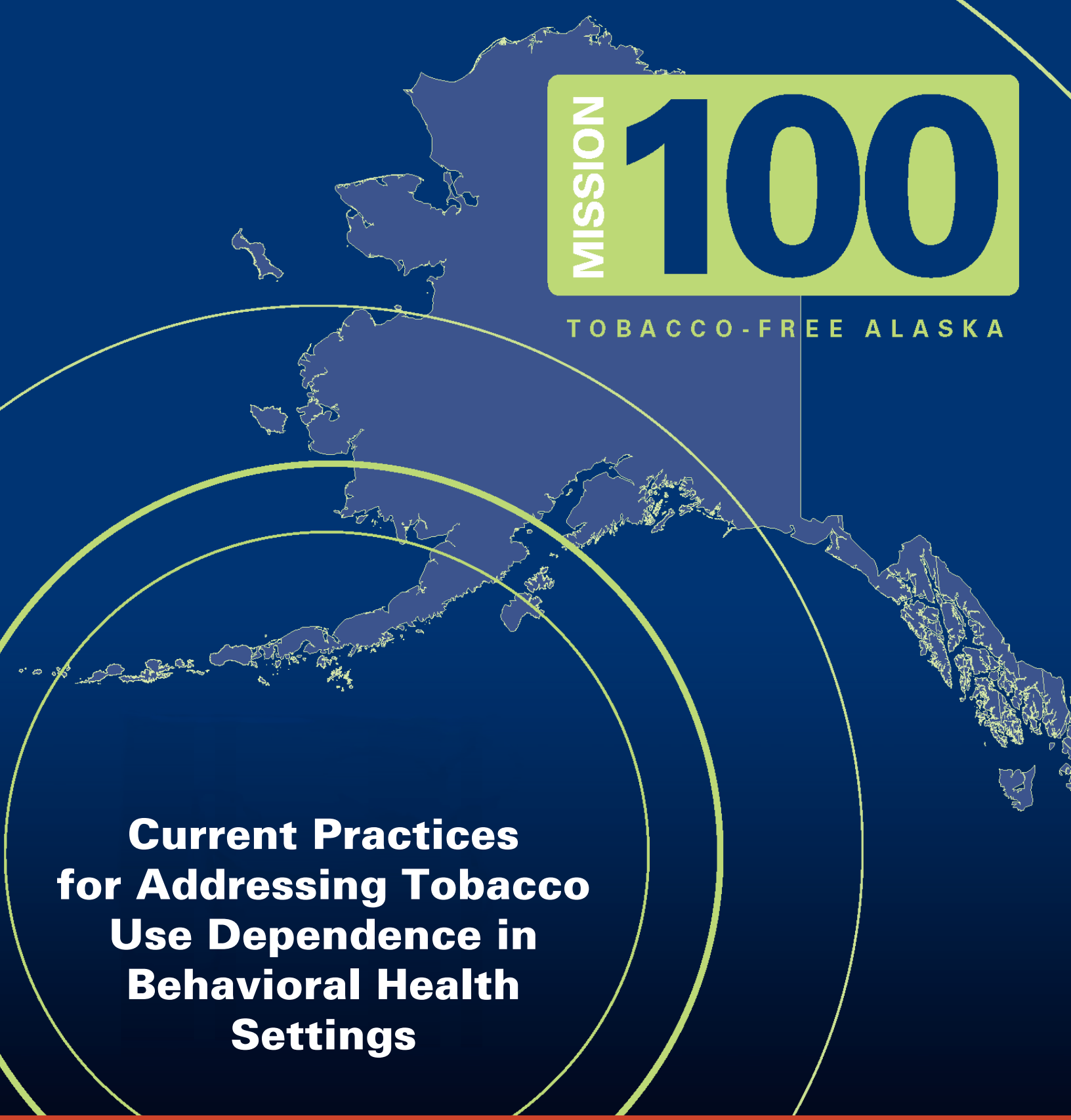

Current Practices for Addressing Tobacco Use Dependence in Behavioral Health Settings

A Survey of Alaska Behavioral Health Organizations

March 2014

Produced for the State of Alaska Tobacco Prevention and Control Program | Agnew::Beck Consulting

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Mission 100: Promoting a 100% Tobacco-free Alaska

Dear Behavioral Health Leader,

2014 is proving to be a great year for addressing the harms of tobacco. We celebrated the 50th anniversary of the landmark Surgeon General's Report, "The Health Consequences of Smoking," and marked a fundamental shift in the social norms of tobacco use. We applauded the decision of CVS Caremark who joined Target Corporation to stop selling tobacco products in its 7,600 pharmacies nationwide. We have seen even more communities, schools, businesses and healthcare organizations in Alaska choose to be tobacco-free. Now more than ever, momentum is building to support Alaskans to quit tobacco for good.

Healthcare providers are a critical partner in promoting tobacco cessation, and an influential voice in an individual's decision to quit. Alaska's behavioral health system is uniquely positioned to turn the curve of tobacco use prevalence: your client population is disparately impacted and suffer a higher burden of tobacco-related disease. You have the opportunity to help them choose to be tobacco-free. While overall prevalence of tobacco use is down, across the U.S. those living with mental illness or addiction show a persistent trend:

- People with mental illness and addictions smoke **44%** of all the cigarettes being consumed.
- People with mental illness and addictions are dying an average of **25 years early** due to tobacco-related diseases like heart disease and lung cancer.
- Almost half of the tobacco-related deaths in the U.S. every year are among people with mental illness and addictions—that's **200,000** deaths a year out of 435,000.

Despite these alarming figures, this same population is often willing and able to quit:

- Up to **80%** of behavioral health clients in the nation want to quit smoking.
- **Behavioral health clients can quit** tobacco successfully. Their quit rates are just a little under the general population.
- Quitting smoking at the same time as quitting drugs or alcohol **improves treatment and recovery** for co-morbid addictions and mental illnesses.[1]

This winter, Mission 100: A Tobacco-free Alaska conducted a survey of behavioral health organizations across Alaska to better understand how tobacco use dependence treatment is integrated into organizations' policies and practices. The survey was designed to establish a baseline of tobacco cessation practices in Alaska's behavioral health system, identify current areas of strength and opportunities for improving clinical practices and policies, and communicate these opportunities to behavioral health leaders in order to work together on reducing tobacco use.

The following report provides an overview of best practices for addressing tobacco use in behavioral health, summary findings from the 2014 survey of Alaska behavioral health organizations, and more information about how Mission 100 can assist you to integrate these

[1] All data above cited in the Association for the Treatment of Tobacco Use and Dependence (ATTUD), Disparate Populations Committee, Policy Statement: "Integrating Tobacco Treatment within Behavioral Health" (2012).

best practices to help your clients become tobacco-free. Mission 100 is an innovative approach to public health policy and systems change, led by the State of Alaska Tobacco Prevention and Control Program. The Mission 100 team works with healthcare organizations to implement the Clinical Practice Guidelines for Tobacco Use and Dependence. While many behavioral health organizations in Alaska have implemented one or more of these practices, providers consistently expressed interest in strengthening policies and requested assistance to implement these improvements.

Addressing tobacco dependence among people living with mental illness and substance use disorders is a priority for the Tobacco Prevention and Control Program, working in partnership with the State of Alaska Division of Behavioral Health, the Alaska Native Tribal Health Consortium and the Alaska Mental Health Trust Authority. We invite you to become a partner and leader in our effort to reduce the burden of tobacco use in Alaska.

Sincerely,

Alison Kulas
Program Manager
State of Alaska
Tobacco Prevention and Control Program

Jeff Jessee
Chief Executive Officer
Alaska Mental Health Trust Authority

Best Practices in Tobacco Dependence Treatment

Nicotine is an addictive substance. Analysis of major brands of cigarettes has shown that nicotine yields per cigarette have increased 11% since 1996, causing smokers to become addicted sooner and struggle more to quit.[2] Those with substance use and mental health disorders have higher prevalence rates than the general population, estimated to be as high as 75% in some populations.[3]

For clients receiving behavioral health services, however, there are opportunities for meaningful change through tobacco cessation policies and interventions. All smokers with psychiatric disorders, including substance use disorders, should be offered tobacco dependence treatment by healthcare providers and in behavioral health treatment settings. Quitting tobacco has been shown to improve treatment outcomes for co-morbid mental illnesses and addictions, helping clients achieve and maintain abstinence. Treating smoking in this population will improve quality of life for those struggling with addiction and mental illness, and successful quit attempts will reduce early deaths due to heart disease, cancer, and other tobacco-related diseases.

