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TOBACCO-FREE ALASKA

TREATING TOBACCO DEPENDENCE AS A STANDARD OF CARE:

A HEALTH SYSTEMS APPROACH

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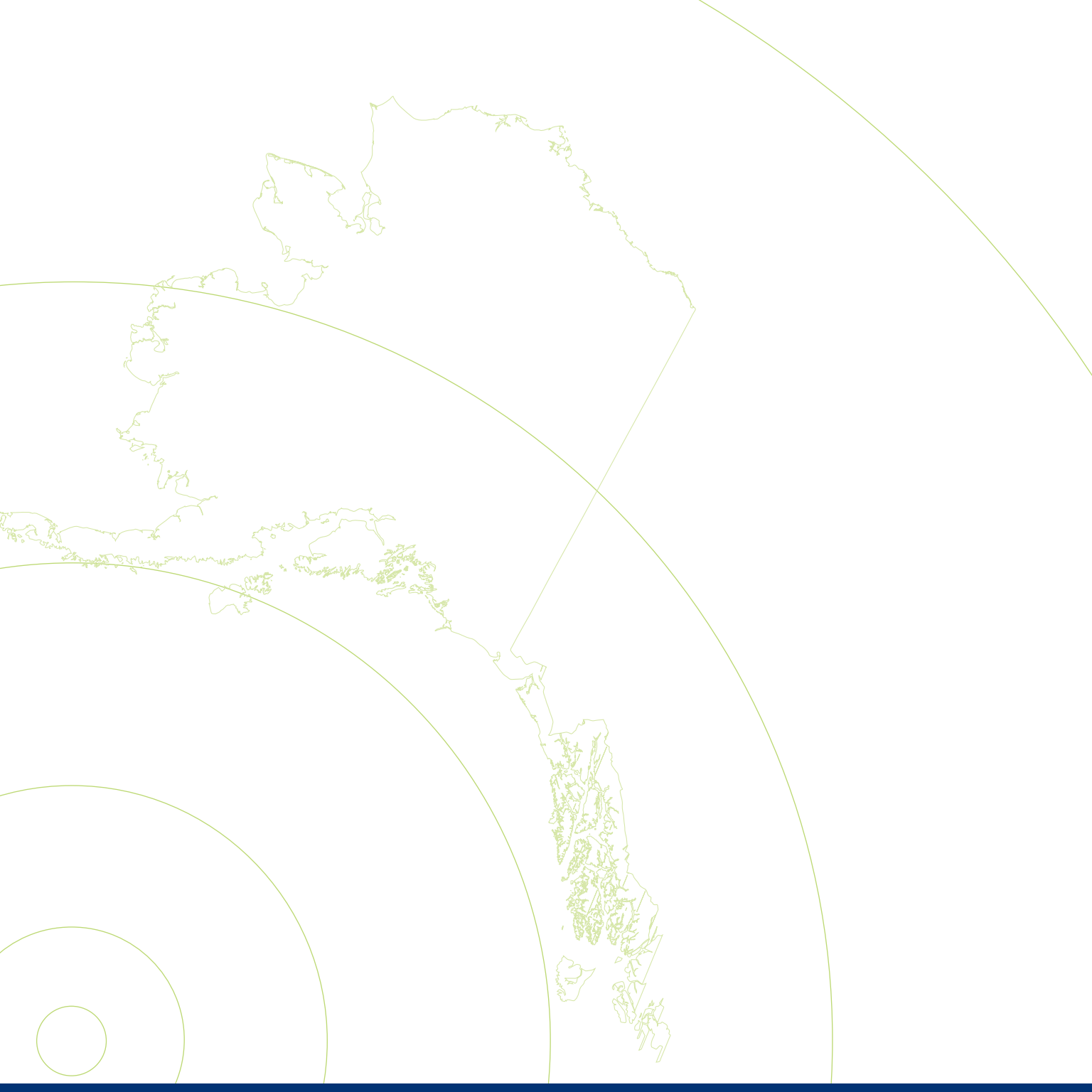
THANK YOU FOR JOINING MISSION 100!



"Hospitals and nursing homes in Alaska are taking extraordinary measures to control tobacco use by their patients, residents and employees. They are leaders in this very important health campaign."

- Karen Perdue, President/CEO
Alaska State Hospital and Nursing Home Association

"Not using tobacco is one of the single BEST things a pregnant woman can do to improve the chances her baby will be born healthy and stay healthy! The list of benefits for babies is HUGE!"

- Debbie Golden, Perinatal Nurse Consultant
Alaska Division of Public Health,
Section of Women's, Children's & Family Health

Mission 100: Tobacco Free Alaska

- 100 percent of patients are **ASKED** about tobacco use
- 100 percent of tobacco users are **ADVISED** to quit
- 100 percent of tobacco users are **REFERRED** to the Alaska's Tobacco Quit Line
- 100 percent of tobacco users are Referred to appropriate medication/ Nicotine Replacement Therapy (NRT)
- 100 percent of healthcare providers use systems to document tobacco use
- 100 percent of healthcare providers get reimbursed for tobacco cessation services
- 100 percent of healthcare campuses are tobacco-free

Unless otherwise noted, all data in this manual come from the Alaska Tobacco Facts, 2012 Update:
http://www.hss.state.ak.us/dph/chronic/tobacco/alaska_tobacco_facts.pdf

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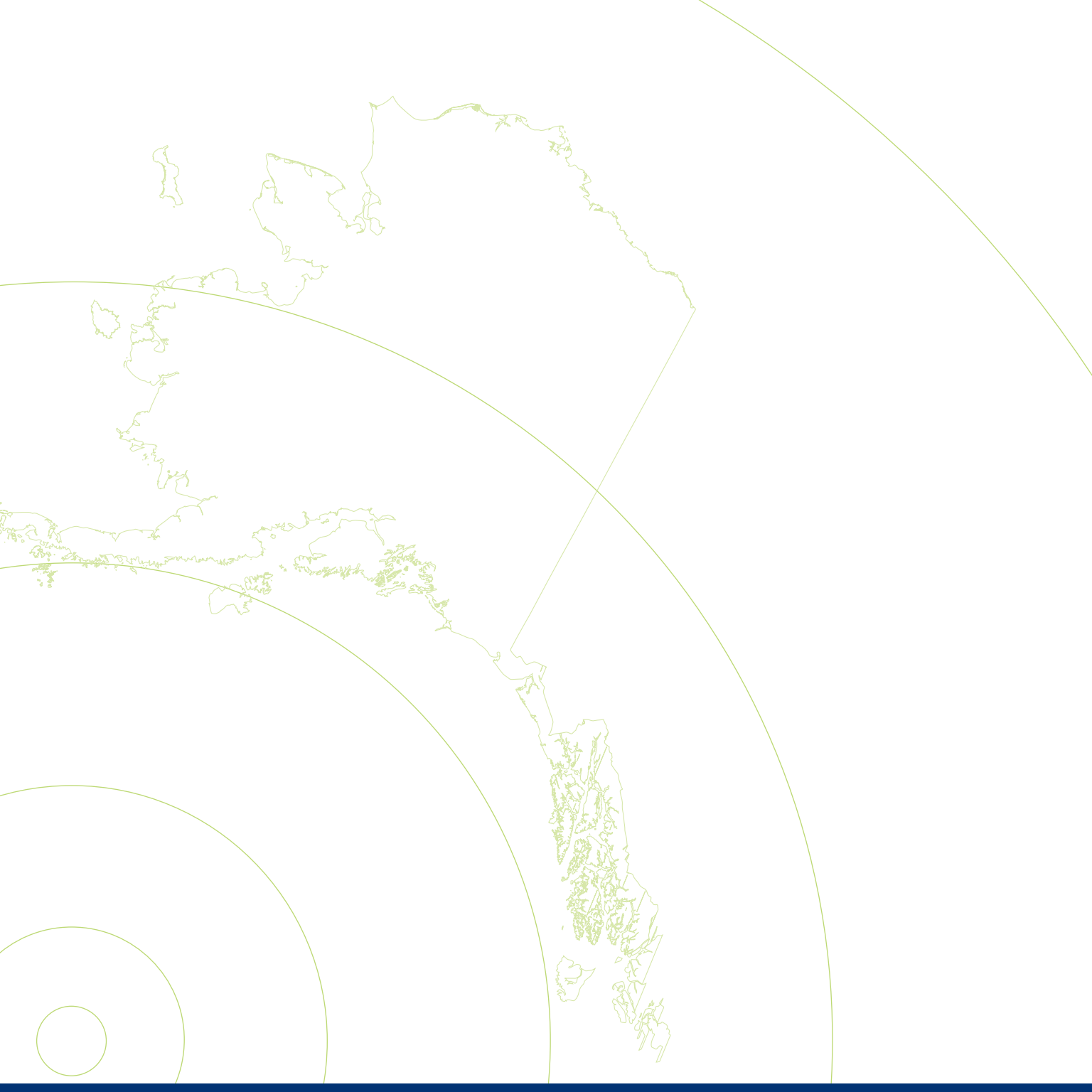

Treating Tobacco Use and Dependence: Helping People Quit for Life!

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Alaska's healthcare providers play a critical role in helping people quit tobacco.

The clinic visit is a key opportunity to treat tobacco use and dependence:[1]

- At least 70 percent of smokers see a physician every year
- Advising a tobacco user to quit significantly increases their odds of quitting successfully
- Tobacco cessation counseling and medication are safe, effective and reimbursable by Medicaid, Medicare, and most health plans

Most tobacco users want to quit.[2] In Alaska, 71 percent of smokers and 57 percent of smokeless tobacco users want to quit.

Patients are more satisfied with their healthcare if their provider offers tobacco cessation interventions - even if they are not yet ready to quit.[3]

Many Alaska healthcare providers are already advising tobacco users to quit. In 2010, 77 percent of smokers who visited their healthcare provider were advised to quit—an increase from 73 percent in 2001.[4]

Together, we can make that 100 percent.

INTRODUCTION

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WHY MISSION 100?

Tobacco use is the number one preventable cause of death and disease in our communities.

Alaska has made tremendous progress in reducing tobacco use—smoking prevalence has declined significantly from 28 percent in 1996 to 21 percent in 2010, but there is still much work to be done.

Mission 100 works with all healthcare organizations to make tobacco cessation a top priority.

Mission 100 has the tools, training and resources to assist providers and their organizations all over Alaska. We will assist you with setting up a clinical system to:

- **ASK** every patient about tobacco use
- **ADVISE** every tobacco user to quit
- **REFER** tobacco users to treatment, such as Alaska's Tobacco Quit Line, which provides both counseling and medication
- Support quit attempts with a **tobacco-free campus**
- Get **reimbursed** for tobacco cessation services

Tobacco use is the single most preventable cause of disease, disability, and death in the United States and in Alaska.

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Tobacco remains a significant public health problem in Alaska, killing nearly 600 people annually and generating almost $579 million annually in direct medical costs and lost productivity.

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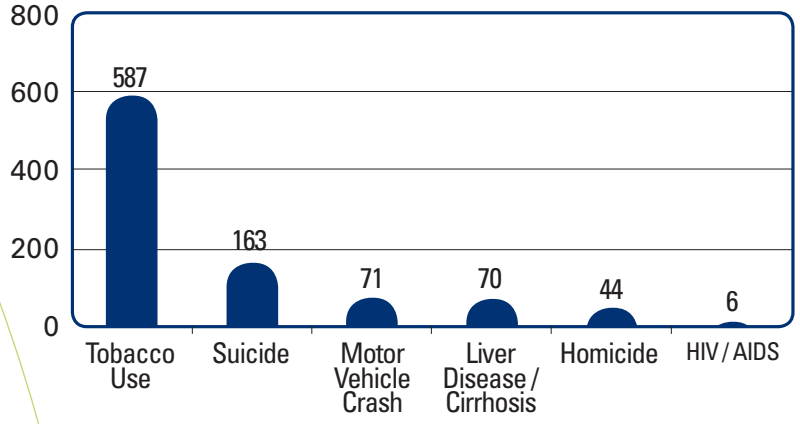
More Alaskans die annually from the effects of tobacco use than from suicide, motor vehicle crashes, chronic liver disease and cirrhosis, homicide, and HIV/AIDS combined. Approximately one-fifth of all deaths in Alaska are caused by tobacco use.

TOBACCO FACTS

Figure 1 Number of Deaths Due to Selected Causes, Alaska, 2009



- This sums to an astounding $579 million, yet it underestimates total costs; lost productivity from tobacco-related illness and costs due to secondhand smoke exposure-related illness or death are not included.

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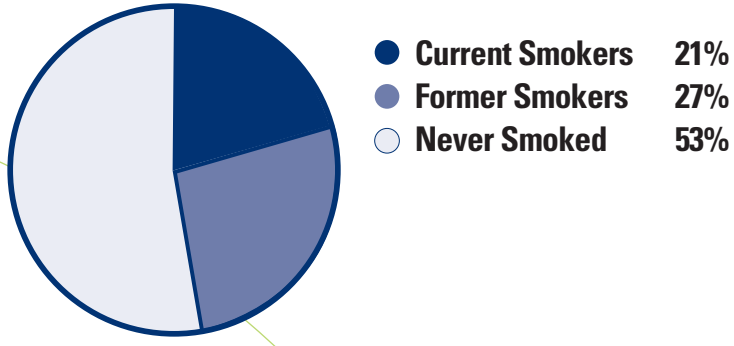
In Alaska, over one-fifth of all adults smoke.

Figure 2 Smoking Status of Adults, Alaska, 2010



TOBACCO FACTS

- Younger adults remain a priority group for tobacco prevention efforts. In 2010, almost one in three (32%) young adults aged 18 to 29 reported being a smoker. This proportion has remained about the same since 1996.
- More than half of all current smokers (57%) were smoking by the time they were 17 years old.

