none"> • Set a quit date. Ideally, the quit date should be within two weeks. • Tell family, friends, and coworkers about quitting, and request understanding and support. • Anticipate challenges to the upcoming quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. • Remove tobacco products from your environment. Before quitting, avoid smoking in places where you spend a lot of time, such as work, home, car. Make your home smoke-free.

<p>Recommend approved medications (except when contraindicated).</p>	<p>Recommended over-the-counter medications:</p> <ul style="list-style-type: none"> • Nicotine replacement therapy (NRT) gum • NRT lozenge • NRT patch <p>Other recommended, FDA-approved medications:</p> <ul style="list-style-type: none"> • NRT nasal spray • NRT inhaler • Bupropion SR • Varenicline (Chantix)
<p>Provide practical counseling and problem-solving skill training.</p>	<p>This counseling can involve either one-on-one counseling or group counseling (individual counseling is most effective). Strategies focus on:</p> <ul style="list-style-type: none"> • Abstinence. Striving for total abstinence is essential. Not even a single puff after the quit date. • Past quit experience. Identify what helped and what hurt in previous quit attempts. Build on past success. • Anticipate triggers or challenges in the upcoming attempt. What are your challenges and triggers? Let's talk about how you will successfully overcome them (e.g., avoid triggers, alter routines). • Alcohol. Because alcohol is associated with relapse, consider limiting or abstaining from alcohol while quitting. • Other smokers in the household. Quitting is more difficult when there is another smoker in the household. Encourage housemates to quit with you or not to smoke in your presence.
<p>Provide encouragement and social support.</p>	<p>Provide a supportive clinical environment while encouraging your patient in his or her quit attempt. "My office staff and I are available to assist you." "I'm recommending treatment that can provide ongoing support."</p>
<p>Provide supplementary materials, including information on quitlines.</p>	<p>Sources: Federal agencies (Smokefree.gov), nonprofit agencies (BecomeAnEX.org), national quitline network (1-800-QUIT-NOW), or local/state/tribal health departments/quitlines.</p> <p>Type: Culturally/racially/educationally/age-appropriate for your patient.</p> <p>Location: Readily available wherever you see patients.</p>

Source: U.S. Department of Health and Human Services. (2008, May). Clinical Interventions for Tobacco Use and Dependence. In *Treating Tobacco Use and Dependence: 2008 Update*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from http://www.ahrq.gov/clinic/tobacco/treating_tobacco_use08.pdf

RESOURCE C: IMPLEMENTING TOBACCO CESSATION SERVICES IN COMMUNITY HEALTH CENTERS—SAMPLE OBJECTIVES, GOALS, AND STRATEGIES

OBJECTIVE 1:

Dedicate a tobacco cessation program champion for organizing clinic efforts.

Goals

1. Each clinic has at least one staff member—executive-level management, governing board member, or medical staff—to organize the clinic tobacco cessation efforts.

Strategies

1. Clinic will identify the champion based on viability in light of other organizational commitments and personal interests.

OBJECTIVE 2:

Educate clinic staff about tobacco cessation treatment in clinic settings.

Goals

1. All clinic staff and key volunteers will have an understanding of best practices based on the *Treating Tobacco Use and Dependence: 2008 Update*.
2. Clinic will establish on-site training program for new and existing staff.

Strategies

1. Designate one or more staff members to be responsible for staff trainings and briefings.
2. Hold training sessions for current staff, and include tobacco cessation training as a component of new staff orientation.
3. Provide regular staff meetings for continuing education and to discuss challenges, lessons learned, and areas for improvement.

OBJECTIVE 3:
Integrate tobacco use identification into current clinical services.

Goals

1. Clinic staff ask all patients their tobacco use status.
2. Paper records are flagged using a colored identification system using a different sticker or stamp depending on tobacco use status.
3. Electronic records prompt providers to obtain tobacco use status during vitals.
4. All records show if a patient is a current or former smoker, or has never smoked.

Strategies

1. Train staff to ask all patients during vitals about tobacco use status, and document response in patient records.
2. Train staff to add visual prompts to patient records—paper or electronic—based on patients' tobacco use status.
3. Clinics with electronic records should include a field code for tobacco use status.