Clinical Practice Guidelines

Health policy experts have developed a set of best practices for healthcare organizations to promote cessation, the mostly widely-used of which is the **USPHS Clinical Practice Guidelines for Treating Tobacco Use and Dependence**.

Best practices include **the 5 As** (also called **Ask Advise Refer**), **Documentation** and a **Comprehensive Tobacco-free Campus Policy**.

Ask Providers should ask every client about tobacco use at intake and every subsequent visit. Even if the client is not a tobacco user, ask whether they are routinely exposed to secondhand smoke.

Advise Conduct a brief 3-minute intervention to advise the client to quit, share the health harms of tobacco use and suggest possible methods of quitting, including pharmacotherapy options.

Assess Determine willingness to make a quit attempt and assess past history of quit attempts, if any. For those with substance abuse disorders, assess interest in quitting while undergoing treatment.

Assist Assist the client to develop a quit plan as integrated part of the overall treatment plan. Determine which nicotine replacement therapy (NRT) or pharmacotherapy options are appropriate and shown to be most effective with treatment for co-occurring disorders.

Arrange Integrate the client's quit plan into an overall discharge plan. Plan to follow up with client and monitor progress in quit plan during subsequent visits, and/or

[2] Massachusetts Department of Health and Harvard School of Public Health (2007).
[3] The Association for the Treatment of Tobacco Use and Dependence (ATTUD), Disparate Populations Committee, Policy Statement: "Integrating Tobacco Treatment within Behavioral Health" (2012).

schedule follow up contacts through outside cessation resources. Quitting may take repeat interventions because relapse rates within this population are higher.

Refer If cessation resources are not available directly through the organization, refer to the Alaska Tobacco Quit Line or a locally-based cessation resource for more intensive treatment. Alaska's Tobacco Quit Line is a free web, text, and toll-free telephone based cessation program that provides free services, including coaching, self-guided quit materials, and nicotine replacement therapy (NRT) to all Alaska adults who want to quit tobacco. Ideally an organization can offer access to in-person and telephonic support.

Document Record the client's current tobacco use status, history, quit plan and individual quit attempts, as well as documenting provider interventions. If using electronic health records (EHR), integrate tobacco intervention protocols using as few clicks as possible. Referral to the Quit Line can be integrated into the protocol using electronic referral through EHR, or using fax referral.

Campus Having a comprehensive policy—one that covers smoking and smokeless tobacco, both indoor and outdoor spaces, and applies to clients, staff and visitors—creates a supportive environment that reinforces clients' success in remaining tobacco-free. A comprehensive policy should be consistently and collectively enforced by all staff, and implemented concurrently with providing cessation resources to encourage quit attempts among clients and staff. A strong policy should allow the use of nicotine delivery methods only for cessation.

A Shared Priority of Behavioral Health Professionals

The following national organizations support integration of tobacco use dependence treatment into all behavioral health settings:

- American Psychiatric Association
- American Psychiatric Nurses Association
- American Society of Addiction Medicine, Inc.
- ATTUD: The Association for Treatment of Tobacco Use and Dependence
- NAADAC: The Association for Addiction Professionals
- NAMI: The National Alliance on Mental Illness
- NASMHPD: National Association of State Mental Health Program Directors
- NIDA: National Institute of Drug Abuse
- SAMHSA: Substance Abuse and Mental Health Services Administration
- USPHS: U.S. Public Health Service

Summary Findings

In order to identify opportunities for change among behavioral health organizations in Alaska, it is important to know how Alaska's behavioral health organizations integrate tobacco dependence into their current practices. The findings below suggest what is currently working well, what is not being done consistently, and what behavioral health providers could benefit most from technical assistance through the Mission 100 team.

This survey was designed by Mission 100 to gather information from organizations about how tobacco use dependence is currently addressed as part of treatment for substance use and mental health issues. The survey complements a baseline survey of medical and primary care organizations (community health centers, tribal health organizations and hospitals) administered in 2012.

Key Findings

Alaska behavioral health organizations have some policies in place to identify and treat tobacco dependence, but there are many opportunities to strengthen and implement best practices for addressing tobacco use through behavioral health interventions.

Ask **Most organizations screen clients for tobacco use, but only at intake or periodically—not at every visit.** Almost 70% of respondents routinely screen for tobacco use, including smokeless tobacco. Of those, most screen at intake and periodically (every 3 to 6 months).

Advise **Seventy percent of organizations do *not* have a protocol for advising clients to quit tobacco**. While a majority of respondent organizations (57%) indicate that staff routinely advise known tobacco users to quit, only thirty percent of respondent organizations have a clear protocol for advising. Of those, most will routinely document the intervention in the client's record.

Assess

Assist **Most respondents provide some form of counseling, and many also provide onsite or offsite pharmacotherapy options**. Over 60% of respondents provide some form of tobacco cessation counseling—primarily individual counseling or web, text, or telephone-based counseling such as Alaska' Tobacco Quit Line. Only one quarter provide onsite pharmacotherapy options, while half refer to offsite options. Insurance status can influence the provider's action. Those with insurance are provided pharmacotherapy directly, while those without insurance are referred to the Quit Line.

Arrange **Few organizations conduct discharge planning for treating tobacco dependence**. Only three respondents reported that they conduct discharge planning for tobacco dependence treatment; of those, all refer to the Quit Line and two refer to self-help materials for quitting. Organizations may be conducting other forms of follow-up with clients, but not necessarily in a systematic way.

Refer **Most organizations provide some form of referral, primarily to the Quit Line and self-directed quit guides**. About 60% of respondents refer clients to the Quit Line, and just under half provide information in the form of self-help guides,

on-site or off-site counseling. Only 3 organizations reported using the Quit Line Fax Referral system, which initiates a call to the client by a quit coach, rather than relying on the client to make first contact. Only 60% of respondents document the referral in the client's records.

Document

One-third of organizations have implemented an electronic health record (EHR) system, and many organizations do not consistently document cessation interventions. Two thirds of respondent organizations use paper records for clients' data. Most organizations reported that they use AK-AIMS, the data reporting system for the Division of Behavioral Health, but do not have access to population-level data about their clients' tobacco use. While over 80% of organizations document whether the client's tobacco use status, fewer document counseling and other cessation services provided—a missed opportunity for billing Medicaid and third-party insurance.

Tobacco Free Campus

Most organizations have elements of a tobacco-free campus policy, but only 25% have a comprehensive policy. 100% of respondents reported a ban on indoor smoking, but many allowed tobacco use on their facility's grounds, with rules for minimum distance from building entrances. About half of respondents had a policy that included smokeless tobacco, but some noted that their policy, although generally understood and enforced, was not formally written down. One quarter of respondents indicated that staff are allowed to smoke with clients.

Providers' Capacity to Provide Cessation Services

Over 90% of respondents believe that treating tobacco dependence is a high priority for their providers. Respondents' attitudes toward treating tobacco are encouraging: approximately two-thirds of respondents did not agree with statements that "clients have far more important issues" or that clients are "not ready or willing to change their habits."

Addressing a client's tobacco use tends to be a higher priority for clients in substance abuse treatment than for those with mental illness. Some respondents expressed a nuanced view of whether treating tobacco dependence is a priority for their clients. Connections between tobacco and other substance use is perceived to be stronger than with mental illness.

Over half of respondent organizations have recently conducted trainings for staff about tobacco cessation interventions. Several organizations indicated that they have held some form of training for providers in the last twelve months. Popular topics included information about referrals to the Alaska Tobacco Quit Line and the AK Brief Interventions training offered by the Tobacco Prevention and Control Program. Only one organization received training on how behavioral health providers can bill counseling and cessation services to Medicaid.

Behavioral health providers are interested in providing tobacco cessation interventions, but half of respondents do not feel that they have the proper training. While some organizations have taken initiative to provide training to their providers about best practices in tobacco dependence treatment, there is broad demand for building capacity. Additionally, one-third of respondents believed their providers do not have the time to implement new tobacco cessation interventions, and a third also responded that they do not receive adequate reimbursement for cessation services.