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"Help us end tobacco use so Alaska Native people can be the healthiest people in the world. Help support healthy choices through screening, education and referral. Screen all of our patients for tobacco use. Educate everyone including children about the dangers of tobacco use. Refer to programs that work."

- Andy Teuber, Chairman and President
Alaska Native Tribal Health Consortium

"The light of the Alaska Native culture shines brightly in the communities we serve, illuminating all who embrace it. By actively screening and treating tobacco use, we directly ensure the brightest future for all Alaska Native people."

- Joy Britt, Technical Assistance Coordinator
Alaska Native Tribal Health Consortium

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1 Treat Tobacco Use to Prevent and Manage Chronic Diseases

WHY TREAT TOBACCO USE?

Tobacco use and secondhand smoke cause:

- Heart disease and stroke
- Cancer, including lung, throat, mouth, kidney, and bladder
- Lung disease, including chronic obstructive pulmonary disease (COPD)

Smokeless tobacco use is a known cause of cancer of the mouth and gums, and is linked to oral health problems like periodontitis and tooth loss.

Using tobacco products:

- Increases heart rate
- Narrows blood vessels
- Increases blood pressure
- Increases insulin resistance
- Lowers High Density Lipoprotein (HDL) levels

Tobacco use also interferes with surgical outcomes and causes poor wound healing.

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WHY TREAT TOBACCO USE?

In Alaska, four-fifths of lung cancer deaths, two-thirds of respiratory disease deaths, and almost one-fifth of heart disease deaths are due to smoking and could have been prevented if tobacco use was eliminated.

- Tobacco use is associated with widespread organ damage, reflecting the systemic distribution of tobacco smoke components and their high level of toxicity. Thus, active smokers are at higher risk for wide-ranging diseases such as cataracts, heart disease, several cancers, pneumonia, and a general reduction in positive health status. Of the 3,466 deaths in Alaska in 2008, 42 percent (1,445) were from conditions for which tobacco use is a known risk factor.
- An estimated 38 percent (546) of deaths from tobacco-related diseases were caused by tobacco use.

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Figure 3 Mortality Associated with Tobacco Use

Causes of Death Associated with Tobacco Use	Total Deaths	Tobacco-Related Deaths	Percent Tobacco-Related Deaths
Malignant Neoplasms	437	262	60%
Trachea, Bronchus, and Lung	257	208	81%
Esophagus	25	17	68%
Pancreas	62	14	23%
Lip, Oral Cavity, and Pharynx	11	6	55%
Urinary Bladder	19	6	32%
Larynx	4	4	100%
Kidney and Renal Pelvis	19	4	21%
Stomach	18	3	17%
Cervix, Uteri	11	0	0%
Acute Myeloid Leukemia	11	0	0%
Cardiovascular Disease	769	135	18%
Ischemic Heart Disease	365	76	21%
Other Heart Disease	213	27	13%
Cerebrovascular Disease	166	24	14%
Aortic Aneurysm	10	8	80%
Atherosclerosis	5	0	0%
Other Arterial Disease	10	0	0%
Respiratory Diseases	221	147	67%
Chronic Airways Obstruction	149	118	79%
Bronchitis, Emphysema	27	24	89%
Pneumonia, Influenza	45	5	11%
Perinatal Conditions	18	2	11%
Total	**1,445**	**546**	**38%**

WHY TREAT TOBACCO USE?

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2 Treat Tobacco Use to Protect Children's Health

Approximately 9,560 Alaska children are exposed to secondhand smoke in their homes each year.

According to the U.S. Surgeon General, secondhand smoke contains more than 250 chemicals that are toxic or cause cancer, including formaldehyde, benzene, vinyl chloride, arsenic, ammonia, and hydrogen cyanide. There is no risk-free level of secondhand smoke exposure.[5]

Prenatal smoking and exposure to secondhand smoke causes:

- Stillbirth
- Low birth weight
- Sudden infant death syndrome (SIDS)
- More frequent and severe asthma attacks
- Ear infections
- More frequent colds
- Higher risk of pneumonia and other lung infections

WHY TREAT TOBACCO USE?

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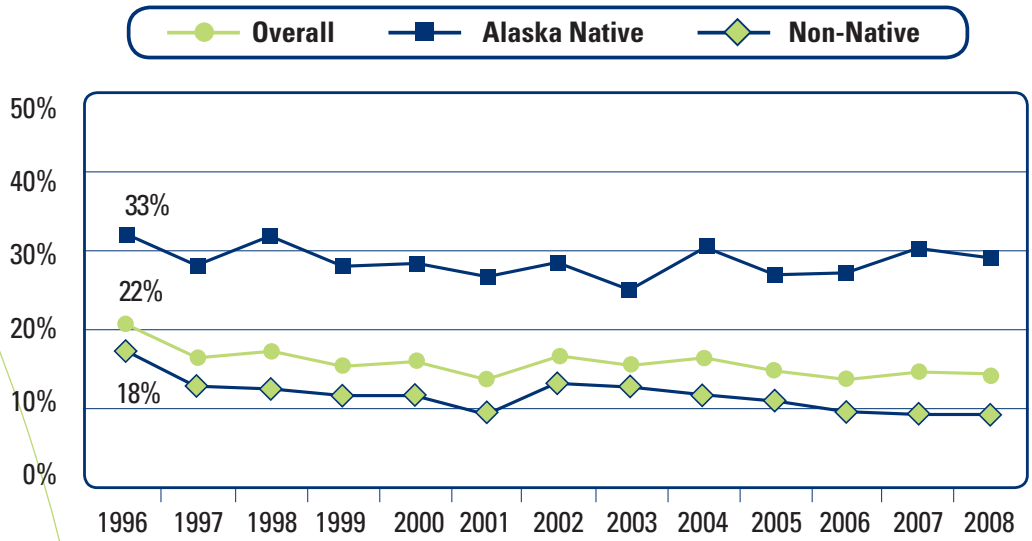
Prenatal smoking prevalence has not changed significantly among Alaska Native women. Among Alaska Native women, for the period 2004 to 2008, prenatal smoking prevalence was significantly higher in four tribal health regions: Arctic Slope, Bristol Bay, Northwest Arctic, and Norton Sound.

Figure 4 **Prenatal Cigarette Smoking (last three months), by Year Alaska, 1996-2008**



WHY TREAT TOBACCO USE?

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WHY TREAT TOBACCO USE?

- Prenatal tobacco use accounts for 20-30 percent of all low birth weight births in the United States. According to the 2004 Surgeon General's Report, eliminating maternal smoking may lead to a 10 percent reduction in all sudden infant deaths and a 12 percent reduction in deaths from perinatal conditions.

- Overall, prenatal cigarette use in Alaska has decreased significantly from 21.6 percent in 1996 to 15.1 percent in 2008, as well as among non-Native women. However, most of the decrease occurred between 1996 and 1997.

3 Treat Tobacco Use to Prevent Infectious Diseases

Tobacco use and secondhand smoke exposure increase patients' susceptibility to:[6]

- Invasive meningococcal disease
- Pneumococcal disease
- Influenza
- Tuberculosis
- Bronchitis
- Common cold

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4 Treat Tobacco Use to Reduce Health Disparities

Smoking and tobacco use are more common among Alaska Natives, Alaskans with lower education and income levels, and young adults age 18-29.

Higher levels of smoking and tobacco use cause a greater burden of disease and death among disadvantaged populations.

- Alaska Natives:
  - Smoking among Alaska Natives (41%) is over twice the rate of non-Native Alaskans (17%).
  - Smoking among Alaska Native high school students (26%) is over twice the rate of students of other racial/ethnic backgrounds.
  - Smokeless tobacco use is high in the Alaska Native population; 17 percent of men and 9 percent of women use smokeless tobacco.

WHY TREAT TOBACCO USE?

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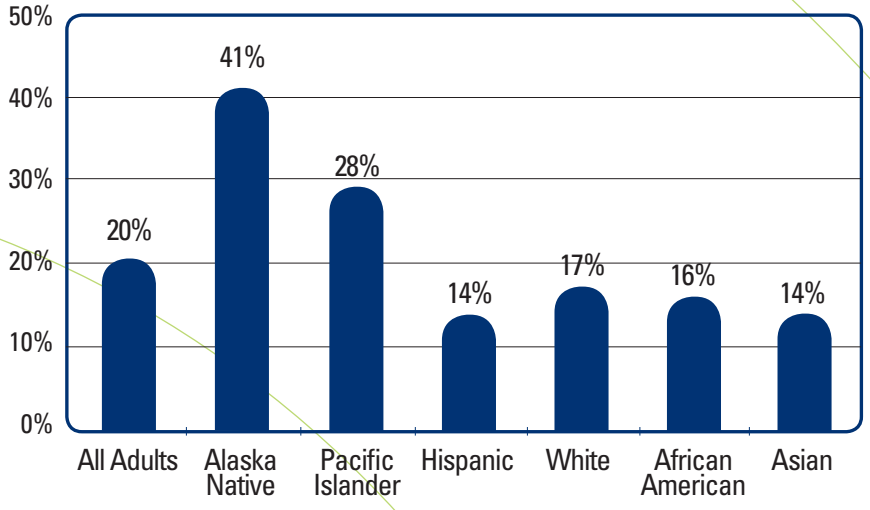
WHY TREAT TOBACCO USE?

Figure 5 **Percentage of Adults who Smoke by Race/Ethnicity, Alaska, 2008-2010**



- Alaska Native adults are more likely to be smokers than Hispanic, White, African American, or Asian adults.
- There is no significant difference in smoking prevalence between White, African American, Asian, Pacific Islander, and Hispanic adults.

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WHY TREAT TOBACCO USE?

- Low Socioeconomic Status:
  - Alaska Natives and non-Natives with fewer years of education and/or lower household income are more likely to smoke.
  - Smoking among non-Natives with low socioeconomic status (32%) is over twice the rate of those with higher socioeconomic status (16%).
  - Smoking among Alaska Natives with low socioeconomic status is 50 percent.
- Young Adults:
  - Smoking among young adults (32%) is significantly higher than those aged 30-55 (20%).
  - Younger Alaskans aged 18-44 are significantly more likely to use smokeless tobacco than those who are 45 and older (6% versus 3%).
- Adolescents:
  - Smoking among high school students dropped from 37 percent in 1995 to 14 percent in 2011.
  - Smokeless tobacco use is higher among Alaska Native girls (13%) than White (2%) or Other Race girls (3%).
  - Smokeless tobacco use is higher among Alaska Native boys (22%) than White (12%) or Other Race boys (7%).

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WHY TREAT TOBACCO USE?

Figure 6 **Percentage of Youth Who Smoke, by Race Group and Gender, Alaska, 2009 and 2011 combined**

	Alaska Native Youth	Non-Hispanic White Youth	Youth of Other Races	Total
Girls	29%	13%	7%	16%
Boys	22%	12%	7%	14%
All Youth	25%	12%	7%	15%

- Alaska Native girls are significantly more likely to smoke than boys or girls from any other group, including Alaska Native boys. Non-Hispanic White girls are also more likely to smoke than girls of Other Race (including Asian, African American, Hawaiian/Pacific Islander, and multiple race youth).
- Alaska Native boys are more likely to smoke than non-Hispanic White boys. Boys from the Other Race group are less likely to smoke than either Alaska Native or non-Hispanic White boys.

- Regional Differences:
  - Smoking rates also vary by region, with some of the highest rates found in North, Northwest and Interior Alaska (39%) and Southwest Alaska (31%).
  - Smokeless tobacco is used by 22 percent of adults in Southwest Alaska.

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Figure 7 Percentage of Adults age 25-65 who Smoke by Socioeconomic Status (SES) and Race, Alaska, 2008-2010

SES Status (age 25-64)*	Alaska Natives	Non-Natives
Lower SES	50%	31%
Higher SES	33%	15%
All Adults	42%	18%

** Lower SES is calculated as those persons with less than a High School education or less than 185 percent of the Alaska Poverty Level Guideline. Measurement of SES is also restricted to age 25 to 64 because younger adults (age 18-24) may not have had a chance to complete their education and begin to earn an income. Older adults aged 65 and over are similarly excluded because income and education might be inadequate SES markers for those who are potentially retired and eligible for Medicare.*

- In addition to Alaska Natives, non-Native adults age 25-64 of lower SES are disproportionately likely to smoke, compared to their higher SES non-Native counterparts (31% versus 15%).
- Regardless of race group, more than two in five adult smokers (42%) live in households earning less than 185 percent of the Alaska Poverty Level Guideline, compared to 27 percent of the overall adult population.
- Employment status is another factor related to both SES and smoking. Although unemployed adults and those who are unable to work comprise about 11% of the overall adult population, they are disproportionately likely to smoke; 45% of unemployed adults and 41% of those who are unable to work are smokers, compared to 19% of employed adults who smoke.

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- Other populations:
  - Smoking is higher among people with mental health and substance abuse issues (nationally).[7]
  - Smoking is higher among people who are gay, lesbian, bisexual, and transgendered (nationally).[8]

WHY TREAT TOBACCO USE?

5 Treat Tobacco Use to Tame Medical Costs

Tobacco-related diseases are a major cause of sky-rocketing medical costs. Treating tobacco use and dependence can prevent the development of many costly chronic diseases, including heart disease, cancers, and lung diseases.