OBJECTIVE 4:
Use effective evidence-based tobacco cessation treatment for those identified as tobacco users.

Goals

1. Clinic staff will advise all tobacco users to quit.
2. Clinic staff are knowledgeable of on-site counseling resources, community programs, and quitline services along with how to refer patients to them.

3. Clinic staff will offer pharmacotherapy and be knowledgeable of access to low- or no-cost benefits through Medicare, Medicaid, and/or the state quitline.
4. Clinic staff will set a time for a follow-up, either in person or on the telephone, with the patient.

Strategies

1. Provide a script clinic staff can follow in advising, assessing, and assisting tobacco users based on the 5 A's model.
2. Clinic staff are made aware of drug benefits and resources for tobacco users during regularly scheduled training.
3. When available, utilize electronic health records in prompting staff to counsel, treat, refer, and follow up.

OBJECTIVE 5: Create an environment that reinforces clinical practices.

Goals

1. On-site visual alerts in waiting rooms and patient rooms.
2. Indoor and outdoor tobacco bans.
3. Clinic staff are tobacco-free.

Strategies

1. *Patient room and waiting rooms contain free brochures, pamphlets, posters, and videos on tobacco cessation.*
2. *Clinic enforces a tobacco-free policy inside and surrounding the clinic.*
3. *Provide cessation support for clinic staff who are tobacco users.*

Adapted from "Integrating Evidence-Based Tobacco Cessation Interventions in Free Medical Clinics: Opportunities and Challenges," published in the September 2012 issue of *Health Promotion Practice*.

RESOURCE D:

INTEGRATING TOBACCO CESSATION INTO ELECTRONIC HEALTH RECORDS, FROM THE AMERICAN ACADEMY OF FAMILY PHYSICIANS⁸⁴

Integrating Tobacco Cessation Into Electronic Health Records

The U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, calls for systems-level tobacco intervention efforts. Electronic health records (EHRs) allow for integration of this Guideline into the practice workflow, facilitating system-level changes to reduce tobacco use.

The American Academy of Family Physicians (AAFP) advocates for EHRs that include a template that prompts clinicians and/or their practice teams to collect information about tobacco use, secondhand smoke exposure, cessation interest and past quit attempts. The electronic health record should also include automatic prompts that remind clinicians to:

- Encourage quitting
- Advise about smokefree environments
- Connect patients and families to appropriate cessation resources and materials

The tobacco treatment template should be automated to appear when patients present with complaints such as cough, upper respiratory problems, diabetes, ear infections, hypertension, depression, anxiety and asthma, as well as for well-patient exams.

Meaningful Use

The Health Information Technology for Economic and Clinical Health Act (HITECH), which was part of American Recovery and Reinvestment Act of 2009 (ARRA), provides incentives to eligible professionals (EP) and hospitals that adopt certified EHR technology and can demonstrate that they are meaningful users of the technology. To qualify as a meaningful user, EPs must use EHRs to capture health data, track key clinical conditions, and coordinate care of those conditions.

Smoking status objectives and measures included in the Meaningful Use Stage 1 criteria are:

- Objective: Record smoking status for patients 13 years old or older.

- Measure: More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded.
- EHR requirement: Must enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; and unknown if ever smoked.

Patient education objectives and measures included in the Meaningful Use Stage 1 criteria are:

- Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient, if appropriate.
- Measure: More than 10% of all unique patients seen by the EP are provided patient-specific education resources.
- EHR requirement: Must enable a user to electronically identify and provide patient-specific education resources according to, at a minimum, the data elements included in the patient's: problem list; medication list; and laboratory test results; as well as provide such resources to the patient.

Payment for Counseling

As you incorporate tobacco cessation into your EHR templates, be sure to involve those who do your medical billing. Electronic claims systems may need to be modified to include tobacco dependence treatment codes. For a list of CPT & ICD-9 Codes related to tobacco cessation counseling, click on the Ask and Act Practice Toolkit link at www.askandact.org.

Template recommendations are on the back of this document.



ASK AND ACT
A TOBACCO CESSATION PROGRAM

What should be included in a tobacco cessation EHR template?