Opportunities for Future Engagement

Behavioral Health Providers Are Ready for Positive Change

Addressing tobacco use dependence and addiction is a priority for behavioral health organizations in Alaska. Our survey findings suggest that:

- Overall, behavioral health providers recognize that the harms of tobacco place a heavy burden on their clients, and that becoming tobacco-free has many benefits.
- Behavioral health organizations are interested in implementing recognized best practices in tobacco cessation: screening, advising and referring to cessation resources; documentation and monitoring of clients' quit attempts; and creating a tobacco-free environment that supports abstinence from tobacco.
- Some organizations have implemented strong systems for tobacco prevention and treatment, while others are just beginning that journey.
- Many organizations are *ready* to make systems change, but would benefit from additional training and resources.

Opportunities for Systems Change

Quitting tobacco can help behavioral health clients stay substance free. There is increasing evidence that a client who quits using tobacco while in treatment for other substance use, addressing their nicotine addiction holistically and concurrently with other addictions, has more success maintaining abstinence over time.

Behavioral health providers can provide necessary interventions and counseling for treating tobacco dependence. The Affordable Care Act includes significant incentives for the integration of primary care and behavioral health, making behavioral health providers an important partner in their clients' overall access to quality care.

Consistent and systematic protocols for tobacco cessation interventions will increase clients' success in quit attempts. Implementing protocols for including tobacco cessation in a client's treatment plan provides opportunities for referral from primary care providers, assessment and cessation counseling as part of treatment, provision of pharmacotherapy such as nicotine replacement therapy (NRT), and scheduling follow-ups during discharge planning.

Behavioral health providers can increase billing by providing and documenting cessation counseling. In 2013, the Division of Behavioral Health published a guidance document for behavioral health providers on how to receive Medicaid reimbursement for cessation services provided to clients when tobacco dependence is identified in the client's treatment plan. Strengthening and implementing screening and intervention protocols can streamline this process and increase billing opportunities for your organization.

Trainings such as AK Brief Interventions are already available to educate providers on effective screening, assessment and referral protocols. The Tobacco Prevention and

Control Program provides online training for providers on brief interventions for tobacco cessation counseling. This resource, combined with technical assistance for other systems change within your organization, can increase providers' knowledge and capacity to provide cessation services for your clients. Trainings are also available on the effects of tobacco on the body, the links between nicotine addiction and behavioral health disorders, and effective uses of pharmacotherapy in combination with other treatments.

Electronic health records can support your organization's implementation of screening and treatment protocols, billing for services and monitoring clients' progress toward success. Fax referrals to the Quit Line can increase clients' engagement with tobacco cessation resources, but implementing an effective electronic health records (EHR) system can transform your organization's approach to quality care by integrating screening and treatment protocols into your providers' workflow.

Mission 100 Can Help You Make Systems Change

Mission 100: A 100% Tobacco-free Alaska is an innovative approach to public health policy and systems change, led by the State of Alaska Tobacco Prevention and Control Program. The Mission 100 team works with healthcare organizations to implement the Clinical Practice Guidelines for Tobacco Use and Dependence, including: screening for tobacco use, referral to cessation resources, integration of cessation into treatment and discharge planning, and a comprehensive tobacco-free campus policy. Our team includes:

- **Health policy experts** who provide technical assistance and training about best practices and how to implement them in your organization
- **Community-based partners** funded by the Tobacco Prevention and Control Program to engage with partners in each region in the state
- **Your peers: healthcare organizations in Alaska** who have implemented these systems and have begun to transform their own approach to addressing tobacco use among their client population.

If you are interested in increasing your organization's capacity to reduce tobacco use among your clients, the Mission 100 team can help you implement systems change. If you have begun implementing these policies and want to share your success story and lessons learned, you can work with Mission 100 as a peer leader. **15 organizations** have already volunteered to assist other Alaska healthcare organizations by sharing their experience and serve as a mentor.

Contact the Mission 100 team to become a partner in creating a 100% Tobacco-free Alaska.

Appendix A **Full Survey Results**

The following pages include a detailed summary of the initial survey results, including both percentage and count of responses for each question. There are slight discrepancies in the percentages listed and the final, corrected data presented in the report, due to some respondents' incomplete submissions and multiple submissions by the same organization.

Methodology

The survey, the analogue to a baseline survey distributed to primary care organizations (community health centers, tribal health organizations and hospitals) in 2012, was designed to gather information about whether and how tobacco dependence is currently measured and addressed as part of treatment for substance use and mental health issues.

The instrument was an online questionnaire with a series of questions about current policies and practices at the organization:

- Frequency and procedures for screening, advising and referral
- Mode(s) of documenting client data and services provided
- Whether the organization has a tobacco-free campus policy
- What training and support has been provided at the organization
- Whether the organization is interested in implementing tobacco cessation systems

The survey was distributed by e-mail to the approximately 80 organizations receiving treatment grant funds from the State of Alaska Division of Behavioral Health. Recipients were also personally encouraged to complete the survey by members of the Nicotine Addiction in Behavioral Health (NABH) workgroup, who reached out to organizations in their respective geographic areas. In addition, some respondents—primarily private organizations that do not receive DBH grant funding—were not on the original list but also completed the survey as a result of the outreach from NABH members. A total of 39 organizations responded to the survey including tribal, non-profit and private healthcare organizations.

Tobacco Dependence Treatment in Behavioral Health Settings
Survey of Current Practices in Alaska

1. What is the name of your organization?

39 unique organizations (including multiple clinics in the same organization) completed responses. Some total responses below (up to 46) reflect multiple survey responses and incomplete surveys.

2. What is your title and role in the organization?

The survey was sent to CEOs and division heads of organizations; most filled out the survey directly, and others were filled out by tobacco specialists or midlevel staff.

3. Approximately how many individual clients does your organization serve annually?

	Response Percent	Response Count
Less than 50	4.3%	2
51 to 100	15.2%	7
More than 100	**80.4%**	**37**

4. What is your organization's current system for keeping client records? Please choose all that apply.

	Response Percent	Response Count
AKAIMS (Alaska's Automated Information Management System)	**67.4%**	**31**
Electronic health / medical records (EHRs) other than AKAIMS	28.3%	13
Paper records	63.0%	29
Other (please specify)	17.4%	8

5. Does your organization screen every client for tobacco use, including smoking and smokeless tobacco?

	Response Percent	Response Count
Yes, for smoking and smokeless tobacco use	**68.2%**	**30**
Yes, for smoking only	6.8%	3
No, for neither tobacco use	25.0%	11

6. What population of your clients is screened for tobacco use?

	Response Percent	Response Count
Every client over the age of 12	**45.5%**	**15**
Every client over the age of 18	30.3%	10
Other (please specify)	24.2%	8

Some respondents chose "Other" and added that they screen all clients, regardless of age.

7. Clients are asked about tobacco use:

	Response Percent	Response Count
At every provider-client visit	12.1%	4
At intake only	**45.5%**	**15**
Every six months only	0.0%	0
Once a year only	0.0%	0
Other (please specify)	42.4%	14

Several respondents chose "Other" and noted that they screen at intake as well as perodically (usually every 3 to 4 months). A few respondents also referenced the client's treatment plan.

8. Is information about clients' tobacco use recorded?

	Response Percent	Response Count
Yes	**83.7%**	**36**
No	16.3%	7

9. Information about clients' tobacco use is recorded in: Please choose all that apply.

	Response Percent	Response Count
AKAIMS (Alaska's Automated Information Management System)	67.6%	23
Electronic health / medical record system, other than AKAIMS	26.5%	9
Paper chart	**76.5%**	**26**
Other (please specify)	8.8%	3

10. If a staff member becomes aware of a client using tobacco, will he or she routinely advise the client to quit?

	Response Percent	Response Count
Yes	**57.1%**	**24**
No	42.9%	18

11. Once a client has been identified as a tobacco user, does your organization have a protocol for advising them to quit?