- In 2010, tobacco use cost Alaska $348 million in direct medical expenditures and an additional $231 million in lost productivity due to tobacco-related deaths.
- Tobacco treatment is the "gold standard" in healthcare cost effectiveness according to the Agency for Healthcare Research and Quality.[9]
- The cost of tobacco treatment is modest when compared to other routine screenings and preventive services, such as mammography, hypertension screening, and Pap smears.
- Tobacco treatment is cost-effective no matter how it is calculated (e.g., cost per quality-adjusted-life-year saved (QALY), cost per quit, healthcare costs and utilization pre- and post-quit, and return on investment (ROI).

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6 Treat Tobacco Use because Your Patients Want to Quit

- Nearly three out of five current smokers (58%) have attempted to quit in the past 12 months; quit attempts were made by over half of those who smoke every day (55%) and nearly two-thirds of those who smoke some days (64%).
- Quit attempts among Alaska Native people who currently smoke have increased from 59 percent in 2001 to 65 percent in 2010.
- The proportion of Alaska smokers who had a healthcare visit in the past 12 months and received advice from their healthcare provider to quit has increased from 73 percent in 2001 to 77 percent in 2010.
- Being able to stay quit for three or more months greatly increases the chances of quitting tobacco for life. About nine percent of Alaska adults who smoked in the past year have been successfully quit for three or more months. Longer-term quits over the past year are higher for smokers who are non-Native than Alaska Native (10% vs 4%).

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WHY TREAT TOBACCO USE?

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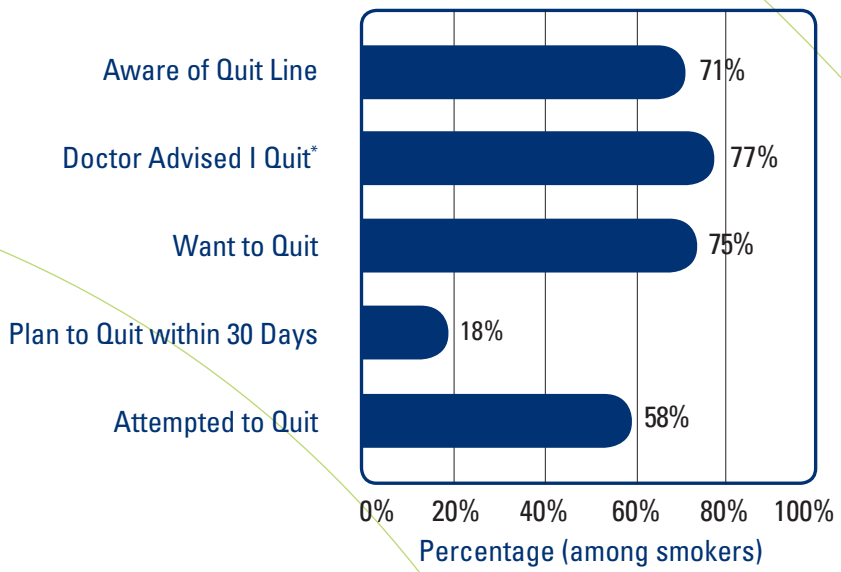
WHY TREAT TOBACCO USE?

Figure 8 **Percentage of Adult Smokers Endorsing Key Cessation Variables, Alaska 2010**



**Among current smokers who had a healthcare visit in the past 12 months.*

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P: 1-855-877-M100
W: mission100alaska.org

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"Screening and treatment for tobacco cessation may be the single most important action that clinicians can take to make Alaska Native people the healthiest in the world."

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

"Clients who quit tobacco while in substance abuse treatment have a 25% 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.

Integrating Tobacco Cessation Best Practices Into Your Healthcare Organization: One Step at a Time

This section includes a step-by-step process for adopting best practices to address tobacco use and dependence.

The best practices are described in the following sections:

- Tobacco Cessation Best Practices: Overview
- Tobacco Cessation Best Practices: Healthcare Providers
- Tobacco Cessation Best Practices: Healthcare Organizations

Note: A similar and overlapping process for adopting tobacco-free facilities and ground policies is in the section called, "Going Tobacco-Free."

Organizational change does not happen overnight.

Take time to develop support for adopting tobacco cessation best practices among leadership and staff. The process could take six months to a year.

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STEPS FOR INTEGRATION

Mission 100 will provide support, guidance, and resources throughout the process. Use these steps as a general outline for the process:

1. Demonstrate leadership support
2. Form a workgroup
3. Assess current practices and policies
4. Set a goal
5. Create an action plan
6. Prepare providers and staff
7. Develop office systems that support tobacco treatment
8. Celebrate successes

Step 1 Demonstrate Leadership Support

Support from leadership, including board members, administrators and managers, is essential.

Leadership support includes verbal and written support, as well as resources.

Cultivate leadership support through formal and informal meetings and presentations.

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Roles for leadership:

- Communicate an inspiring vision for the initiative.
- Describe how tobacco cessation supports the mission of the organization.
- Communicate support at meetings and in writing (managers meetings, staff meetings, board meetings, newsletters, memos, etc.).
- Involve staff from across the organization in the process.
- Dedicate adequate resources to support the initiative, including staff time, training resources, and medical records upgrades.

Talking points can be found in *Appendix A.*

Step 2 Form a Workgroup

Adopting tobacco cessation best practices requires a team approach. Providers, nurses, health aides, and administrative staff all have a role.

Depending on the size of the organization, form a workgroup of at least two people, including providers and staff. Involving people from across the organization throughout the planning process will ease implementation.

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STEPS FOR INTEGRATION

This workgroup will guide the organization throughout the change process. The workgroup may include:

- Clinical or medical director
- Member of board of directors or governing council
- Physician
- Pharmacist
- Health educator
- Nurse
- Health aide
- Facilities maintenance
- Environmental services
- Public affairs/Communications
- Union
- Electronic medical records/Billing specialist

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Four questions that can be used to guide the workgroup are:[10]

- Where are we now? (Assess current practices)
- Where do we want to be? (Set a goal)
- How will we get there? (Create an action plan)
- How will we know we are getting there? (Celebrate successes)

Step 3 | Assess Current Practices and Policies

"Where are we now?"

Every organization is unique. Use the Tobacco Cessation Checklist in Appendix B to determine the current level of tobacco cessation services and systems at the clinic site or throughout the organization.

It may also be helpful to conduct individual or group meetings with key people within the organization to gauge their level of support and discover concerns that may need to be addressed.

After completing the assessment, share the results with leadership in order to set a goal and create an action plan.

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STEPS FOR INTEGRATION

Step 4 | Set a Goal

"Where do we want to be?"

Discuss the results of the assessment with leadership to create a shared understanding about priorities.

Goals will vary from organization to organization, but examples include:

- All providers will screen for and document tobacco use, advise patients to quit, and fax-refer tobacco users to Alaska's Tobacco Quit Line.
- All providers will follow prescribing guidelines for FDA-approved tobacco cessation medications.
- The vital signs will include tobacco use.
- The medical records system will prompt providers to screen and document tobacco use.
- All FDA-approved tobacco cessation medications will be included in the formulary.
- The facility and grounds will be tobacco-free.

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Step 5 | Create an Action Plan

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"How will we get there?"

Based on the assessment and the organization's goal(s), the workgroup will develop an action plan for adopting tobacco cessation services and systems. The action plan will include a number of activities designed to reach the goal.

A sample action plan form is included in *Appendix D.*

Examples of activities include:

- Work with Mission 100 staff to conduct staff training on brief tobacco cessation interventions (**ASK**, **ADVISE**, **REFER**).
- Encourage providers to earn a Continuing Medical Education credit by completing the Alaska Brief Tobacco Intervention training at: www.akbriefintervention.org.
- Work with Mission 100 staff to access and implement Alaska's Tobacco Quit Line Fax Referral Program.
- Train providers and health aides on using the fax referral form to Alaska's Tobacco Quit Line.
- Update the medical record system (paper or electronic) to include provider reminders and templates for tobacco use interventions.
- Work with billing staff to ensure tobacco cessation counseling is coded and billed correctly.

STEPS FOR INTEGRATION

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STEPS FOR INTEGRATION

Step 6 | Prepare Providers and Staff

Smooth your path to implementation through frequent contact with staff. Provide plenty of training on tobacco cessation best practices and using the new forms and medical records documentation procedures.

Use frequent two-way communication to give updates and seek input. This will ensure potential problems are voiced and solved prior to implementation.

- Host meetings to describe the initiative, get ideas, and discover concerns.
- Invite providers and staff to offer suggestions, get involved, and voice any concerns at staff meetings, presentations, grand rounds, "town hall" meetings, personal conversations, or simply through a suggestion box.
- Arrange for, and promote, staff education and training on tobacco cessation best practices and how to use the new tools and systems, such as:
  - How to **ASK** about tobacco use, including documentation in the medical record
  - How to **ADVISE** patients to quit

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- The Alaska Brief Tobacco Intervention CME
- Alaska's Tobacco Quit Line Referral Program
- Prescribing guidelines
- Diagnosis and billing codes

Step 7 Develop Office Systems That Support Tobacco Treatment

Develop organization-wide systems to make it easier for providers to treat tobacco use as described in the section: *Changing the System: Support Tobacco Cessation Interventions.*

Example activities include:

- Change the vital records or electronic medical records system to remind providers to document tobacco use status.
- Include tobacco-related diagnosis and billing codes in the medical records and billing systems.
- Train staff on using Alaska's Tobacco Quit Line Fax Referral Program.

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STEPS FOR INTEGRATION

Step 8 | Celebrate!

"How will we know we are getting there?"

Throughout the change process, keep track of successes. Publicly recognize each accomplishment and celebrate milestones—even small ones.

Say, "Thank you!" often.
This will keep tobacco cessation "top of mind," keep people engaged and encouraged, and foster a culture that values tobacco cessation best practices.

Here are some ideas:

- Publicly acknowledge providers who are already conducting tobacco cessation interventions and ask them to give a presentation to other staff.
- Share success stories from other healthcare organizations to get staff inspired and motivated.
- Invite staff to participate in national and statewide webinars on tobacco cessation interventions and give them a certificate of completion.
- Communicate progress on the Action Plan at staff meetings, the employee newsletter or bulletin board.

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STEPS FOR INTEGRATION

- Give updates to the board of directors or governing council as important milestones are reached.
- Publicly thank workgroup members for their contributions.
- Plan a "kick-off" event or launch party for the new tobacco cessation systems (e.g, vital records, fax referral) or tobacco-free facilities and grounds policy.
- Using the medical records system, keep track of tobacco use screening and referral rates, and provide feedback to providers on their performance individually and across the organization.

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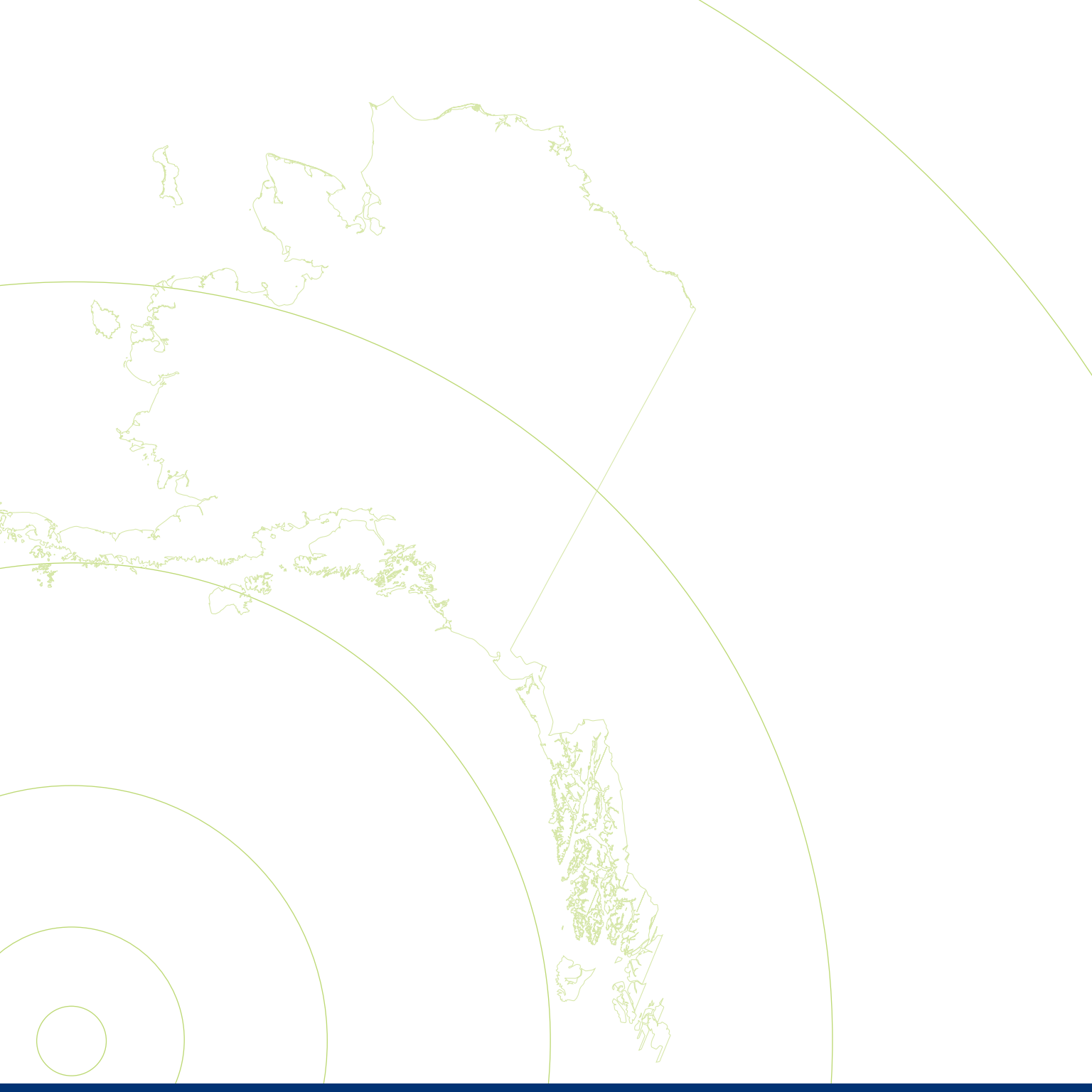

"Working towards becoming a tobacco-free facility is a measure very much worth the time, energy and commitment you spend, because the rewards are to potentially help improve the lives of your family, your friends, coworkers and those in your community."