Including tobacco use status as a vital sign provides an opportunity for office staff to begin the process. Status can be documented as:

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Unknown if ever smoked

A complementary field can document secondhand smoke exposure: current, former or never, and work, home or social.

The template may include some or all of the following data points or prompts:

HISTORY

Type of tobacco:

- Cigarettes Packs per day/week (20 cigarettes/pack): _____
- Pipe Bowls per day/week: _____
- Cigars Number per week: _____
- Smokeless Cans/pouches per day/week: _____
- Other tobacco products (orbs, strips, sticks, hookah, etc)
Amount per day/week: _____
- E-Cigarettes Cartridges per day/week: _____

Approx date of last quit attempt: _____

a) How long quit this time? _____

Longest period of time quit in past: _____

a) How long ago? _____

b) What caused relapse? _____

Medication used in previous quit attempt:

- Nicotine patch
- Nicotine gum
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine oral inhaler
- Varenicline
- Bupropion
- Nortriptyline
- Other (i.e., herbal): _____
- No medication

ASSESSMENT

Readiness to Quit:

- Not interested in quitting
- Would like to quit sometime (but not within the next month)
- Would like to quit now or soon (within the next month)

Other smokers in household (Y / N)

PLAN

Quit date: _____

Counseling:

Time counseled:

- < 3 minutes
- 3 - 10 minutes
- > 10 minutes

Topics covered:

- Tobacco-proof home and car
- Changing daily routines
- Dealing with urges to smoke
- Getting support
- Anticipating/avoiding triggers
- Secondhand smoke
- Teach behavioral skills
- Reinforce benefits

Counseling notes: _____

PHARMACOTHERAPY

Recommended OTC:

- NRT Gum
- NRT Lozenge
- NRT Patch
- NRT Patch Plus (combination of patch plus gum or lozenge)

Medical Treatment:

- NRT Nasal Spray
Dosing: 1-2 doses/hour (8-40 doses/day); one dose = one spray in each nostril; each spray delivers 0.5 mg of nicotine
- NRT Oral Inhaler
Dosing: 6-16 cartridges/day; initially use 1 cartridge q 1-2 hours (best effects with continuous puffing for 20 minutes)
- Bupropion SR
Dosing: Begin 1-2 weeks prior to quit date; 150 mg po q AM x 3 days (as tolerated), then increase to 150 mg po bid. Contraindications: head injury, seizures, eating disorders, MAO inhibitor therapy.
- Varenicline
Dosing: Begin 1 week prior to quit date; days 1-3: 0.5 mg po q AM; days 4-7: 0.5 mg po bid; weeks 2-12: 1 mg po bid
Black box warning for neuropsychiatric symptoms.

AAFP Handouts provided:

- Quit Smoking 'Prescription'
- Outline Referral Card
- Steps to Help You Quit Smoking Brochure
- Stop Smoking Guide (Self-Help Booklet)
- Secondhand Smoke Brochure
- Familydoctor.org information
- Other: _____

FOLLOW-UP PLAN

- Fax referral to quitline
- Referred to cessation program: _____
- Follow-up visit in 2 weeks
- Staff to follow up in _____ weeks
- Quit date call: _____
- Address at next visit

RESOURCE E: ACTIONTOQUIT WEB PAGE
ACTIONTOQUIT.ORG/COMMUNITY_HEALTH_CENTERS

Action TO QUIT
 Advancing Tobacco Control Policy

Partnership for Prevention
 Smoking Policies • Improving Health

ABOUT OUR WORK COMMUNICATIONS STATE PROJECTS NEWS POPULATIONS RESOURCES | Site Map

Community Health Centers

Community health centers (CHCs) in the United States serve almost twenty million patients per year, primarily the economically disadvantaged, uninsured, and homeless. 93% of CHC patients are below 200% of the poverty level. These vulnerable populations receive their primary care at CHCs, but tobacco cessation screening and treatment are often not a part of this care. Thus, in some 8000 CHC sites nationwide serving high smoking rate populations for whom few interventions exist or are easily accessible, there is great potential for increased intervention.