	Response Percent	Response Count
Yes	31.0%	13
No	**69.0%**	**29**

12. Who is responsible for advising the client to quit? Please choose all that apply.

	Response Percent	Response Count
Behavioral Health Aide, Community Health Aide or Medical Assistant	50.0%	6
Psychiatrist, Psychologist, Physician, Pharmacist, Nurse Practitioner or Nurse	**58.3%**	**7**
Clinical Social Worker or Licensed Professional Counselor / Licensed Therapist	**58.3%**	**7**
Peer Counselor	8.3%	1
Other Staff (please specify)	33.3%	4

13. Is information about advising clients to quit recorded?

	Response Percent	Response Count
Yes	**83.3%**	**10**
No	16.7%	2

14. Information about advising clients to quit is recorded in: Please choose all that apply.

	Response Percent	Response Count
AKAIMS (Alaska's Automated Information Management System)	30.0%	3
Electronic health / medical record system other than AKAIMS	40.0%	4
Paper chart	**60.0%**	**6**
Other (please specify)	20.0%	2

15. Once a client has been identified as a tobacco user, does your organization typically: Please choose all that apply.

	Response Percent	Response Count
Provide self-help materials about quitting tobacco (e.g., workbooks and quit guides)	59.0%	23
Provide information about Alaska's Tobacco Quit Line (e.g., pamphlets, flyers, etc.)	**61.5%**	**24**
Refer the client, through fax-referral, to Alaska's Tobacco Quit Line	10.3%	4
Refer the client to on-site or in-house counseling for tobacco treatment/dependence	30.8%	12
Refer the client to an outside provider or community-based counseling program	17.9%	7
Discuss and/or prescribe pharmacological treatment options, such as Nicotine Replacement Therapy (e.g., nicotine patches or gum), bupropion, Chantix (when indicated)	33.3%	13
Other (please specify)	17.9%	7

Some respondents noted that they take action (primarily referrals) only if the client expresses interest in quitting.

16. Is information about referring clients to tobacco dependence treatment or counseling recorded?

	Response Percent	Response Count
Yes	**64.1%**	**25**
No	35.9%	14

17. Information about referring clients to tobacco dependence treatment or counseling is recorded in: Please choose all that apply.

	Response Percent	Response Count
AKAIMS (Alaska's Automated Information Management System)	37.5%	9
Electronic health / medical record system other than AKAIMS	25.0%	6
Paper chart	**75.0%**	**18**
Other (please specify)	12.5%	3

18. Is tobacco cessation counseling available within your organization?

	Response Percent	Response Count
Yes	**65.8%**	**25**
No	34.2%	13

Some respondents indicated that counseling is offered if part of the client's treatment plan, or if they request cessation support.

19. What types of tobacco cessation counseling are available through your organization? Please choose all that apply.

	Response Percent	Response Count
Individual counseling with health professionals (e.g., psychologist, counselor, social worker)	**84.0%**	**21**
Group counseling in any form	32.0%	8
Peer counseling	12.0%	3
Telephonic counseling (via Alaska's Tobacco Quit Line or "in-house" service)	52.0%	13
Other (please specify)	8.0%	2

20. Does your organization conduct discharge planning for tobacco dependence?

	Response Percent	Response Count
Yes	7.9%	3
No	**92.1%**	**35**

21. Which of the following services does your organization normally include in a discharge plan to address a client's tobacco use? Please choose all that apply.

		Response Percent	Response Count
Fax referral to Alaska's Tobacco Quit Line		0.0%	0
Referral to a community-based counseling program		0.0%	0
Monitoring success of client following referral to treatment		0.0%	0
Self-help materials about quitting tobacco, such as workbooks or quit guides		66.7%	2
Information about Alaska's Tobacco Quit Line through pamphlets, flyers, and other materials		**100.0%**	**3**
Prescription pharmacological treatment options, such as Nicotine Replacement Therapy (e.g., nicotine patches or gum), bupropion, Chantix (when indicated)		33.3%	1
Other (please specify)		0.0%	0

22. Once a client has been identified as a tobacco user, does your organization provide pharmacotherapy to clients on site for tobacco use?

	Response Percent	Response Count
Yes	23.7%	9
No	**76.3%**	**29**

23. Once a client has been identified as a tobacco user, does your organization refer clients off site to receive pharmacotherapy for tobacco use?

	Response Percent	Response Count
Yes	**50.0%**	**19**
No	**50.0%**	**19**

Some respondents indicated that off-site pharmacotherapy is usually referred if the client requests.

24. Does your organization's protocol require the following in order to receive covered pharmacotherapy products? Please choose all that apply.

	Response Percent	Response Count
A prior authorization to receive covered products	14.3%	4
Enrollment in a counseling program	14.3%	4
Setting and documenting an intended quit date	3.6%	1
A co-payment of covered products	3.6%	1
Other (please specify)	**71.4%**	**20**

Some respondents indicated that they do not offer pharmacotherapy. Others had no specific requirements. Some noted that patients would receive pharmacotherapy if covered by insurance, and referred to the Quit Line if uninsured.

25. In the past 12 months, has your organization provided training to staff members to increase their knowledge about helping people quit using tobacco? (e.g. lectures, in-service sessions, webinars, etc.)

	Response Percent	Response Count
Yes	**55.3%**	**21**
No	44.7%	17

Some respondents mentioned in-service trainings, a presentation about the Quit Line and a training offered by ANTHC.

26. In the last 12 months, has your organization: Please choose all that apply.

	Response Percent	Response Count
Provided lectures, workshops or in-service sessions to staff, such as psychologists and counselors, about tobacco use, tobacco-related performance measures and/or treatments	42.1%	8
Trained staff on brief interventions for tobacco cessation services	47.4%	9
Trained staff on Medicaid reimbursement for tobacco cessation services	5.3%	1
Trained staff about referring patients to Alaska's Tobacco Quit Line	**52.6%**	**10**
Other (please specify)	10.5%	2

27. Please describe your organization's ability to review data at a "client-population" level and describe the quality assurance activities at your organization. Please indicate the types of data that you are able to access.

		Response Percent	Response Count
"How many clients in our population use tobacco?"		**63.2%**	**24**
"How many clients in our population are being advised to quit at each visit?"		10.5%	4
"How many clients in our population are being referred to cessation resources, such as Alaska's Tobacco Quit Line, at each visit?"		13.2%	5
"How many tobacco users in our population receive prescriptions for nicotine replacement therapy or pharmacotherapy for quitting tobacco?"		7.9%	3
I am unable to access information about any of these questions		36.8%	14

One respondent noted that data is not accessible to them through AK-AIMS.

28. Does your organization have any quality assurance activities related to tobacco cessation that you are implementing or have implemented in the past 12 months? For example, ensuring providers are asking about tobacco use status, providing feedback on provider motivational interviewing or cessation counseling, etc.

	Response Percent	Response Count
Yes	23.7%	9
No	**76.3%**	**29**

29. Briefly describe any quality assurance activities related to tobacco cessation that you are currently implementing or have implemented in the past 12 months. For example, ensuring providers are asking about tobacco use status, providing feedback on provider motivational interviewing or cessation counseling, etc.

Respondents' examples included reporting during weekly staff meetings; reporting tobacco use data in AK-AIMS; conducting individual and group counseling; holding AK Brief Interventions trainings for staff; and monitoring staff's behavior to ensure consistency in screening.

30. Please indicate whether you agree or disagree with the following statements.

	Agree	Disagree	Rating Count
It is not the facility's or provider's responsibility to implement tobacco dependence treatment or counseling.	16.2% (6)	**83.8% (31)**	37
Our clients have far more important issues than tobacco dependence.	37.8% (14)	**62.2% (23)**	37
Our clients are not ready or not willing to change their habits and/or receive treatment for tobacco dependence.	32.4% (12)	**67.6% (25)**	37
Our providers are not interested in implementing tobacco dependence treatment or counseling.	8.1% (3)	**91.9% (34)**	37
Our providers believe that our clients benefit from smoking.	13.5% (5)	**86.5% (32)**	37
Our providers believe that they do not have time to implement tobacco dependence treatment or counseling.	32.4% (12)	**67.6% (25)**	37
Our providers believe that they do not get adequate reimbursement for implementing tobacco dependence treatment or counseling.	37.8% (14)	**62.2% (23)**	37
Our providers believe that they do not have adequate training to implement tobacco dependence treatment or counseling.	**51.4% (19)**	48.6% (18)	37

Respondents added comments noting that their responses to the above questions would depend on the individual clients, e.g. tobacco interventions are perceived to be more relevant for substance abuse treatment programs than for mental health programs. Respondents responded most positively to the statement that tobacco dependence treatment should be a priority, but that they need additional training and support to implement such interventions.