- Connie Markis, RN, Care Coordinator
Anchorage Neighborhood Health Center

"As dental professionals one of the most important aspects of an oral health exam is to identify patients who use tobacco. Tobacco use is a significant risk factor in periodontal disease and oral cancer. Education regarding these risks and performing oral cancer screenings should be provided for all patients. Assisting patients in obtaining resources to quit tobacco should be a high priority for all clinicians. Let's help Alaskans have healthy smiles and become "Tobacco Free."

- Royann Royer RDH, MPH
Alaska State Dental Hygienist's Association

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BEST PRACTICES OVERVIEW

Tobacco Cessation Best Practices: Overview

This manual provides practical tips and resources to assist tribal health organizations, community health clinics, and hospitals to adopt tobacco cessation best practices.

Healthcare-related best practice guidelines include:

- Quick, effective ways to treat tobacco use
- Healthcare systems that make it easier for providers to treat tobacco use
- Tobacco-free healthcare facilities and grounds

The best practices are based on:

- U.S. Public Health Service, Clinical Practice Guideline for Treating Tobacco Use and Dependence, 2008 Update: www.surgeongeneral.gov/tobacco
- Guide to Community Preventive Services, Tobacco Use: www.thecommunityguide.org/tobacco
- The experiences and success stories of healthcare providers across Alaska

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BEST PRACTICES OVERVIEW

The U.S. Public Health Service Clinical Practice Guideline makes 10 key recommendations for healthcare providers:

1. Treat tobacco dependence as a chronic disease, requiring multiple interventions and quit attempts.
2. Consistently identify, document, and treat tobacco use at every visit.
3. Offer counseling and medication to every patient who is willing to quit. Tobacco treatment is effective across populations.
4. Offer brief tobacco interventions to every patient who uses tobacco (**ASK**, **ADVISE**, **REFER**).
5. Individual, group and telephone counseling are effective and their effectiveness increases with treatment intensity, particularly:
   - Practical counseling (problem-solving/skills training); and
   - Social support delivered as part of treatment.

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6. Cessation medications are effective. Encourage their use unless contraindicated (i.e., pregnant women, smokeless tobacco users, light smokers and adolescents).
   - These include nicotine gum, inhaler, lozenge, nasal spray and patch, as well as Buproprion SR (Zyban®) and Varenicline (Chantix®).
7. Encourage all individuals making a quit attempt to use both counseling and medication.
8. Refer all patients to Alaska's Tobacco Quit Line, which is effective across populations.
9. Provide motivational interviewing to all tobacco users who are unwilling to quit at this time.
10. Tobacco treatments are cost-effective. Insurance plans and purchasers should include counseling and medication as covered benefits.

This toolkit includes details on how to implement these guidelines in the section: *Provider Best Practices.*

BEST PRACTICES OVERVIEW

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BEST PRACTICES OVERVIEW

Healthcare Systems That Make it Easier for Providers to Treat Tobacco Use: Systems Change Strategies from the Clinical Practice Guideline

In contrast to approaches that target either providers or tobacco users, systems strategies address the healthcare organization itself. According to the Clinical Practice Guideline, the five recommended systems strategies are:

1. Implement a tobacco user identification system in every clinic.
2. Provide education, resources, and feedback to promote provider intervention.
3. Dedicate staff to provide tobacco dependence treatment and assess its delivery in staff performance evaluations.
4. Promote hospital policies that support and provide inpatient tobacco dependence services.
5. Include tobacco dependence treatments (both counseling and medication) identified as effective in the guideline, as paid or covered services in all subscribers or members of health insurance packages.

This toolkit includes details on how to implement these guidelines in the section: *Provider Best Practices.*

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BEST PRACTICES OVERVIEW

Making Your Facility and Grounds Tobacco-free:
Guide to Community Preventive Services

Healthcare organizations and other employers across Alaska and throughout the United States are going tobacco-free within their facilities and on their grounds. Tobacco-free policies support the mission of healthcare organizations to promote health in their communities.

Tobacco-free policies are an evidence-based means to reduce tobacco use among employees and the public, and are recommended by the Community Preventive Services Task Force. The Task Force is an independent, nonfederal, uncompensated body of public health and prevention experts, whose members are appointed by the Director of Centers for Disease Control.

The Task Force reviewed 35 studies and found strong evidence that smoke-free workplace policies reduce tobacco-use among workers.

The Task Force's recommendations for tobacco cessation, protecting people from secondhand smoke, and preventing tobacco use among youth can be found at: *www.thecommunityguide.org/tobacco*.

This toolkit includes details on how to adopt a tobacco-free policy in the section: *Going Tobacco Free.*

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BEST PRACTICES OVERVIEW

Mission 100: Your Partner in Implementing Best Practices

Every healthcare organization is different. Mission 100 will work collaboratively with your organization to develop ways to put the best practices into place, tailored to your organization and your providers.

This toolkit provides many resources to get you started, and the Mission 100 team is standing by to provide assistance and support.

Drawing from the wisdom and experience of "real-world" Alaskan examples, and operating with cultural humility and cultural awareness, the Mission 100 team will work with your organization to develop strategies that work for you.

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For more information, contact:

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

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"To assure Kahtnuht'ana Dena'ina thrive forever, the Kenaitze Indian Tribe is committed to elevating the wellness of our people by promoting clinical practice guidelines and comprehensive tobacco programming. Providers in the health system are available to provide integrated assistance for our people who are ready to quit using tobacco, reduce exposure to secondhand smoke for all from birth through elder, and prevent our young people from becoming addicted to nicotine. For too long, Alaskan Natives have been targeted by tobacco companies and have suffered inequitable rates of death and disease."

- Deborah Nyquist, Wellness Manager
Dena'ina Health Clinic, Kenaitze Indian Tribe

"Every training Yukon Kuskokwim Health Corporation does for our health care staff increases awareness about tobacco prevalence in our patient populations. A lot of other issues take priority, but increasing awareness of the importance of this issue—things like causing chronic disease, cancer, cardiac issues and other ailments caused by tobacco use is helping people recognize that it is important to treat. We are increasing the help our patients are getting and raising awareness throughout the region."

- Laura Ellsworth, Program Manager
Yukon Kuskokwim Health Corporation Nicotine Control & Research

Tobacco Cessation Best Practices:
Healthcare Providers

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Brief Tobacco Interventions: **ASK. ADVISE. REFER.**

Mission 100: 100 percent of Alaska's healthcare providers ask about tobacco use, advise patients to quit, and refer patients to treatment, such as Alaska's Tobacco Quit Line.

ALASKA'S TOBACCO QUIT LINE
1-800-QUIT-NOW
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Healthcare organizations are busy places. Healthcare providers must meet more needs with less time. The population is aging and there is an increasing burden of chronic disease.

It may seem there is not enough time to treat tobacco dependence, that it won't make a difference, or that patients might not want to be asked about their tobacco use, but **treating tobacco use is the single most important thing you can do for your patients' health**.

Patients are more motivated to quit when encouraged by their healthcare provider.[11]

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PROVIDER BEST PRACTICES

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PROVIDER BEST PRACTICES

In Alaska, many smokers are quitting or getting ready to quit:

- Seven in 10 Alaskans who currently smoke (71%) want to quit.
- Nearly three out of five current smokers (58%) have attempted to quit in the past 12 months; quit attempts were made by over half of those who smoke every day (55%) and nearly two-thirds of those who smoke some days (64%).
- Quit attempts among Alaska Native people who currently smoke have increased from 59 percent in 2001 to 65 percent in 2010.

Many Alaska healthcare providers are already advising tobacco users to quit. In 2010, 77 percent of smokers who visited their healthcare provider were advised to quit—an increase from 73 percent in 2001.

Together, we can make that 100 percent.

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Providers can significantly increase patients' likelihood of quitting tobacco with a Brief Tobacco Intervention (2 As and an R):

1. **ASK** all patients about tobacco use, and document tobacco use in the patient's record
2. **ADVISE** all patients to quit, and
3. **REFER** them to Alaska's Tobacco Quit Line, 1-800-QUIT-NOW, which provides both counseling and medication.

The Brief Tobacco Intervention is a quick, effective way to help patients quit tobacco.

Brief Tobacco Intervention: 2A's and an R

ASK	Identify and document tobacco use status for every patient at every visit.	Expand the vital signs to include tobacco use screening.
ADVISE	In a clear, strong, personalized manner, urge every tobacco user to quit.	"I need you to know that quitting tobacco is the most important thing you can do for your health. We can help you."
REFER	Refer all tobacco users to treatment, such as Alaska's Tobacco Quit Line, which provides both counseling and medication.	Use the Quit Line Fax Referral Program. See the prescribing guide in Appendix H.

PROVIDER BEST PRACTICES

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A free online course for Continuing Medical Education (CME) credit called, "The Brief Tobacco Intervention: Helping Alaskans Quit" is available at: www.akbriefintervention.org.

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Brief Tobacco Interventions get an 'A' grade from the Clinical Practice Guideline.

Clinical Practice Guidelines findings for Brief Tobacco Interventions:

- All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention.
- All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates.
- Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention.
- Tobacco dependence treatment is effective and should be delivered even if specialized assessments are not used or available.
- Treatment delivered by a variety of clinician types increases abstinence rates. Therefore, all clinicians should provide smoking cessation interventions. (Strength of Evidence = A)

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Multiple staff can deliver the intervention.

For example:

- Medical assistant or nurse can ask about tobacco use
- Clinician can advise the patient to quit and refer to treatment, such as Alaska's Tobacco Quit Line, which provides both counseling and medication
- Medical assistant, nurse, or office assistant can process the Quit Line Fax Referral form
- Quit Line coach will call the patient to deliver cessation counseling and NRT

Ask: Screening and Documenting Tobacco Use

Providers are significantly more likely to deliver Brief Tobacco Interventions when there is a clinic-or hospital-wide tobacco use screening system, such as including tobacco use status in the vital signs, chart stickers or computer prompts.

Mission 100 can provide assistance to your healthcare organization to develop a system that ensures that for every patient, at every visit, tobacco use is queried and documented.

Appendix E includes a sample Vital Signs chart sticker and a tobacco use screening template for Electronic Medical Records.

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PROVIDER BEST PRACTICES

"Do you smoke or use tobacco? Have you ever?"

Clinical Practice Guidelines Findings for Screening and Documenting Tobacco Use

- All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A)

Tips:

- Decide who is responsible for asking about and documenting tobacco use (e.g., the medical assistant or nurse) and train them.
- Involve medical records and billing staff to ensure that appropriate diagnostic and billing codes are being utilized.

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Advise: Encourage Tobacco Users to Quit
A physician's advice to quit is powerful.

Brief advice to quit significantly increases tobacco users' likelihood of quitting and staying quit.

Clinical Practice Guidelines Findings for Advising Patients to Quit Smoking

- All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A)

In a clear, strong, and personalized manner, urge every tobacco user to quit.
Examples:

- "As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health. The clinic staff and I will help you."
- "It is important that you quit smoking (or using chewing tobacco) now, and I can help you."
- "A combination of counseling and medication will give you the best chances of quitting."
- "Cutting down while you are ill is not enough."
- "Occasional or light smoking is still dangerous."

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PROVIDER BEST PRACTICES

Tie your advice to quit to things that are important to the patient:

- Current symptoms and health concerns
- The impact of tobacco use on children and others in the household
- Social and economic costs

Examples:

- "Continuing to smoke makes your asthma (diabetes, heart condition, etc.) worse, and quitting may dramatically improve your health."
- "Quitting smoking may reduce the number of ear infections your child has."

What to do with patients who have already quit:
Tobacco use is a chronic disease, and relapse is common in the months, or even years, after quitting.

Healthcare providers can help prevent relapse by congratulating the patient on quitting and encouraging them to stay quit.

Ask open-ended questions to identify any issues, such as cravings or weight gain.

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Possible concerns and recommendations:

- Cravings or withdrawal symptoms: recommend medication
- Concerns about weight gain: recommend healthy diet and active lifestyle
- Lack of social support: recommend Alaska's Tobacco Quit Line

"It is wonderful you quit tobacco! That is the most important thing you can do for your health. How is it going?"

What to do with patients not yet ready to quit:
There is a dose-response relationship between the number of times a patient has been advised to quit by a provider and their eventual success in quitting. Even when patients are not currently willing to make a quit attempt, clinician-delivered brief interventions enhance motivation and increase the likelihood of future quit attempts.

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"As your healthcare provider, I strongly recommend you quit smoking for your health and for the health of your loved ones. When you are ready to quit, we can help. Here's a card for Alaska's Tobacco Quit Line, 1-800-QUIT-NOW."

PROVIDER BEST PRACTICES

Every time a clinician asks about and advises a patient to quit tobacco, they are improving the chances that the patient will eventually quit and stay quit.

Refer: Alaska's Tobacco Quit Line

Counseling combined with medication increases tobacco users' chances of quitting and staying quit.

Alaska's Tobacco Quit Line provides free, evidence-based, culturally-competent counseling and nicotine replacement therapy (NRT) to Alaskans over the age of 18.