Partnership for Prevention recommends that CHCs screen all patients for tobacco use, record tobacco use status, and provide cessation assistance to all patients who use tobacco. This system change would:

The Network
 Engaging Employers
 Health Systems
 Hospitals
 Community Health Centers
 Health Care Providers
 Medicaid

Join the Network!

Complete the form below to subscribe to the ActionToQuit listserve. Join the conversation about tobacco control policy and receive weekly updates.

First Name

Last Name

Email Address

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LEGACYFORHEALTH.ORG/COMMUNITY-ENGAGEMENT

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COMMUNITY ENGAGEMENT

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Community Engagement

Youth Activism

Stories from the Field

Legacy reaches low-income families with cessation and secondhand smoke education through partnerships with Head Start and Early Head Start (EHS). We also provide funds to and partner with the Hispanic Association of Colleges and Universities (HACU) and the Inter-Tribal Council of Michigan to support tobacco control efforts on college campuses. In addition, we've recently collaborated with the National Association of Community Health Centers in an effort to address adult tobacco cessation.

Community Health Center Initiative

Community health centers provide vital primary care to 20 million patients in more than 8,000 sites. More than 70 percent of their client base lives in poverty and 86 percent are uninsured¹. Smoking rates are much higher among adults living below the poverty level (29 percent) than among those at or above the poverty level (18 percent)².

Between 2008-2011, Legacy and the National Association of Community Health Centers (NACHC) collaborated on a pilot project to enhance the capacity of Federally Qualified Health Centers and State Primary Care Associations to address adult tobacco cessation. Over a three year period, we placed Community HealthCorps members in eight community health centers across the country to enhance cessation efforts. Founded by NACHC, Community HealthCorps is the largest health-focused, national AmeriCorps program that promotes health care for America's underserved, while developing tomorrow's health care workforce.

RESOURCE F: WEB LINKS FOR RESOURCES CITED IN THIS GUIDE

1: Introduction			
ANNOTATION	ORGANIZATION	RESOURCE	URL
A	HRSA	About Health Centers	bphc.hrsa.gov/about/whatishealthcenter/index.html
2: The Burden Of Tobacco Use For Low Socioeconomic Status Populations			
B	CDC	Smoking and Tobacco Use	cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm
C	Campaign for Tobacco-Free Kids	Smoking Harms	tobaccofreekids.org/facts_issues/fact_sheets/toll/products/smoking
D	HRSA	2011 <i>UDS National Report</i>	bphc.hrsa.gov/uds/doc/2011/National_Universal.pdf
3: Making The Case For Tobacco Cessation Services in Health Centers			
E	CDC	Secondhand Smoke	cdc.gov/tobacco/basic_information/secondhand_smoke/index.htm
F	CDC	Smoking During Pregnancy	cdc.gov/tobacco/basic_information/health_effects/pregnancy/index.htm
G	Legacy	Secondhand Smoke	legacyforhealth.org/what-we-do/tobacco-control-research/fact-sheets

ANNOTATION	ORGANIZATION	RESOURCE	URL
H	Campaign for Tobacco-Free Kids	Benefits from Quitting Tobacco Use	tobaccofreekids.org/research/factsheets/pdf/0246.pdf
I	Campaign for Tobacco-Free Kids	Immediate Smoker Savings from Quitting in Each State	tobaccofreekids.org/research/factsheets/pdf/0337.pdf
J	HRSA	Clinical and Financial Performance Measures	bphc.hrsa.gov/policiesregulations/performanceasures
K	Office of the Surgeon General	National Prevention Strategy	cdc.gov/features/PreventionCouncil
L	CDC	<i>National Prevention Council Action Plan</i>	surgeongeneral.gov/initiatives/prevention/2012-npc-action-plan.pdf
M	HRSA	340B Drug Pricing Program & Pharmacy Affairs	hrsa.gov/opa/index.html
N	Multi-State Collaborative for Health Systems Change	Multi-State Collaborative for Health Systems Change	multistatecessationcollaborative.org/healthsystemschange/healthsystemschange
O	CMS	Medicare and Medicaid EHR Incentive Programs	cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