31. Which of the following best matches your facility's current policy related to indoor smoking?

	Response Percent	Response Count
Smoking is not permitted anywhere indoors	**100.0%**	**36**
Smoking is allowed indoors, but only in specific places	0.0%	0
Smoking is allowed throughout the facility without restrictions	0.0%	0

32. Which of the following best matches your facility's current policy related to outdoor smoking on the facility grounds?

	Response Percent	Response Count
Smoking is not permitted anywhere on the facility grounds	36.1%	13
Smoking is permitted on the facility grounds, but with some restrictions	**61.1%**	**22**
Smoking is permitted on the facility grounds without any restrictions	2.8%	1

The most common restrictions on outdoor smoking were 50-foot minimum distances from buildings or designated smoking areas ("shacks") on campus.

33. Does your facility currently have any restrictions on the use of other tobacco products (such as chew, SNUS or other smokeless tobacco products) on facility grounds by clients or employees?

	Response Percent	Response Count
Yes	**58.3%**	**21**
No	27.8%	10
Don't know	13.9%	5

34. Are employees at your facility allowed to smoke or use tobacco with clients?

	Response Percent	Response Count
Yes	27.8%	10
No	**72.2%**	**26**

Most respondents who chose "Yes" indicated that their organization does not have a written policy but that it is a discouraged practice.

35. Does your facility use cigarettes or other forms of tobacco as incentives or rewards for taking medication, following rules, attending therapy or other positive behaviors?

	Response Percent	Response Count
Yes	0.0%	0
No	**100.0%**	**36**

36. Are employees at your facility allowed to give to or purchase for their clients cigarettes and other forms of tobacco?

	Response Percent	Response Count
Yes	8.3%	3
No	**91.7%**	**33**

One respondent commented that if a client's family members provide money to purchase tobacco, an employee may purchase tobacco products on behalf of the client.

37. Please indicate whether your facility and staff would like to receive more information from the Alaska Tobacco Prevention and Control Program about: Please choose all that apply.

	Response Percent	Response Count
Information about Alaska's Tobacco Quit Line	56.3%	18
Implementing systems for identifying tobacco users	18.8%	6
Implementing systems for advising tobacco users to quit	**65.6%**	**21**
Implementing systems for offering referral and assistance to tobacco users	50.0%	16
Creating a tobacco free workplace and campus policy	25.0%	8
Establishing an effective monitoring system of tobacco users; successes and quit attempts	37.5%	12
Learning from peer organizations about their experience, successes and lessons learned in implementing systems change for addressing tobacco use	46.9%	15
Other (please specify)	12.5%	4

38. We are aware that some of the organizations we are surveying have been successful in implementing good systems and practices for identifying tobacco users, helping them to quit and/or implementing a tobacco free campus policy. Would your organization be willing to help other providers and facilities also be successful?

	Response Percent	Response Count
Yes	41.7%	15
No	**58.3%**	**21**

39. Our organization would be willing to help other providers by Please choose all that apply.

	Response Percent	Response Count
Sharing stories of your facility's experiences and practices with the Alaska Tobacco Prevention and Control Program, to be profiled in newsletters and other publications	57.1%	8
Presenting information about your practices through presentations at meetings, teleconferences and conferences	28.6%	4
Peer-to-peer mentoring for other Alaska facilities	**64.3%**	**9**
Other (please specify)	7.1%	1

Most respondents who chose "No" indicated that they are instead interested in receiving training and support, because they do not have policies in place or are only beginning to implement them.

Appendix B **Further Resources**

Mission 100

Mission 100 has a variety of resources available to healthcare providers and organizations to implement policy and systems change and address tobacco use in your community. Included in this packet are **fact sheets** on tobacco use among the behavioral health population and why it is important to quit, the Alaska Tobacco Quit Line and the Quit Line fax referral system. Also included is a **poster** illustrating the goal of Mission 100: tobacco policy and systems change must happen in all settings at the community level in order to create comprehensively supportive environments for promoting cessation, preventing initiation and protecting the public from secondhand smoke. More resources, including the **Healthcare Systems Change Manual** and information about how Mission 100 can help your organization are online at mission100alaska.org.

AK Brief Intervention Training

The Brief Tobacco Intervention: Helping Alaskans Quit (akbriefintervention.org) is a web-based training for healthcare providers that will provide information on the Ask, Advise, Refer Brief Tobacco Intervention. Components of this training include demonstrations on how to talk to tobacco users about quitting, information on Alaskan cessation services and interactive activities to guide a provider in initiating tobacco screening and referral to cessation services in their office, clinic, hospital or organization. Accredited for 1.0 CEU/CME by the Alaska Commission for Behavioral Health, Alaska Pharmacists Association, ANTHC CHA/P, and American Academy of Family Physicians.

Guidance Document: Medicaid Billing for Behavioral Health Providers

In 2013 the Division of Behavioral Health published a **Guidance Document on Coverage of Smoking and Tobacco Cessation Interventions**. This document indicates that community-based behavioral health professionals can bill Medicaid for the tobacco cessation services they provide to clients, and provides guidance on the criteria for reimbursement.

Best Practices and Policy Recommendations

The following pages are an overview of the **best practices** for integrating tobacco cessation into behavioral health settings. Individuals with substance use disorders and mental illness have high morbidity and mortality rates due to tobacco use, but want to quit tobacco at the same rate as the general population (over 70%) and can successfully quit with assistance. Tobacco cessation during a client's treatment has not does not negatively affect recovery or treatment, and recent evidence shows that tobacco cessation improves long term recovery outcomes for substance use disorders.

These recommendations were developed for and can be used by mental health providers, administrators and behavioral health organizations. The source organizations also provide detailed recommendations and policy statements.

ASK	
Practice	**Recommendations**
Ask every patient at every visit if they use tobacco. **Ask** every patient if they are routinely exposed to secondhand smoke, even if they do not use tobacco.	**American Psychiatric Association** – *All individuals undergoing a psychiatric evaluation should be screened for a substance use disorder, regardless of their age, presentation, or referral source. Nicotine use, past cigarettes use in pack-years (defined as the number of packs per day multiplied by the number of years of smoking), and for current smokers, the time from waking in the morning to their first cigarette should be part of the inquiry.* **Association for Treatment of Tobacco Use and Dependence** – *Providers should screen for tobacco use and dependence at treatment intake, concurrent with assessment for other chemical dependencies.* **Association for Addiction Professionals** – *All patients presenting for substance abuse services should be screened and assessed for tobacco use and, where applicable, that a tobacco or nicotine diagnosis, using DSM-IV or ICD 9 criteria, be made in the patient's chart*. **USPHS Clinical Practice Guidelines: Treating Tobacco Use and Dependence** – *Clinicians and health care systems should ask every patient who presents to a health care facility is s/he uses tobacco.* *Note*: USPHS, SAMSHA, and the US Preventive Services Task Force Providers advise providers to have systems in place to document tobacco use status and quit attempts in patient records. Moreover, systems that allow for review of patient population data are strongly recommended.

ADVISE	
Practice	**Recommendations**
Advise every tobacco user to quit.	**Substance Abuse and Mental Health Services Administration, USPHS Clinical Practice Guidelines: Treating Tobacco Use and Dependence** – *All tobacco users should be advised to quit in a clear, strong and personalized manner.* **SAMSHA –** *Educate clients about the health dangers of tobacco use and about approaches to quitting*

ASSESS	
Practice	**Recommendations**
Assess all users' willingness to make a quit attempt within the next 30 days. **Assess** past quit attempts.	**American Psychiatric Association** – *Use the Fagerstrom Test for Nicotine Dependence to determine the level of nicotine dependence and predict which smokers are likely to quit and which may benefit from high-dose NRT.* *Assess the willingness of all tobacco users to make a quit attempt using motivational interviewing strategies and stages of change model (Precontemplation, Contemplation, Preparation, Action, Maintenance).* *Assessment should include:* ✓ *Detailed history of the patient's past and present use of nicotine* ✓ *History of efforts to stop nicotine use and outcomes* ✓ *Current readiness to change* **SAMSHA** – *Counselors should ask their clients who smoke or use other tobacco products about their interest in quitting while in substance abuse treatment.* **American Society of Addiction Medicine** – *Ensure that training is available for counselors to assess for nicotine addiction when they do assessments for other chemical addictions.* *Notes*: Effective identification of tobacco use status not only opens the door for successful interventions, but also guides clinicians to identify appropriate interventions based on patients' tobacco use status and willingness to quit.[4]

ASSIST	
Practice	**Recommendations**
Assist the patient with a quit plan.	**American Psychiatric Association Practice Guidelines** – Strongly recommends *tailoring the*

[4] For more-complete recommendations and strategies, reference American Psychiatric Association, *Practice Guideline for the Treatment of Patients With Substance Use Disorders*, 2nd ed.