Healthcare providers can refer patients to Alaska's Tobacco Quit Line using the Fax Referral Program. The Fax Referral form is in *Appendix F*.

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Alaska's Tobacco Quit Line services include:

- Eight weeks of free nicotine patches or gum, regardless of insurance coverage
- Multiple calls with a Quit Coach over two to six months (up to 12 months)
- Callers under the age of 18 are encouraged in their quit attempt and are referred back to their primary care provider for additional support and services. Youth callers will always receive education materials when requested, but are not eligible for NRT or counseling.
- Pregnant and nursing women receive expanded services:
  - 10 proactive follow-up calls during pregnancy and postpartum
  - Several intervention calls in the two-week period following a quit attempt
  - Another call just before due date
  - Two further calls within two months of delivery
  - NRT may be available, with written approval from the woman's healthcare provider

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Because the mail system in Alaska can be delayed, individuals should call the Quit Line up to 30 days before they are ready to quit to enroll in the program and ensure they have NRT to use on their quit date.

Answers to "Frequently Asked Questions" about the Quit Line can be found in *Appendix G.*

Fax Referral: 1-2-3 Quit!
Mission 100 staff will work with you to set up the Fax Referral Program.

The Fax Referral Program makes referring patients to the Quit Line easy:

1. Fill out and have the patient sign the Fax Referral form *(Appendix F)*
2. Fax the form to the Quit Line
3. Within 48 hours, a Quit Coach calls your patient to begin counseling

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Tobacco Quit Lines get an 'A' grade from the Clinical Practice Guideline

Clinical Practice Guidelines findings on Cessation Counseling

- Proactive telephone counseling, group counseling, and individual counseling formats are effective.
- Two types of counseling and behavioral therapies result in higher abstinence rates: (1) providing smokers with practical counseling (problem-solving skills/skills training), and (2) providing support and encouragement and encouragement as part of treatment.
- The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone.
- There is a strong relation between the number of sessions of counseling, when it is combined with medication, and the likelihood of successful smoking cessation.
- There is a strong dose-response relation between the session length of person-to-person contact and successful treatment outcomes. Intensive interventions are more effective than less intensive interventions and should be used whenever possible.
- Person-to-person treatment delivered for four or more sessions appears especially effective in increasing abstinence rates.
- Motivational intervention techniques appear to be effective in increasing a patient's likelihood of making a future quit attempt.

(Strength of Evidence = A)

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How Alaska's Tobacco Quit Line Works

PROVIDER BEST PRACTICES

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Refer: Tobacco Cessation Medications

Tobacco cessation medication doubles the odds of quitting and staying quit.

Seven first-line tobacco cessation medications are approved by the FDA and recommended by the Clinical Practice Guideline as safe and effective.

Seven FDA-approved, First-Line Medications:

Nicotine Replacement Therapies (NRT)	Common Brand Names	Availability	Provided by Alaska's Tobacco Quit Line
Gum	Nicorette®	Over-the-Counter (OTC)	Yes - 8 weeks
Lozenge	Commit®	OTC	
Inhaler	Nicotrol®	Prescription	
Nasal spray	Nicotrol®	Prescription	
Patch	Nicoderm®, Habitrol®, Prostep®, Nicotrol®	OTC or Prescription	Yes - 8 weeks
Non-nicotine Replacement Therapies	**Common Brand Names**	**Availability**	**Provided by Alaska's Tobacco Quit Line**
Varenicline	Chantix®	Prescription	No
Bupropion SR	Zyban®, Wellbutrin®	Prescription	No

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PROVIDER BEST PRACTICES

Free nicotine replacement therapy (patch and gum) is available through Alaska's Tobacco Quit Line, 1-800-QUIT-NOW. Other medications are available over-the-counter or can be prescribed. First-line medications should be added to the formulary, if applicable.

Tobacco cessation medication is recommended for all smokers, with the exception of four populations:

- Pregnant women (contraindicated, not shown to be effective)
- Smokeless tobacco users (not shown to be effective)
- Light smokers (not shown to be effective)
- Adolescents (not shown to be effective)

Appendix G contains a summary of the Clinical Practice Guideline treatment recommendations for these four populations, as well as other specific populations.

Nicotine Replacement Therapy (NRT)
The nicotine-patch, gum, lozenge and inhaler deliver nicotine to the body to help reduce the urges and cravings of tobacco withdrawal. NRT is safe and effective, and is not addictive. Pros and cons of different NRTs and dosing guidelines can be found in the Prescribing Guide in *Appendix I*.

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Non-nicotine Replacement Therapies
Bupropion SR (Zyban®) and Varenicline (Chantix®) are prescription medications that do not contain nicotine. Pros and cons of these medications and dosing guidelines can be found in the Prescribing Guide in *Appendix I*.

- Varenicline works due to nicotine receptor agonist and antagonist effects. Varenicline may cause psychiatric side-effects, such as depression, agitation, and suicidal ideation, so patients with any history of psychiatric illness must be monitored closely.
- Buproprion SR works by blocking the reuptake of dopamine and norephinephrine and blocks nicotinic acetylcholinergic receptors. It can be combined with NRT.

Combining Medications
Certain combinations of first-line medications have been shown to be more effective than either medication alone. NRT combinations are especially helpful for highly dependent smokers or those with a history of severe withdrawal.

Effective combinations:

- Long-term nicotine patch (>14 wks) + NRT gum or nasal spray
- Nicotine patch + bupropion SR
- Nicotine patch + nicotine inhaler

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PROVIDER BEST PRACTICES

Going Beyond Brief Tobacco Interventions: Clinical Cessation Counseling

Referral to Alaska's Tobacco Quit Line is an evidence-based means to provide intensive counseling and medication to tobacco users.

However, providers who want to go beyond the Brief Tobacco Intervention can also provide intermediate (three to 10 minutes) or intensive (more than 10 minutes) counseling.

Intermediate and intensive tobacco cessation counseling are reimbursable by Medicaid and Medicare. See *Appendix J* for more information about reimbursement, and *Appendices K* and *L* for Medicaid and Medicare billing.

Intermediate Intervention: The 5A's

ASK	Identify and document tobacco use status for every patient at every visit.	Expand the vital signs to include tobacco use.
ADVISE	In a clear, strong, personalized manner, urge every tobacco user to quit.	"I need you to know that quitting tobacco is the most important thing you can do for your health. We can help you."

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PROVIDER BEST PRACTICES

ASSESS	Is the tobacco user willing to make a quit attempt at this time?	"On a scale of 1-10, how willing are you to quit?" "How soon would you be willing to quit?"
ASSIST	If willing to quit, refer to treatment, including medication, counseling, and Alaska's Tobacco Quit Line. If not willing to quit now, provide a motivational intervention.	Set a quit date. Select medication, unless contraindicated. Refer patient to the Quit Line.
ARRANGE	If willing to quit, schedule a follow-up visit within a week after the quit date. If not willing to quit now, address tobacco dependence at next visit.	Schedule an appointment to ensure patient was connected to treatment, to monitor/ adjust medication, provide support, and document whether quit attempt was successful.

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PROVIDER BEST PRACTICES

Continuing Medical Education and Training
Healthcare providers who want to provide more intensive clinical cessation counseling services can participate in training through multiple sources, including:

- Alaska CACHE (Clearinghouse for Alaska's Continuing Health Education) is a portal to tobacco cessation CMEs recommended by Mission 100, including Rx For Change: Clinician-Assisted Tobacco Cessation: http://www.akcache.org/profession/profession_search_result.php?keyword=tobacco.

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

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"At Central Peninsula Hospital we are committed to providing a healing environment for our patients, staff and the community. Our tobacco-free policy is intended to preserve the health of our patients, visitors and staff."

- Bonnie Nichols, Director of Organizational Experience
Central Peninsula Hospital

"Tobacco use in the Army has a direct impact on the Soldier's ability to accomplish the mission, negatively impacting force readiness and exposing Soldiers to the well known health risks associated with tobacco use. The United States Army Public Health Command supports Soldiers and beneficiaries in their efforts to become tobacco free through evidence based public health practices providing a comprehensive and holistic approach to improvement of their health and well being."

- Major Randall Freeman, Chief, Preventive Medicine
Bassett Army Community Hospital, Fort Wainwright

Tobacco Cessation Best Practices:
Healthcare Organizations

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Changing the System of Care: Support Tobacco Cessation Interventions

Mission 100 goal: 100 percent of Alaska's healthcare organizations adopt systems to treat tobacco use and dependence

Healthcare organizations can make it easier for providers to treat tobacco use by making basic systems-wide changes.[12]

Clinical Practice Guideline Systems Strategies

1. Implement a tobacco user identification system in every clinic.
2. Provide education, resources, and feedback to promote provider intervention.
3. Dedicate staff to provide tobacco dependence treatment, and assess the delivery of this treatment in staff performance evaluations.
4. Promote hospital policies that support and provide inpatient tobacco dependence services.
5. Include tobacco dependence treatments (both counseling and medication) identified as effective as paid or covered services for all subscribers or members of health insurance packages.
6. Tobacco-free policy.

CHANGING THE SYSTEM

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CHANGING THE SYSTEM

Systems Change Strategies

1. Implement a tobacco user identification system in every clinic.

Steps:

- Whether using paper or electronic medical records, expand the vital signs to include tobacco use. Sample chart stickers and an electronic medical records template are in *Appendix E*.
- Train responsible staff on the importance of screening for tobacco use, including the nurse, medical assistant, receptionist or other individuals responsible for recording the vital signs.
- Adopt a protocol to screen tobacco use for every patient at every visit, regardless of the reason for their visit. Repeated assessment is not necessary for adults who have never used tobacco or who have not used tobacco for many years, and for whom this information is clearly documented in the medical record.

Common diagnosis and billing codes are in *Appendix J*, which provides an overview on reimbursement for tobacco cessation services.

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CHANGING THE SYSTEM

2. Provide education, resources, and feedback to promote provider intervention.

Educate all staff about the importance of treating tobacco use and dependence, their responsibilities, and available resources. Include this information in new staff orientation.

- Frequently Asked Questions about Alaska's Tobacco Quit Line can be found in *Appendix G*.
- Treatment Guidelines for Specific Populations can be found in *Appendix H*.

Offer training at new employee training orientation and regularly thereafter. Training resources include:

- **The Brief Tobacco Intervention: Helping Alaskans Quit:** *www.akbriefintervention.org*.
- **Alaska CACHE (Clearinghouse for Alaska's Continuing Health Education)** is a portal to tobacco cessation CMEs recommended by Mission 100, including *Rx For Change: Clinician-Assisted Tobacco Cessation: www.akcache.org/health/health_landing.php?z_healthtopicid=100264*.

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CHANGING THE SYSTEM

Educate all staff about the resources that are available to them and keep these materials stocked in exam rooms and the waiting area:

- Alaska's Tobacco Quit Line materials (available from Mission 100 staff)
- Alaska's Tobacco Quit Line Fax Referral form *(Appendix F)*
- Patient education sheets: www.alaskaquitline.com/health-professionals/factsheets
- Medication Prescribing Guide *(Appendix H)*

3. Dedicate staff to provide tobacco dependence treatment, and assess the delivery of this treatment in staff performance evaluations.

Make tobacco dependence treatment a priority. Designate a person to coordinate treatment, such as a nurse, medical assistant, or other clinician. Roles and responsibilities for this person may include:

- **ASK** patients about tobacco use (i.e., collecting Vital Signs)
- **ADVISE** tobacco users to quit

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- **REFER** tobacco users to treatment, such as Alaska's Tobacco Quit Line, which provides both counseling and medication
- Provide intensive tobacco dependence counseling
- Schedule follow-up visits
- Conduct follow-up calls
- Track data

Collect data on tobacco treatment and include tobacco treatment data in performance reviews. Assure quality by collecting data on tobacco use screening and referrals. Report data to accrediting organizations.

Quality measures from Indian Health Service, The Joint Commission, and the Centers for Medicare & Medicaid Services are included in *Appendices M, N*, and *O*.

Motivate providers to treat tobacco use by using data to provide feedback to providers about their performance, including data from chart audits, electronic medical records, and computerized patient databases. Evaluate the degree to which providers are identifying, documenting, and treating patients who use tobacco.

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CHANGING THE SYSTEM

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CHANGING THE SYSTEM

4. **Promote hospital policies that support and provide inpatient tobacco dependence services.**

- Provide tobacco dependence treatment to all tobacco users admitted to a hospital.
- Implement a system to identify and document the tobacco use status of all hospitalized patients.
- Identify a clinician(s) to deliver tobacco dependence inpatient consultation services for every hospital and reimburse them for delivering these services.
- Offer tobacco dependence treatment to all hospitalized patients who use tobacco.
- Expand hospital formularies to include FDA-approved tobacco dependence medications.
- Ensure compliance with The Joint Commission regulations mandating that all sections of the hospital be entirely smokefree.
- Educate hospital staff that first-line medications may be used to reduce nicotine withdrawal symptoms, even if the patient is not intending to quit at this time.

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Tobacco treatment services are high-value and cost-effective. Cost analyses have shown that tobacco treatment benefits, from a health plan's perspective, are cost-saving within 3 years. The return on investment per treatment is $750-$1,120 after 5 years.[13]

Information about conducting a Return on Investment Analysis for your organization can be found in *Appendix O*.

5. Include tobacco dependence treatments (both counseling and medication) identified as effective as paid or covered services for all subscribers or members of health insurance packages.