4: Integrating Tobacco Cessation into Your Center's Clinical Services

ANNOTATION	ORGANIZATION	RESOURCE	URL
P	Institute for Healthcare Improvement	Triple Aim Initiative	ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx
Q	AAP Julius B. Richmond Center of Excellence	Downloadable PowerPoint presentations on tobacco, secondhand smoke, and tobacco cessation interventions	aap.org/richmondcenter/PowerpointPresentations.html
R	NACHC	Community HealthCorps	communityhealthcorps.org
S	SAMSHA	Motivational Interviewing	motivationalinterview.org
T	Legacy	Case Study	legacyforhealth.org/what-we-do/community-initiatives/community-engagement
U	Legacy	Case Study	legacyforhealth.org/what-we-do/community-initiatives/community-engagement
V	Institute for Healthcare Improvement	PDSA Worksheet	ihi.org/knowledge/Pages/Tools/PlanDoStudyActWorksheet.aspx

ANNOTATION	ORGANIZATION	RESOURCE	URL
W	Mayo Clinic	Tobacco Treatment Specialist Certification	mayoresearch.mayo.edu/mayo/research/ndc_education/tts_certification.cfm
X	University of Massachusetts Medical School	Tobacco Treatment Specialist Training and Certification Program	umassmed.edu/tobacco/training/index.aspx
Y	University of Arizona HealthCare Partnership	Basic Tobacco Intervention Skills Certification Program	healthcarepartnership.org
Z	University of Medicine and Dentistry at New Jersey	Certified Tobacco Treatment Specialist Training	tobaccoprogram.org/tobspeciatrain.htm
AA	American Lung Association	Freedom from Smoking training	lung.org/stop-smoking/how-to-quit/freedom-from-smoking
BB	Association for the Treatment of Tobacco Use and Dependence	ATTUD homepage	attud.org
CC	Association for the Treatment of Tobacco Use and Dependence	Council for Tobacco Treatment Training Programs homepage	attudaccred.org

ANNOTATION	ORGANIZATION	RESOURCE	URL
DD	University of Wisconsin School of Medicine and Public Health	Tobacco Use and Dependence: An Updated Review of Treatments	cme.uwisc.org/index.pl?id=532379
EE	University of California, San Francisco	Rx for Change training	rxforchange.ucsf.edu
FF	North Carolina Tobacco Prevention and Control Branch	QuitlineNC.com	quitlinenc.com/docs/tobacco-use-screening-tools/conversation-starters-and-strategies.pdf?sfvrsn=2
GG	Partnership for Prescription Assistance	Partnership for Prescription Assistance	pparx.org/en/prescription_assistance_programs
HH	NACHC	Understanding the 340B Program: A Primer for Health Centers	nachc.com/client/documents/5.11%20340%20Manual%20Primer%20for%20Health%20Centers2.pdf
II	HRSA	340B Drug Pricing Program & Pharmacy Affairs	hrsa.gov/opa
JJ	Legacy	<i>A Hidden Epidemic: Tobacco Use and Mental Illness</i>	legacyforhealth.org/content/download/608/7232/file/A_Hidden_Epidemic.pdf
KK	HHS	Diagnosis and Billing for Tobacco Dependence Treatment	ncbi.nlm.nih.gov/books/NBK63955

ANNOTATION	ORGANIZATION	RESOURCE	URL
LL	AAFP	Reimbursement/ Payment	aafp.org/dam/AAFP/documents/patient_care/tobacco/codes-tobacco-cessation-counseling.pdf
MM	Center for Tobacco Research and Intervention, University of Wisconsin	Smoking-Cessation Billing and Diagnostic Counseling Codes	ctri.wisc.edu/News.Center/Fact%20Sheets/Updated%20ROS%20Handouts/14.Codes.pdf
NN	AAFP	Group Visits 101	aafp.org/fpm/2003/0500/p66.html
OO	Legacy	Case Study	legacyforhealth.org/what-we-do/community-initiatives/community-engagement
PP	Legacy	Case Study	legacyforhealth.org/what-we-do/community-initiatives/community-engagement
5: Case Studies			
QQ	Robert Wood Johnson Foundation Diabetes Initiative	Chronic Disease Self Management Assessment	improveselfmanagement.org/index.acspx

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