Assist in recommendations of approved nicotine replacement therapy (NRT) and/or pharmacotherapy in combination with counseling.	*treatment plan to individual needs and preferences, such as:* ✓ *Considering patient preferences for specific treatment approaches* ✓ *Choosing treatments that take into consideration the patient's characteristics and clinical status* ✓ *Using the patient's needs to adjust treatment duration, which may vary from a few months to many years* *Use specific pharmacological and psychosocial treatments in the context of an organized treatment program that combines different treatment modalities.* **Association for Addiction Professionals** – *Treatment plans should include tobacco dependence and tobacco education for family members of clients should be utilized, as this will put them in a better position to support and encourage recovery from tobacco dependence for the patient.* **SAMSHA** – *Counseling and nicotine uses cessation medications are the primary approaches used and are often used together.* **USPHS Clinical Practice Guidelines: Treating Tobacco Use and Dependence** – *Effective medications are available for tobacco dependence and providers should encourage their use by all patients attempting to quit smoking—except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).* *Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates:* ✓ Nicotine gum ✓ Nicotine inhaler ✓ Nicotine lozenge ✓ Nicotine nasal spray ✓ Nicotine patch ✓ Bupropion SR ✓ Varenicline *Notes*: Varenicline, commonly marketed as Chantix, has consistently demonstrated efficacy in clinical trials, both in comparison with placebo and with nicotine patch and bupropion. However, post marketing

	surveillance data revealed a correlation between varenicline and neuropsychiatric decompensation. Though no demonstration of this has occurred in randomized clinical trials, a black box warning is in effect. It is prudent for providers to ensure that psychiatric disorders are stabilized before initiation of varenicline and to monitor patients closely throughout treatment.[5] APA and USPHS provide more detailed information about various methods of psychosocial treatment. SAMSHA provides reviews of psychosocial options.
Assist the tobacco user ***unwilling*** to quit	**USPHS Clinical Practice Guidelines: Treating Tobacco Use and Dependence** – The "5 R's", *Relevance*, *Risks*, *Rewards*, *Roadblocks* and *Repetition*, are designed to motivate smokers who are unwilling to quit at this time. ✓ *Relevance* - Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation). ✓ *Risks* - The provider should ask the patient to identify potential negative consequences of tobacco use. The provider may suggest and highlight those that seem most relevant to the patient. The provider should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks. ✓ *Rewards* - The provider should ask the patient to identify potential benefits of stopping tobacco use. The provider may suggest and highlight those that seem most relevant to the patient. ✓ *Roadblocks* - The provider should ask the patient to identify barriers or impediments to quitting and provide treatment (problem solving counseling, medication) that could address barriers. ✓ *Repetition* - The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

[5] Danovitch, I., The Clinical Assessment and Treatment of Nicotine Dependence: The Journal of Lifelong Learning in Psychiatry, 2011 Dec 9(1):15-24.

	- See Motivational Interviewing Strategies. *Note*: For in-patient settings that are tobacco-free, providers may need to offer NRT to patients while they are residents.[6]

ARRANGE	
Practice	**Recommendations**
Arrange for follow-up contacts, either in person or via telephone.	**Association for the Treatment of Tobacco Use and Dependence** – Provide discharge plans to facilitate transitions in care and provide referrals for continued support. **Association for Addiction Professionals** – Discharge plans should address all unresolved problems, including the use of tobacco, identified at admission or during treatment. **USPHS Clinical Practice Guidelines: Treating Tobacco Use and Dependence** – Follow-up contact should begin soon after the quit date, preferably during the first week. A second follow-up contact is recommended within the first month. Schedule further follow-up contacts as indicated. *Action during follow-up contact*: For all patients, identify problems already encountered and anticipate challenges in the immediate future. Assess medication use and problems. Remind patients of quit line support. Address tobacco use at next patient encounter. For patients who are abstinent, congratulate them on their success! If the person has relapsed, review the circumstances and elicit recommitment to total abstinence. ✓ Remind patient that a lapse can be used as a learning experience. ✓ Identify problems already encountered and anticipate challenges in the immediate future. ✓ Assess NRT/medication and problems. ✓ Consider use or referral to more intensive treatment. ✓ Give positive feedback about the patient's attempts to quit.

[6] American Psychological Association; National Association of State Mental Health Program Directors.

	Note: Individuals often cut down substantially on their tobacco use before quitting, and this harm reduction needs to be recognized and congratulated.[7]

REFER	
Practice	**Recommendations**
If providers have limited time or are unable to provide cessation on-site, **Refer** to available community resources and/or Alaska's Tobacco Quit Line (**1-800 QUIT NOW**).	**USPHS Clinical Practice Guidelines: Treating Tobacco Use and Dependence** – *Telephone quit line counseling is effective with diverse populations and has broad reach. Therefore, both clinicians and health care delivery systems should ensure patient access to quit lines and promote quit line use.* **Alaska Resource: Alaska's Tobacco Quit Line Fax Referral** – Faxing a referral to Alaska's Tobacco Quit Line is a timesaving benefit that ensures the patient will receive contact within 48 hours. By checking the HIPAA Compliant box and providing a return fax number, you will receive a patient status report from the Quit Line. Alaska's Tobacco Quit Line offers: ✓ Free nicotine replacement treatment (NRT) ✓ 24 hours a day / 7 days a week ✓ Free tobacco cessation service available to all Alaskan adults (18+ years) ✓ No break in patient service ✓ Free materials for youth ✓ Expanded services for pregnant and nursing women ✓ Five proactive calls to patient from Quit Line ✓ Translators available *Note*: Quit Line quit coaches are not trained to identify or diagnose Mental and Behavioral Health disorders. Providers must disclose this information on the fax referral form or clients must self-identify a disorder during registration or in conversation with the quit coach.

[7] The Tobacco Cessation Toolkit for Mental Health Providers. University of Colorado Denver, Department of Psychiatry, Behavioral Health and Wellness Program, updated January 2009.

Mission 100 Will Be Complete

When Every Community is Tobacco-free!

Mission 100 Promotes Tobacco-free Communities by Working With:

1. **State and Local Media** to assist in changing community norms
2. **Homeowners, Housing Authorities and Landlords** to maintain smokefree homes
3. **Healthcare Organizations** to ask, advise and refer at every visit and pass tobacco-free campus policies
4. **Head Starts and Child Care Centers** to educate families about the dangers of secondhand smoke and tobacco use
5. **Schools and Universities** to pass tobacco-free campus policies
6. **Community Centers and Community Organizations** to host tobacco-free events
7. **State and Local Governments** to pass smokefree workplace ordinances and tobacco tax increases
8. **Tribal Governments** to pass tobacco-free workplace resolutions
9. **Retail Stores** to prohibit sales to minors and restrict tobacco industry advertising
10. **Restaurants** to become smokefree establishments
11. **Worksites** to establish employee wellness programs and tobacco-free job sites

MISSION 100 TOBACCO-FREE ALASKA

For more information, contact:
E: info@mission100alaska.org
P: 1-855-877-M100
W: mission100alaska.org

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TOBACCO-FREE ALASKA

Tobacco Use and Behavioral Health

Behavioral Health Clients Are More Likely To Die From A Tobacco-Related Disease Than From Any Other Cause

- Tobacco use is the leading preventable cause of death among people with behavioral health issues.
- People with mental illness and addictions die an average of 25 years early due to tobacco-related diseases, including heart disease and lung cancer.
- Up to 80% of behavioral health clients want to quit smoking.
- Behavioral health clients respond well to tobacco cessation treatment.
- Behavioral health providers are critical to clients' success quitting tobacco.
- Smoking is often a trigger for alcohol and drug use. Quitting smoking improves clients' abstinence from alcohol and drugs.
- Tobacco use interferes with many psychiatric medications, so quitting smoking can make managing medications easier for clients.
- Quitting smoking does not worsen psychiatric symptoms.