- Cover tobacco cessation counseling and treatment for employees and beneficiaries
- Cover tobacco cessation counseling and treatment in employee health plans
- Cover multiple episodes of treatment with no lifetime limit
- No cost-sharing or deductibles
- Educate providers and patients that tobacco cessation medication and counseling are covered by Medicaid and Medicare, *Appendices K and L*
- Adequate reimbursement for services: Train staff on using diagnostic and billing codes for tobacco cessation, *Appendix K*

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CHANGING THE SYSTEM

- Refer to "The Gold Standard in Tobacco Treatment Design" from the Alaska Tobacco Control Alliance to design employee tobacco cessation benefits. See the ATCA website: www.alaskatca.org/wp-content/documents/tobacco_cessation_insurance_coverage.pdf.

6. Tobacco-free Policy

- A tobacco-free policy for the facilities and grounds encourages employees, patients, visitors, and the broader community to quit tobacco and stay quit.
- Smokefree policies and smoking bans are strongly recommended by the Community Guide to Preventive Services[14] to reduce employee and community tobacco use and exposure to secondhand smoke.
- According to the Community Guide, smokefree policies complement other tobacco cessation interventions.
- Information on developing and implementing a Tobacco-free Policy is in the section: *Going Tobacco-Free.*

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For more information, contact:

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

THANK YOU FOR JOINING MISSION 100!

"Thank you to the healthcare facilities and other workplaces that are implementing comprehensive tobacco control policies. You are helping save thousands of Alaskan lives each year by ensuring healthy work and community environments."

- Ward Hurlburt, M.D., MPH, Chief Medical Officer
State of Alaska Department of Health and Social Services

"As an Alaska Native, I understand the reservation of my people when confronted with tobacco use. They are afraid of being judged, do not want to be told what to do from someone who they feel doesn't understand, and of being unsupported in their struggle, as many do not have family support. Therefore, the support of a healthcare provider who voices concern, encouragement and praise makes that healthcare provider an extended family member to their patient. By talking to your patients about tobacco use as if they were your brother, sister, uncle, mother, you create a closeness and sameness with them. Tobacco use is creating a rift in my people's health, that WE can help close."

- Sadie White, Tobacco Treatment Specialist
Alaska Native Tribal Health Consortium

Mission 100: 100% Tobacco-free Healthcare Campuses

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Tobacco-free facilities and grounds:

1. Help patients quit
2. Help employees quit
3. Reinforce the message that treating tobacco is a priority
4. Prevent exposure to secondhand smoke, a major health hazard

Going Tobacco-Free

Depending on your healthcare organization's current status and readiness to change, adopting a tobacco-free policy for the facilities and grounds may be done at the same time you are adopting clinical tobacco cessation best practices, or this may be done before or after. Going tobacco-free follows a stepwise process similar to the process outlined in the section: *Changing the System.*

Because the process of going tobacco-free is so intertwined with the process of adopting tobacco cessation clinical best practices, Mission 100 recommends that the Tobacco Cessation Workgroup, together with organizational leadership, guide the way to a tobacco-free campus policy.

Mission 100 staff are available to assist and provide resources at all stages of the process.

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Evidence Supporting Smokefree Policies[15]

The US Community Preventive Services Task Force recommends smoke-free policies based on sufficient evidence of effectiveness in reducing tobacco use among workers.

Their review of 35 studies found that smoke-free workplace policies, including those at healthcare campuses, that prohibit smoking indoors and outside:

- Reduce employee tobacco use
- Increase quit attempts among employees
- Provide protection against secondhand smoke

Smoke-free workplace policies work alone or in combination with other effective strategies to help employees quit tobacco, including:

- Tobacco cessation groups
- Client educational materials or activities
- Telephone-based cessation support
- Counseling and assistance from healthcare providers
- Access to effective pharmacologic therapies

Studies in the review found that smoke-free workplace policies save lives and money:

- Employers could potentially save $10,246 per year for every smoker who quits due to a smoke-free workplace policy.
- Smoke-free workplace policies are cost effective, with a cost of $526 per quality of life adjusted year (QALY) compared to a cost of $4613 per QALY for a free nicotine replacement therapy program.

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10 Steps to Success:

1. Demonstrate leadership support
2. Form a workgroup
3. Assess current practices and policies
4. Create a timeline
5. Develop a communication plan
6. Write the policy
7. Create an implementation plan
8. Prepare staff
9. Launch the policy
10. Celebrate!

Step 1: Leadership Communicates Support

Leadership communicates a clear vision and enthusiasm for going tobacco-free at staff meetings, through memos, and one-on-one with staff. Inform all employees of your plans early in your process. Craft a few simple messages that explain why you want to address tobacco-use at your facility, what you hope to accomplish, and your underlying concern. See *Appendix S* for a Sample Announcement.

Tobacco users need time to get used to the idea of a tobacco-free campus. Those who want to quit will be more successful if they have time to prepare.

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Step 2: Form a Workgroup
If not already developed, form a Tobacco Cessation Workgroup with representatives from across the organization. At minimum, include a clinical champion, front-line workers, and a respected manager. If possible, include facilities and communications staff.

Taking the time to involve people from throughout the organization in the process will produce a much stronger policy, with a greater level of support, and greater likelihood of success.

Step 3: Assess Practices and Policies
Get a sense of the "lay of the land" so you can figure out where to start and where you need to go. You will be able to develop a better plan if you understand employee tobacco-use and support for going tobacco free.

Recommended activities include:

- Review the current tobacco use policy.
- Find out how to change the policy (e.g., who needs to be involved, who makes the decision, what the procedures are).

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- Survey staff or host a "town hall" meeting to determine support for policy change (See Appendix Q). It is likely there is already widespread support for going tobacco-free, which will reassure policy decision-makers and may be persuasive with staff who may not yet be supportive.
- Conduct Health Risk Appraisals to measure current tobacco use among employees.
- If your organization shares a facility or campus with other organizations or tenants, find out how to involve them in the policy process.
- Map out the boundaries around your campus or grounds to decide what areas will be covered by the policy.

Step 4: Create a Timeline

Pick a date to go tobacco-free, such as the Great American Smoke-out (second Thursday in November), Kick Butts Day (March), or World No Tobacco Day (May 31).

See *Appendix R* for a sample timeline.

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Step 5: Develop a Communication Plan

Communicate, communicate, communicate! Use positive messages that talk about the policy as a health and safety issue, not a punitive action. Craft your messages using the sample talking points in *Appendix S* and communication plan *Appendix T*. Frequent communication will build support and help get staff and patients ready. Suggested communication activities include:

- Give presentations and trainings at staff meetings.
- Write updates for employee publications, such as memos, brochures, listservs, newsletters, bulletin boards and paycheck inserts.
- Provide opportunities for people to air concerns and give suggestions. This will help you develop messages and address potential problems.
- Put up posters, flyers, signs, table tents, and banners to announce the upcoming change.
- Develop permanent signs stating the policy: "Organization is proud to be tobacco-free", "Tobacco-free Campus," "Tobacco-free Grounds."
- Publicize cessation resources, such as Alaska's Tobacco Quit Line.

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We are going tobacco-free because we care!

"Policies that discourage smoking can improve our outcomes: Smoking retards wound healing, increases infection rates in surgeries and is the most common cause of poor birth outcomes."

"We are not saying you must quit smoking. But we are saying you cannot use tobacco while you are at work. If you are ready to quit, we want to support your efforts."

As your initiative unfolds, remember that success stories inspire people. Weave them into messages. Look for champions within your institution or at other facilities with strong tobacco cessation programs. Highlight employees who have quit using tobacco or have motivated others to quit.

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Step 6: Write the Policy

Use the model policy in *Appendix U* as a guide. Bring the draft to leadership to get feedback and to discuss what needs to happen next to make the policy official. Make sure to get input from people who will be responsible for enforcing the policy, such as Human Resources, Security, or Facilities Management.

Effective policies include:

- Rationale
- Purpose of policy
- Products covered under policy (e.g. all forms of tobacco, including cigarettes and smokeless tobacco products)
- How the policy applies to employees, patients and visitors
- Physical boundaries of policy (e.g. private vehicles, company equipment, etc.)
- Support to help employees, patients and visitors comply, including cessation services (e.g., employee cessation benefits; nicotine replacement therapy during hospitalization)
- Clear enforcement rules and consequences

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- Name of contact who can answer questions and address concerns
- Policy-review process
- Any exceptions, such as for traditional ceremonial use of tobacco

"We've got you covered"

The tobacco-free campus policy is also meant to help patients quit and staff quit. Publicize employee tobacco cessation benefits early and often!

Make sure benefits for employees and their families include:
- Counseling (individual, group, or telephone quit line)
- Medication (Nicotine Replacement Therapies, Chantix®, Zyban®)
- At least two quit attempts a year, with no lifetime limit
- No out-of-pocket costs

Refer to "The Gold Standard in Tobacco Treatment Design" from the Alaska Tobacco Control Alliance to design employee tobacco cessation benefits. See the ATCA website: www.alaskatca.org/wp-content/documents/tobacco_cessation_insurance_coverage.pdf

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Step 7: Create an Implementation Plan

Your implementation plan should include ways to communicate and enforce the policy. The policy communication plan should include signage and educational materials for employees, patients, and visitors. Policy enforcement plans should spell out rules, consequences, roles and responsibilities.

Signage

The most important way to gain compliance with the policy is by posting visible signs with a clear message.

Things to consider:

- Budget
- Number of signs you need
- Type of material you want (e.g., wood, metal, plastic)
- Your message
- Logos you need on the signs
- Necessary approvals for signage
- Language considerations
- Timeline

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Educational Materials

Educate patients and visitors about the upcoming policy change with flyers, posters, or banners. Develop patient education cards or brochures and place them in waiting rooms, exam rooms, and at the entrance.

Enforcement

Enforcement procedures need to be clearly spelled out in your tobacco-free policy. Develop enforcement plans for employees, patients and visitors.

Decide who is responsible for enforcing the policy. Many organizations expect the entire staff to educate patients, co-workers and visitors about the policy. Employees may feel uncomfortable taking an enforcement role. Train employees on how to communicate the policy in a respectful, brief and non-confrontational way. *Appendix V* has scripts for enforcement.

Successful enforcement takes EDUCATION and PREPARATION.

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Employees

Employee violations can be handled just like any other personnel issue. Consequences for violations should be spelled out and should follow the same steps established for other personnel issues, usually a graduated system of warnings and consequences.

> Oregon Health & Science University, which developed a tobacco-free campus in 2007, developed video vignettes to train staff on respectful ways to enforce the new policy. http://www.ohsu.edu/xd/about/initiatives/tobacco-free/training-guidelines/training-tools.cfm

In some facilities, an employee who observes a co-worker using tobacco is asked to make a confidential, "good faith" report to a supervisor, manager or human resources specialist. Supervisors need to consistently enforce the rules, which need to be clearly explained.

Patients

View tobacco use by patients within the context of care. Tell patients about the policy during clinic visits, and let them know you can help them quit if they are interested. Give them cards or brochures explaining the policy and publicizing Alaska's Tobacco Quit Line.

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Hospitals only: Nicotine replacement therapy can relieve withdrawal symptoms while your patient is in the hospital. Some hospitals stipulate that patients who leave the facility to use tobacco are discharged for leaving "against medical authorization."

This can relieve the hospital of liability for any adverse event that may occur while the patient is off campus using tobacco. Inform all patients of the tobacco-free campus policy at intake or earlier, if possible. See Appendix W for a Sample Patient Release Form.

Visitors

Visitors generally comply easily when informed about a tobacco-free policy. Encourage employees to take a gentle approach with visitors. If visitors refuse to comply, ask them to please pick up their cigarette butts. Consider having a procedure in place in the rare case that a tobacco use violation poses a potential safety threat to the property or to another person. In such cases, security staff generally intervenes.

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Roles and Responsibilities

Decide who will be responsible for communicating and enforcing the policy. Depending on the size of your organization, there may be separate roles for schedulers, healthcare providers, human resources, security, and others.

Sample roles and responsibilities:

- Schedulers, front-desk, or intake staff inform all patients about the tobacco-use policy, its purpose, the assistance that will be available and the consequences.
- The human resources department educates all job applicants and new employees about the policy.
- Supervisors consistently follow procedures in working with those who violate the policy.
- Security staff intervenes with visitors in the rare instances that simple education is not enough.

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Step 8: Prepare Staff

Hold staff meetings, presentations, and training to ensure that all employees understand the policy, know their responsibilities, and have the tools they need for the policy to succeed.

Allow employees time to express concerns and prepare for changes.

Suggestions for staff preparation and training:

- Describe the policy within the broader context of the organization's mission and overall efforts to reduce tobacco use.
- Link the policy to trainings on treating tobacco use (Ask, Advise, Refer). Talk about how the policy will reinforce their efforts to help patients quit.
- Train employees to talk to patients and visitors about the tobacco-free policy. Provide a card or brochure they can hand out that explains the policy and includes Alaska's Tobacco Quit Line. Provide scripts and give employees an opportunity to role-play.
- Share the policy with employees as early as possible in multiple forms. Let them know the planned launch date and provide periodic updates.
- Explain the consequences for violating the policy.

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- Share information about employee cessation benefits.
- Invite employees to get involved in the planning process.
- Let employees know who to speak with about concerns or problems.
- Include the policy in new staff orientation, the employee handbook, and contracts with providers.

Tobacco use policies sometimes raise issues between labor and management. Some labor unions voice concerns that new rules infringe upon member rights. There is no constitutional right to smoke or use tobacco. Employers do have the legal right to prohibit tobacco use on their property.

Successful tobacco-free initiatives engage labor and management as partners, frame smoking as a health and safety issue, support tobacco users who want to quit, and enforce the rules fairly and consistently.

Listen to employee concerns while moving the policy forward.