Leading Behavioral Health Organizations Endorse Tobacco Treatment

- The American Psychiatric Association
- American Society of Addiction Medicine, Inc.
- National Association of Alcoholism and Drug Abuse Counselors

"Clients who quit tobacco while in substance abuse treatment have a 25 percent increased chance of long-term sobriety. This is a huge advantage because even with completing treatment there is no guarantee that an individual will stay clean and sober after treatment."

— Nick Gonzales, Tobacco Prevention & Policy Manager, Akeela, Inc.

Payment and Reimbursement is Available for Tobacco Treatment

Tobacco cessation coaching and medication are covered by Alaska Medicaid, Medicare, the Indian Health Service and many health insurance plans. The State of Alaska is working to streamline reimbursement for tobacco treatment services and behavioral health. Mission 100 is here to assist your organization.

Mission 100 is an innovative, multi-faceted approach to providing tobacco prevention and control technical assistance to all employers and organizations, statewide. We provide tools, training and resources to assist with:

- Training providers to ASK every client about tobacco use, ADVISE every tobacco user to quit, and REFER tobacco users to Alaska's Tobacco Quit Line
- Discharge planning
- Tobacco-related training
- Creating tobacco-free campus policies to support quitting
- Reimbursement for tobacco cessation services

Alaska's Tobacco Quit Line

- The quit line is FREE for all Alaskans and is available by calling 1-800-QUIT-NOW (1-800-784-8669) 24 hours a day, 7 days a week.
- Quit line services include phone coaching sessions and free nicotine replacement therapy.

> *"This is so great for Alaskans. If people don't have the money to get the patches or gum, this gives them a way to be free. I want to give kudos because [your coaches] are so patient, understanding and knowledgeable in what you do. With this program I've felt listened to and I think that with representatives like you all helping customers, people are going to be more likely to quit, and to want to call and to get help. I wish everybody knew what a great program this is."*
>
> — Alaska's Tobacco Quit Line Caller

ALASKA'S TOBACCO QUIT LINE
1-800-QUIT-NOW
IT'S FREE. IT'S CONFIDENTIAL. AND IT WORKS.

For more information, visit **alaskaquitline.com**

06/2013

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TOBACCO-FREE ALASKA

What is Alaska's Tobacco Quit Line?

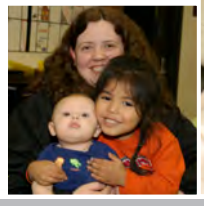
Alaska's Tobacco Quit Line provides free, confidential telephone coaching and medication to help Alaska residents quit tobacco. Smokers and chewers can call **1-800-QUIT-NOW (1-800-784-8669)** to speak with a Quit Coach and create an individualized, effective quit plan to guide them through the quit process.

Who is Eligible?

All Alaskan adults (18+) are eligible for free tobacco cessation services through Alaska's Tobacco Quit Line.

Alaska's Tobacco Quit Line Free Services Include:

- **Telephone coaching:**
  - Callers receive personalized advice and coaching on how to quit, information on medications, and assistance with creating a quit plan and choosing a quit date.
  - Alaska residents may call the quit line as often as they like.
  - Tobacco users have the option of enrolling in a call-back program where they will receive a series of four proactive, individual coaching and support calls.
- **Free nicotine replacement therapy** for all eligible participants.
- **Self-guided materials** to help the tobacco user prepare to quit, set a quit date and quit sucessfully.
- **A secure website** where tobacco users can learn more about Alaska's Tobacco Quit Line, enroll for services and request to speak with an enrollment specialist.
- **Information for those concerned about a tobacco user.**
- **Referrals** to local tobacco cessation resources and services, if desired.
- **Expanded services** for pregnant and nursing women.



How to Reach Us:

- **Call 1-800-QUIT-NOW (1-800-784-8669)**
  - Hours: 24 hours a day, 7 days a week

"The number one thing a tobacco user can do to improve their health and extend their lives is to quit."

— Dr. Jay Butler, Senior Director Department of Community Health Services, Alaska Native Tribal Health Consortium

Help Your Patients Quit

A brief tobacco intervention conducted by a health professional can dramatically improve a person's chances of quitting successfully.

As a health professional, you are a trusted source of information. You can play an important role in helping your patients and clients to quit by connecting them with free tobacco cessation resources:

- **Ask.** Ask your patients and clients, at every encounter, if they use tobacco.
- **Advise.** A brief tobacco intervention conducted by health professionals can double the chances that a patient or client will quit successfully.
- **Refer.** Referring your patients or clients to resources that combine coaching and medication can further increase the chances of a successful quit attempt.

For free, accredited training on how to perform a brief intervention, visit akbriefinformation.org.

Research demonstrates that telephone-based tobacco quit lines can provide effective treatment for tobacco dependence and can serve as convenient referrals for busy health professionals.

Consider these tips for a quick intervention:

- Encourage people to call Alaska's Tobacco Quit Line toll-free at **1-800-QUIT-NOW (1-800-784-8669)**.
- It can be intimidating to make that first call. That's why the quit line has developed a system that removes that barrier. Complete a fax referral form with your patient and the quit line will call them.
- For information on establishing a fax referral program at your site, call 1-855-877-M100.
- Direct patients to **alaskaquitline.com** for helpful quit tools and information about what they can expect when calling the quit line.

A personalized quitting plan will incorporate the following components:

- **Multiple proactive, phone-based coaching sessions with a highly trained Quit Coach**
- **Toll-free access to Quit Coaches for ongoing support throughout the quitting process**
- **Phone-based decision support for the type, dose and duration of medication**
- **Direct mail order fulfillment of nicotine replacement therapy products**
- **Printed, stage-appropriate Quit Guides delivered to participants' homes**

ALASKA'S TOBACCO QUIT LINE
1-800-QUIT-NOW
IT'S FREE. IT'S CONFIDENTIAL. AND IT WORKS.

For More Information, Contact:

E: info@mission100alaska.org
P: 1-855-877-M100
W: mission100alaska.org

06/2013

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TOBACCO-FREE ALASKA

Alaska's Tobacco Quit Line Fax Referral Program

What is Fax Referral?

Fax Referral is a program that builds on the services Alaska's Tobacco Quit Line offers by creating partnerships with healthcare providers. Through the Fax Referral Program, tobacco users no longer have to take the first step by calling the quit line; instead, after talking with their clinician, they can agree to have the quit line call them.

How Does it Work?

Tobacco users who would like to make a quit attempt in the next 30 days can sign a Fax Referral enrollment form during a face-to-face intervention at a doctor's office, hospital, dentist's office, clinic or agency site. The form is then faxed to the quit line. Within 48 hours, a Quit Coach makes the initial call to the tobacco user to begin the intervention.

Why is it Beneficial?

- **Seizing the Moment.**
  Fax Referral connects tobacco users with Alaska's Tobacco Quit Line right from the agency office. Since the quit line initiates the first call, the responsibility is not on the tobacco user to begin services, which increases the chances of a quit attempt.
- **It Saves Time.**
  Many doctors, nurses, dentists and other healthcare providers may not have time to offer comprehensive tobacco treatment. Fax Referral allows them to refer their patients to the quit line for specialized coaching based on years of scientific research.
- **Not Lost in Translation.**
  The tobacco user can identify his or her primary language on the enrollment form and a quit line translator will be on the line when the quit coach places the call. Quit line services are available in many languages spoken throughout Alaska.

What is Alaska's Tobacco Quit Line?

Alaska's Tobacco Quit Line is a free tobacco cessation service available to adult Alaskans (18 and over). It is funded by the Alaska Department of Health and Social Services Tobacco Prevention and Control Program. Quit line coaching services are provided via phone by Quit Coaches, who are specialists trained in tobacco cessation coaching techniques.

Who is Eligible for Services?

Alaskan adults (18 and over) are eligible for tobacco cessation services through Alaska's Tobacco Quit Line. All eligible tobacco users may enroll to receive eight weeks of free nicotine replacement products and up to four proactive coaching calls with a Quit Coach. Expanded services are available for pregnant and nursing women.

ALASKA'S TOBACCO QUIT LINE
1-800-QUIT-NOW
IT'S FREE. IT'S CONFIDENTIAL. AND IT WORKS.

For more information, contact:
E: info@mission100alaska.org **P:** 1-855-877-M100 **W:** mission100alaska.org

When complete fax to: 1-800-483-3114

ALASKA'S TOBACCO QUIT LINE
1-800-QUIT-NOW
IT'S FREE. IT'S CONFIDENTIAL. AND IT WORKS.

Alaska's Tobacco Quit Line Fax Referral Form

Fax referral is best for patients who are **ready to quit in the next 30 days** AND **ready to accept a call from the quit line in the next 48 hours.** If neither of these conditions are met, fax referral is not appropriate at this time. Instead, provide patient with quit line or other tobacco resource information.

Provider Information: **Sent Date:** ____ / ____ / ____

Clinic Name: _____

Healthcare Provider: _____

Contact Name: _____

I am a HIPAA-covered entity: ☐ Yes ☐ No ☐ I don't know

Fax: (____) ____ - ____ **Phone:** (____) ____ - ____

Comments: (e.g. Patient has COPD, diabetes, etc. Include any information that might be helpful to the quit line)

Patient Information: **Gender:** ☐ Male ☐ Female **Pregnant:** ☐ Yes ☐ No

Patient Name: _____ **DOB:** ____ / ____ / ____

Address: _____ **City:** _____ **Zip:** _____

Primary Phone: (____) ____ - ____ **Type:** ☐ Home ☐ Work ☐ Cell ☐ Other

Secondary Phone: (____) ____ - ____ **Type:** ☐ Home ☐ Work ☐ Cell ☐ Other

Language Preference (check one): ☐ English ☐ Spanish ☐ Other _____

Tobacco Type (check all that apply): ☐ Cigarettes ☐ Smokeless Tobacco ☐ Cigar ☐ Pipe ☐ Other

____ I am ready to quit tobacco and request that Alaska's Tobacco Quit Line contact me to help me with my quit plan.

(Initial)

____ I **DO NOT** give my permission to Alaska's Tobacco Quit Line to leave a message when contacting me.

(Initial)

Patient Signature: _____ **Date:** ____ / ____ / ____

Alaska's Tobacco Quit Line will call you. Please check the best 3-hour time frame for them to reach you. The quit line is open 7 days a week. Call attempts over the weekend may be made at times other than during this 3-hour time frame.

☐ 6 a.m.-9 a.m. ☐ 9 a.m.-12 p.m. ☐ 12 p.m.-3 p.m. ☐ 3 p.m.-6 p.m. ☐ 6 p.m.-9 p.m.

Within this 3-hour time frame, please contact me at (check one): ☐ Primary Phone ☐ Secondary Phone

Comments: (e.g. I'm not available weekends, prefer Tues. or Thurs., etc.)

Working Together, Reaching Further

MISSION 100
TOBACCO-FREE ALASKA

- **Tobacco use is the leading cause of preventable death and disease in Alaska, causing nearly 600 deaths each year[1]**
- **For every 8 smokers who die from smoking, 1 nonsmoker dies from exposure to secondhand smoke[2]**
- **Alaska Native adults are almost twice as likely to smoke as non-Native adults[1]**

Mission 100 strategically addresses tobacco use, treatment and secondhand smoke exposure on a statewide level, working with partners toward a common goal of a 100% tobacco-free Alaska.

Mission 100 provides free education, resources and individualized technical assistance across the state to aid in implementing effective tobacco-free policies and practices.

Mission 100 support is available to all entities interested in implementing system-wide changes to reduce tobacco prevalence, including communities and organizations that are not directly grant funded by the Tobacco Prevention and Control Program.

Mission 100 is an innovative, multi-pronged statewide approach that provides comprehensive, evidence-based tobacco prevention, education and cessation technical assistance to increase and sustain the reach of Tobacco Prevention and Control efforts in the State of Alaska.

MISSION 100
TOBACCO-FREE ALASKA

E: info@mission100alaska.org
P: 1-855-877-M100
W: mission100alaska.org

Last year, over 60,000 Alaska adults tried to quit using tobacco.*

They are battling a deadly addiction.

Support more Alaskans in quitting

FOR GOOD.

- Mission 100 works with healthcare organizations and health professionals to help them implement the Public Health Service Clinical Practice Guidelines for Treating Tobacco use and Dependence.
- Mission 100 partners with the statewide Task Force, Leadership for Eliminating Alaskan Disparities (LEAD) to ensure that all tobacco prevention activities and services are reaching Alaska's most vulnerable populations.
- Mission 100 is the main distribution point for all Alaska's Tobacco Quit Line materials and resources, and provides technical assistance on utilization and implementation of quit line protocols.
- Mission 100 supports the Tobacco Prevention and Control Grantee network and provides all technical assistance in these communities and organizations to implement evidence based strategies, prevent the initiation of tobacco use among youth and young adults, eliminate exposure to secondhand smoke in Alaska communities, and increase the number of adults who quit using tobacco.

For more information, contact:

MISSION 100
TOBACCO-FREE ALASKA

E: info@mission100alaska.org
P: 1-855-877-M100
W: mission100alaska.org

Alaska's Tobacco Quit Line

ALASKA'S TOBACCO QUITLINE 1-800-QUIT-NOW

Alaska's Tobacco Quit Line is a toll-free telephone-based cessation program that provides free coaching; self-guided quit materials; and nicotine replacement therapy to all Alaska adults who want to quit tobacco. Professional quit coaches, specially trained to serve a variety of specific Alaska cultures, including Alaska Native callers, assess the caller's readiness to quit, help them determine a quit date and develop a quit plan. Supplemental services are available for pregnant women and nursing mothers.

[1] Alaska Tobacco Facts 2012 Update: http://dhss.alaska.gov/dph/Chronic/Documents/Tobacco/PDF/2012_alaska_tobacco_facts.pdf
[2] Schoenmarklin S. Tobacco Control legal Consortium. 2004. Infiltration of Secondhand Smoke into Condominiums, Apartments, and Other Multi-Use Dwellings. St. Paul, MN: Tobacco Control Legal Consortium.

THE STATE of ALASKA
GOVERNOR SEAN PARNELL

Department of Health and Social Services
DIVISION OF BEHAVIORAL HEALTH
Director's Office

3601 C Street, Suite 878
Anchorage, Alaska 99503-5924
Main: 907.269.3600
Toll Free: 800.770.3930
Fax: 907.269.3623

March 14, 2013

RE: **Guidance Document**: Coverage of smoking and tobacco cessation interventions

Dear Community Behavioral Health Services Provider:

The impact of smoking and tobacco use/addiction by people with behavioral health conditions, and its contributing role in chronic disease is a critical issue within behavioral health practice.

- Cigarette smoking is the leading preventable cause of disease, disability and death in the US.
- About 3 of every 10 cigarettes (31%) smoked by adults are smoked by adults with mental illness.
- Tobacco use is the leading preventable cause of death among people with behavioral health issues;
- Like other smokers, adults with mental illness who smoke want to quit, can quit, and benefit from proven stop-smoking treatments.

Behavioral health professionals can reduce these negative outcomes by making quitting tobacco part of an overall approach to treatment and wellness. In an effort to clarify the Division's position on this topic within behavioral health practice, this letter serves to provide guidance and direction related to Medicaid coverage and reimbursement for tobacco cessation services.

When current community behavioral health service guidelines are followed, agencies may provide and bill for clinical interventions or counseling visits designed to assist patients to quit and to provide relapse prevention of tobacco use and dependence. Services may include any clinic or rehabilitation service recommended in an assessment to meet the recipient's treatment goals. The procedure codes used to describe the interventions or counseling services must adhere to both regulatory requirements and CPT coding guidelines[1].

Specifically, providers must comply with all clinical record and documentation requirements described in the Behavioral Health Services Integrated Regulations (7 AAC 70; 7 AAC 135; 7 AAC 105.230). All services must be documented in the clinical record and must be medically necessary and clinically appropriate as demonstrated by screening (utilizing an AST and initial CSR), professional behavioral health assessment, and a treatment plan outlining the services prescribed to treat the patient's tobacco use.

[1] American Medical Association Current Procedural Terminology Codebook, 2013

The clinical record and claims submitted for billing must document an appropriate diagnostic code that reflects the condition for which the patient is being treated. (e.g. 305.1 - Tobacco use disorder).

If you have any questions regarding the information provided in this guidance document please contact Teri Keklak at 269-2050 for assistance. Thank you for your continued service to Alaska and Alaskans in need.

Sincerely,

Melissa Witzler Stone
Director