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Step 9. Launch the Policy

Working with organizational leadership, finalize the language of the policy and "work it through the channels" to get it adopted. Depending on your organization, this may involve a vote of a Board or Council, a decision by a Medical Director, Executive Director, CEO or President, or some other decision-making process.

Include an effective date or implementation date in the policy: this is your Launch Date!

Make it a big deal:

- Do a count-down on your website, or in your lobby or waiting rooms.
- Plan an event to launch the policy. Make it fun. Provide food.
- Remove all ash receptacles. Unveil new signs.
- Thank the people who made it happen. Honor the Tobacco Cessation Workgroup members.
- Get the media involved. Issue a press release, *Appendix X*, or submit an Opinion-Editorial to the local newspaper.

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Step 10. Celebrate!
Celebration can shift the culture from turning a blind eye to tobacco use to honoring those who assist people in quitting their tobacco addiction.

On the Launch Date and throughout the first few years of implementation, look for ways to celebrate employees who defeat their nicotine addiction and those who help create and sustain a tobacco-free campus. Share good news about improved outcomes for your facility. Share your successes with peers at other organizations and with Mission 100.

Track success of the policy. Discuss progress at meetings about a week after the policy goes into effect, monthly for three months, and every six months thereafter. Use the information you gather to report your progress, plan future projects, improve your efforts and sustain the tobacco-free campus initiative.

Questions that may guide your ongoing assessment of how well the policy is going include:

- What went well?
- What would you have done differently?
- What is the impact of the new policy on visible tobacco use?

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- How many violations have you had?
- Are there fewer violations over time?
- How has the new policy impacted employees who use tobacco?
- How many employees have attempted to quit tobacco?
- How many employees have succeeded?
- (Hospitals only) How many patients have been discharged for smoking against medical authorization?
- How many patients say they want to quit?
- How many patients started their quit attempt while under your care?
- What were the relative costs, including staff time, and results of different aspects of your efforts?
- Did some activities appear to work as well as others but cost less?
- What are the next steps?
- How can you expand your efforts into the broader community?

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Thank you for taking the time to read this document. Mission 100 is a multi-faceted and comprehensive approach to addressing tobacco use and treatment, as a component of the State of Alaska Tobacco Prevention and Control Program, and is rooted in evidenced-based practice designed to provide tobacco education, resources and technical assistance to healthcare organizations and businesses statewide.

We can work together to make Alaska 100 percent tobacco-free!

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For more information, contact:

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

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"Along with a variety of other health reasons to avoid tobacco, is to maintain oral health. Tobacco use increases risk of dental decay, gum disease and oral cancer. Maternal use of tobacco, along with genetic and other factors, increases risk for oral clefts. Please encourage your patients to contact the Alaska Quit Line for assistance in tobacco cessation."

- Brad Whistler, DMD, Dental Official
Alaska Department of Health and Social Services Oral Health Program

"Screen every person, every time, for tobacco use and tobacco exposure."

- Gale M. Sauer, Health & Wellness Coordinator
US Army Test and Evaluation Command
Cold Region Test Center, Fort Greely

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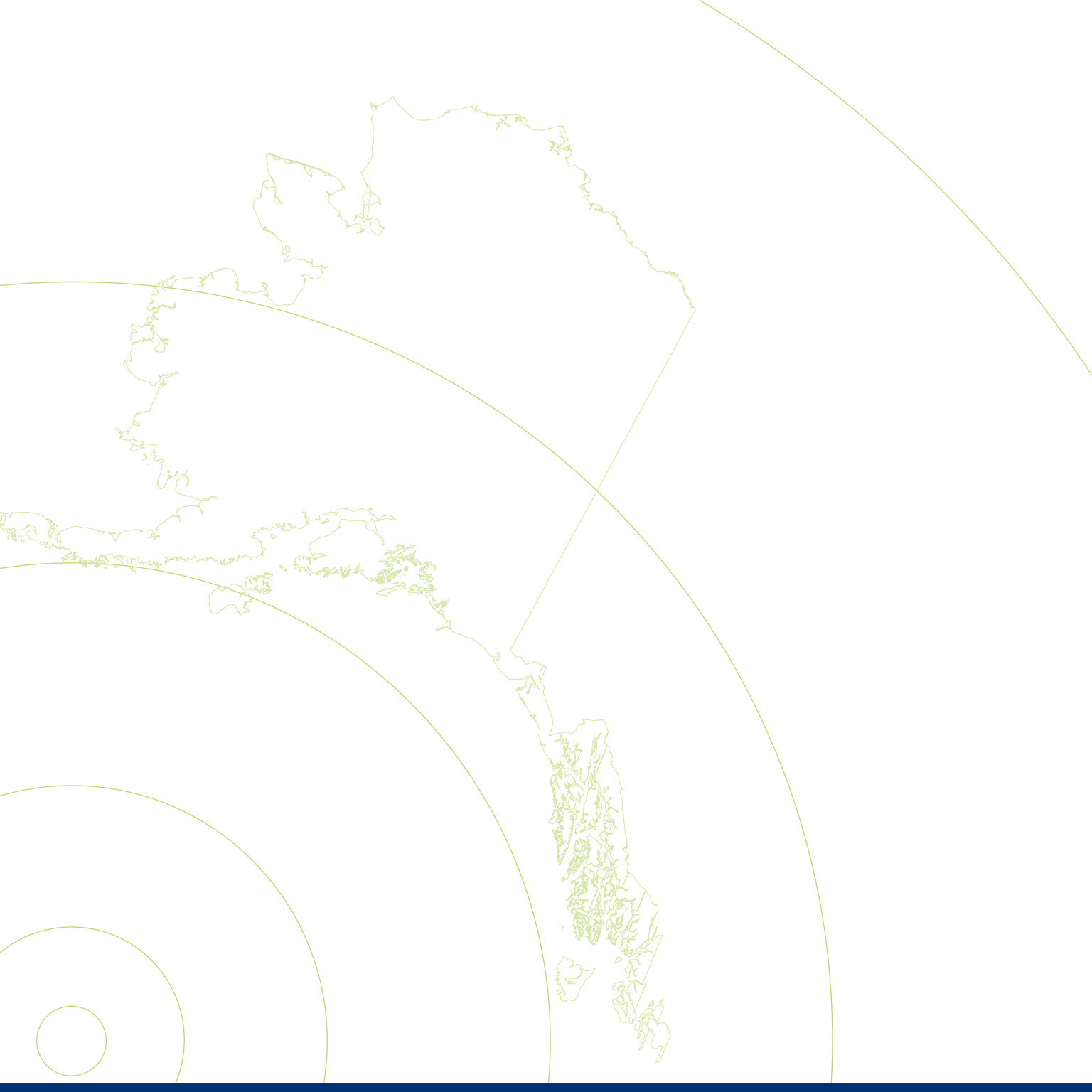


Tobacco Cessation Sample Talking Points

Reducing the use of tobacco in Alaska will dramatically improve the health and well-being of Alaskans and will help the state's economy.

- Tobacco use remains the leading cause of preventable death in Alaska, causing nearly 600 deaths each year.
- Approximately one-fifth of all deaths in Alaska are caused by tobacco use.
- Tobacco use causes more deaths each year in Alaska than suicide, motor vehicle crashes, chronic liver disease and cirrhosis, homicide, and HIV/AIDS combined.
- In 2010, tobacco use cost Alaskans an estimated $579 million in direct medical costs ($348 million) and lost productivity ($231 million).
- In 2010, 21 percent of Alaska adults were smokers and five percent used smokeless tobacco.
- In 2011, 14 percent of Alaska high school students smoked and eight percent used smokeless tobacco.

Tobacco is highly addictive and is the leading cause of preventable death. As a healthcare provider, we will do our part to motivate tobacco users to quit—and helping them stay quit.

- The number one thing tobacco users can do to improve their health and extend their lives is to quit.

APPENDIX A

APPENDIX A

- 75 percent of Alaska's adult smokers want to quit, and an estimated 58 percent have tried to quit within the past year. Counseling and medication are proven to work.
- Alaska's Tobacco Quit Line is available to all Alaskans, regardless of income or insurance coverage. Call 1-800-QUIT-NOW, or visit **Alaskaquitline.com**. It's free. It's confidential. And it works.

We want to provide the highest quality healthcare to our patients. Tobacco cessation is a priority. As an organization, we are putting systems in place to identify tobacco users and help them quit.

1. We realize tobacco dependence is a chronic disease that requires multiple interventions and quit attempts.
2. We will ask every patient about tobacco use at every visit, and document this in their health record.
3. We will advise every patient who uses tobacco to quit.
4. We will refer every patient who wants to quit to Alaska's Tobacco Quit Line and recommend they use medication, such as nicotine replacement therapy, Chantix®, or Zyban®.
5. As an employer, we support employees in quitting tobacco (describe health plan benefits for counseling and medication).

Tobacco Cessation Checklist: Determining Needs and Priorities

Use this assessment tool to:

- Determine what your organization is doing to help tobacco users quit
- Choose priorities for improvement

Team members may not know the answer to each question.

- Talk to someone in the organization who has the information, and answer each question to the best of your knowledge.

The assessment can be done:

- Separately for each clinic or site

  or

- For the organization as a whole.

After completing the assessment, discuss the results within the workgroup and with leadership to:

- Select priorities
- Set goals
- Create an action plan for improvement

Share the results across the organization:

- Highlight what is already going well
- Describe the top priorities for improvement

APPENDIX B

APPENDIX B

Check the box for every "yes" answer.
Does the site/entire organization have a system to:

- ☐ **Ask** every patient (over age 13) about tobacco use at every visit?
- ☐ Document tobacco use in the medical record?
- ☐ Remind providers to screen for tobacco use (e.g., prompt in vital signs or health record)?
- ☐ Assess all tobacco users' willingness to quit?
- ☐ **Advise** all tobacco users to quit?
- ☐ Fax-refer all tobacco users to Alaska's Tobacco Quit Line?
- ☐ **Refer** tobacco users to a local cessation counseling program?
- ☐ Provide tobacco cessation counseling to individuals or groups?
- ☐ Prescribe or recommend FDA-approved tobacco cessation medication?
- ☐ Provide regular training to providers on tobacco treatment?
- ☐ Include feedback on tobacco interventions in staff performance reviews?
- ☐ Bill for tobacco cessation interventions (e.g., billing systems include codes for tobacco interventions)?

Do providers have resources and training to address tobacco use in specific populations:

- □ Adolescents
- □ Women who are pregnant or breastfeeding
- □ Alaska Natives/American Indians
- □ People diagnosed as obese
- □ People with mental illness or substance abuse issues
- □ People with diabetes
- □ People with cardiovascular disease
- □ People with COPD

If there is a pharmacy on-site:

- □ Does the formulary include tobacco cessation medications?
- □ Does the pharmacist provide tobacco cessation interventions?

Tobacco use policy:

- □ Is there a 100 percent tobacco-free policy for the property, both inside and outside on the grounds?
- □ Is there an enforcement plan for the tobacco-free campus policy?

Does your organization collect performance measures, allowing the measurement of:

- □ Smoking status of patients 13 years and older?
- □ How many patients are asked about tobacco use at each visit?

APPENDIX B

APPENDIX B

- ☐ How many tobacco users are advised to quit at each visit?
- ☐ How many tobacco users are referred to cessation resources, such as Alaska's Tobacco Quit Line, at each visit?
- ☐ How many tobacco users are given prescriptions for tobacco cessation medication?
- ☐ How many tobacco users are counseled about tobacco cessation strategies?

If your organization is an in-patient facility, is there a standing order or other system to:

- ☐ Offer cessation counseling to all patients who use tobacco?
- ☐ Provide nicotine replacement therapy to patients to reduce nicotine withdrawal symptoms even if they are not planning to quit?

Would you be willing to take a short survey on the systems that your organization currently has in place to address tobacco use in your facility? This short assessment will provide critical information in shaping approaches to tobacco cessation and provider interaction that best meet our unique needs in Alaska.

Hospital survey link: http://conta.cc/yQ2UeZ

Tribal Health Organization survey link: http://conta.cc/OLJLkN

Community Health Center survey link: http://conta.cc/RdEWmJ

Please note that case matters when typing these survey links into web browsers.

Sample Tobacco-Free Policy Announcement

Tobacco-Free Campus
Open Letter to Physicians and Staff

To all Physicians and Staff,

All of us at [ORGANIZATION] know that we are committed to improving the health of our members and staff. We also know that tobacco use is a health hazard. Therefore, to promote good health, and create a healthy environment for members and staff, smoking and all other forms of tobacco use will no longer be allowed at [ORGANIZATION] facilities and grounds beginning on [DATE].

This new policy, known as the Tobacco-Free Campus, means the existing designated smoking areas will remain in place until [DATE]. After that, there will be no areas where smoking, or any other tobacco use, is permitted.

While physicians and staff are certainly free to continue using tobacco off-campus during breaks and lunch periods, many may decide this is a good time to quit. We recognize that giving up tobacco is difficult – and we are committed to helping any employee or physician who needs support in their efforts to quit.

To assist those who want to quit smoking, [ORGANIZATION] offers [describe cessation benefits available through employee health plan or health promotion program].

APPENDIX C

APPENDIX D

Action Plan Template

Use this form to develop an Action Plan for adopting tobacco cessation best practices.

Goal:				
Activities to accomplish the goal:	Who is responsible?	What resources are needed?	By when will this be done?	How will you know this activity was successful?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Sample Action Plan (partial)

Goal: All providers will Ask about tobacco use, Advise tobacco users to quit, and Refer tobacco user to Alaska's Tobacco Quit Line.

Activities to accomplish the goal:	Who is responsible?	What resources are needed?	By when will this be done?	How will you know this activity was successful?
1. Give presentation at staff meeting about brief tobacco interventions and online CME program	Nurse educator	Laptop Projector Time on Agenda	August 12, 2012	Presentation was conducted. All providers attended presentation.
2. Schedule time on providers calendars for them to earn CME credit by completing Alaska's Brief Tobacco Intervention online training.	Office assistant	Time Computers	September 30, 2012	Time scheduled on all providers calendars. All providers completed CME.
3. Work with electronic health records staff to include a reminder to screen for tobacco use in the vital signs.	Nurse educator, Billing specialist	Electronic Health Records Template	September 30, 2012	Electronic health records system includes fields for tobacco use screening questions that must be filled out before moving on.
4. Train medical assistants and providers on documenting tobacco use in the vital signs.				
5. Train medical assistants and providers on documenting tobacco use in the vital signs.				
6. Consult with Mission 100 staff about the Fax Referral program for Alaska's Tobacco Quit Line.				
7. Train providers and health assistants on using the Fax Referral program.				
8. Stock exam rooms with Fax Referral forms.				

APPENDIX D

Sample Chart Sticker

VITAL SIGNS
Blood Pressure: _____
Pulse: _____ Weight: _____
Temperature: _____
Repiratory Rate: _____
Tobacco Use: __Current __Former __Never
Tobacco Type (circle all that apply): cigarette, chew, iqmik, cigar, pipe, other
Referral to: __Medication __Quit Line __ Local Cessation Program

APPENDIX E

Sample Electronic Medical Records Template

Include prompts to remind providers to **Ask** about:

- Tobacco use status (current, former, never)
- Type of tobacco used (cigarette, chew, iqmik, cigar, pipe, other)
- Secondhand smoke exposure
- Interest in quitting
- Past quit attempts
- Medication used in previous quit attempt

Include prompts that remind providers to **Advise** patients to:

- Quit
- Make their home and car smokefree

Include prompts that remind providers to **Refer** patients to:

- Alaska's Tobacco Quit Line
- Medication
- Patient education materials

Follow Up Plan

- Follow up visit in X weeks
- Staff to follow up in X weeks
- Address at next visit

Sample Electronic Medical Records

Template: Tobacco Outcome Report

✓ Alaska's Tobacco Quit Line
✓ DEMO, PATIENT EAA-FO4-82-98JAN 8, 1970
✓ Outcomes:
Disposition: Declined
☑ Accepted Services:
☑ Contact Date:
Planned Quit Date:
Stage: Precontemplation

Template: Nicotine Cessation Initial Visit

☑ **Nicotine Cessation Initial Visit**
☑ DEMO, PATIENT EAA-F is a 42 year old FEMALE
No Chief Complaint.

☑ **Vital Signs**
☑ BP; 120/80 (Jul 20, 2011@13:54)
☑ Carbon Monoxide level;

☑ **Tobacco Use History**
☑ Smokes 0 cigarettes/day for 0 years
☑ Chews 0 chews/day for 0 years
☑ Chews 0 cans/week

☑ **Nicotine Quitting History**
☑ Has never attempted to quit.
☑ Has attempted to quit 0 times.
0 Days is the longest w/cessation.
☑ Has quit by;
☑ Cold Turkey
☑ Nicotine Gum or Lozenge
☑ Nicotine Patch
☐ Nicotine Nasal Spray
☐ Nicotine Inhaler
☐ Zyban
☐ Hypnosis
☐ Acupuncture
☐ Being Incarcerated
☐ Being Hospitalized
☐ Group Counseling

☑ **Medical History**

☑ Seizures	No
Head Injury	No
ETOH Withdrawal	No
Eating Disorder	No
Oral Sores	No
Peptic Ulcer Ds	No
Hypertension	No
Stroke	No
Asthma	No
Cough	No
Shortness of Breath	No
Emphysema or Chronic Bronchitis	No
Coronary Artery Disease	No
Peripheral Vascular Disease	No
Diabetes or Pre-Diabetes	No
Skin Allergies or Sensitivities	No
Abnormal Paps	No
Cancer	No
Medication Allergies	No

☑ **Counseling Scores**
☑ Importance Scale 0
Confidence Scale 0
Fagerstrom Score 0

☑ Quit Date:
☑ Follow-up Date:
☑ Restart Quit Date:

☑ **Education**
No Patient Education Found

☑ **Current Quit Attempt Medication**
☑ Varenicline, 1 x per Day
☐ *Comments:*
☑ Buproprion, 1 x per Day
☐ *Comments:*
☑ Nicotine Patch, 21 mg
☐ *Comments:*
☑ Nicotine Gum, 2 mg
☐ *Comments:*

☑ **Referrals**
☑ Nutrition: Pt Accepts
☑ Physical Activity Center: Pt Accepts

☑ **Assessment/Plan:**
No Diagnosis Found

☑ **Education provided:**
No Patient Education Found
☑ Follow up months
☑ Patient has the following future appointments:
Future Appt: *None Found*

All None

Template: Nicotine Cessation Follow-up

☑ **Nicotine Cessation Initial Visit**
DEMO, PATIENT EAA-F is a 42 year old FEMALE
No Chief Complaint.

☑ **Time Since Quit**
✓ 1 Week
Other;

☑ **Cessation Success**
✓ Has the patient used tobacco since their quit date? No
✓ What has been the frequency of use? Few Times
✓ If 'daily' how many times currently using?
0 Cigarettes / Day
0 Chews / Day
☑ Has patient used an tobacco in the last 7 Days? No

Not Using
☑ How does patient feel physically? Much Better
☑ Withdrawl Symptoms?
☑ Cravings
☐ Increased Eating
☐ Restlessness
☐ Anxiety
☐ Irritability
☐ Difficulty Concentrating
☐ Other

☑ Has patient gained or lost any weight?
☐ Gained 0 lbs.
☐ Lost 0 lbs.

Is Using
☑ On a scale of 1-10:
1. How important is it for you to quit? 0
2. How motivated are you to quit? 0
3. How confident are you that you can quit? 0
☑ When would you be seriously ready to reset a quit date? ASAP
☑ Reset Quit Date

☑ **Medication**
☑ Nicotine Patch, 21 mg
☐ *Comments:*
☑ Nicotine Gum, 2 mg
☐ *Comments:*
☑ Varenicline, 1 x per Day
☐ *Comments:*
☑ Buproprion, 1 x per Day
☐ *Comments:*
☑ Refill Comments:

☑ **Referrals**
☑ Nutrition: Pt Accepts
☑ Physical Activity Center: Pt Accepts

☑ **Assessment/Plan:**
No Diagnosis Found

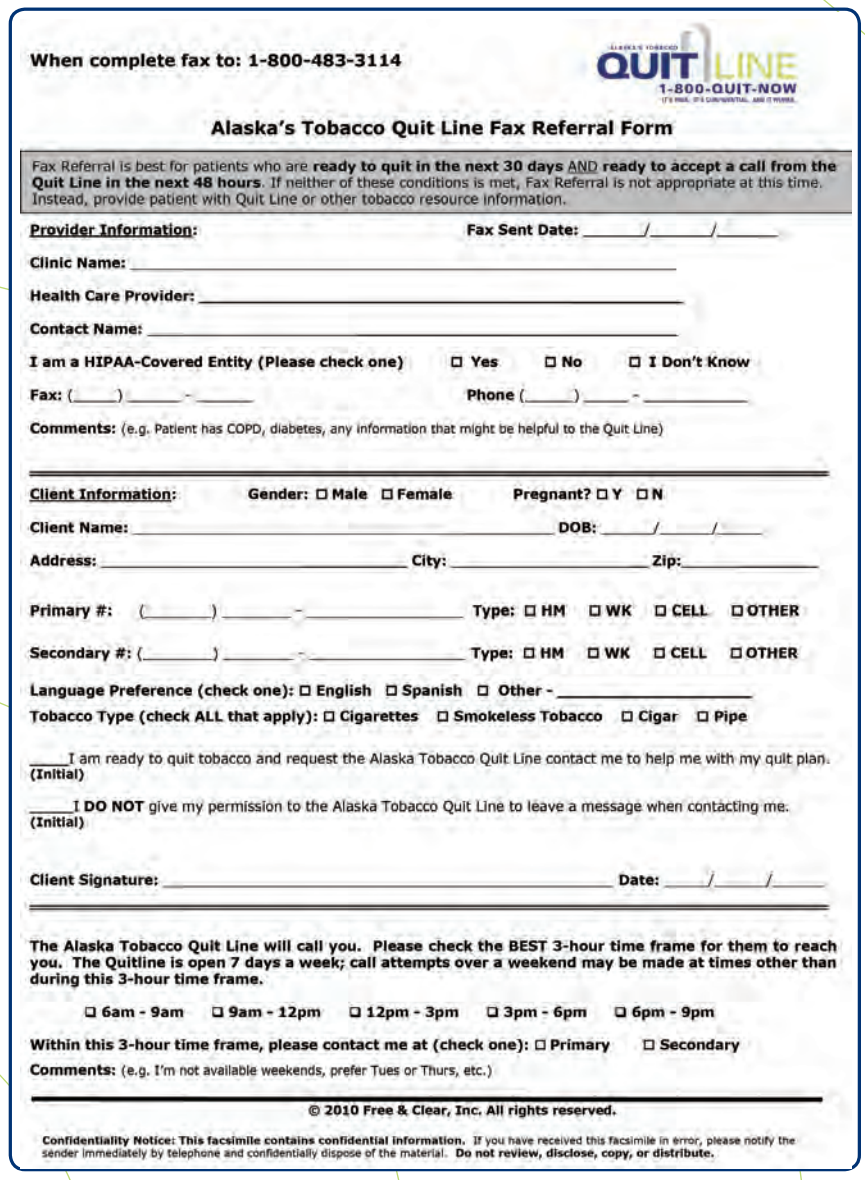
☑ **Education provided:**
No Patient Education Found
☑ Follow up months
☑ Patient has the following future appointments:
Future Appt: *None Found*

All None

APPENDIX E

APPENDIX F

Alaska's Tobacco Quit Line Fax Referral Form



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

QUIT LINE 1-800-QUIT-NOW

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 is met, Fax Referral is not appropriate at this time. Instead, provide patient with Quit Line or other tobacco resource information.

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

Clinic Name: _____

Health Care Provider: _____

Contact Name: _____

I am a HIPAA-Covered Entity (Please check one) ☐ **Yes** ☐ **No** ☐ **I Don't Know**

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

Comments: (e.g. Patient has COPD, diabetes, any information that might be helpful to the Quit Line)

_____

Client Information: **Gender:** ☐ **Male** ☐ **Female** **Pregnant?** ☐ **Y** ☐ **N**

Client Name: _____ **DOB:** ____/____/____

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

Primary #: (____) _____ - _____ **Type:** ☐ **HM** ☐ **WK** ☐ **CELL** ☐ **OTHER**

Secondary #: (____) _____ - _____ **Type:** ☐ **HM** ☐ **WK** ☐ **CELL** ☐ **OTHER**

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

Tobacco Type (check ALL that apply): ☐ **Cigarettes** ☐ **Smokeless Tobacco** ☐ **Cigar** ☐ **Pipe**

____I am ready to quit tobacco and request the Alaska Tobacco Quit Line contact me to help me with my quit plan. **(Initial)**

____I **DO NOT** give my permission to the Alaska Tobacco Quit Line to leave a message when contacting me. **(Initial)**

Client Signature: _____ **Date:** ____/____/____

_____

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

☐ **6am - 9am** ☐ **9am - 12pm** ☐ **12pm - 3pm** ☐ **3pm - 6pm** ☐ **6pm - 9pm**

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

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

_____

This form can also be found online at www.mission100alaska.org

Frequently Asked Questions About Alaska's Tobacco Quit Line

Is the Quit Line really free?
Yes, Alaska's Tobacco Quit Line helps people successfully quit using forms of all tobacco. Alaska's Tobacco Quit Line offers eight weeks of free patches and gum to individuals who enroll in the multiple-call program. This service is available even if individuals are uninsured or without coverage from their health plan.

Does the Quit Line help with all forms of tobacco use?
Alaska's Tobacco Quit Line helps people successfully quit using all forms of tobacco, including smokeless products such as chewing tobacco and Iqmik.

What if someone misses their phone call from the Quit Coach?
If you miss a call from the Quit Coach, the Quit Coach will leave a message and attempt another call in 24 hours. Individuals can always call the Quit Line and talk to a Quit Coach between scheduled calls.

Do individuals have to attend any classes?
No. All sessions take place over the telephone. Individuals can talk to a Quit Coach any day of the week—even Saturday or Sunday.

How does the Quit Line get NRT to individuals?
Once an individual enrolls into the multiple-call program, four weeks of NRT (gum or patches) is mailed directly to them. A second four week supply of NRT is mailed to them when the

APPENDIX G

first follow-up call with the Quit Coach is completed. Because the mail system in Alaska can be delayed, it may take weeks to receive your shipment of NRT. Individuals can call the Quit Line up to 30 days before they are ready to quit and enroll in the program to ensure they have NRT to use on their quit date.

How long does the Quit Line program last?
A typical Quit Line call schedule will be completed within two to six months, depending on how an individual moves through the process of quitting. However, the Quit Coaches will be available to help individuals establish their new tobacco-free lifestyle and provide them with ongoing support for up to 12 months after they enroll.

What if a patient starts using tobacco again?
For most people, quitting takes practice. Quit Coaches will not judge individuals if they slip; they are there to provide support and help them try to quit again. Each time an individual tries to quit tobacco, they will learn more about what it takes to quit, so they can use that knowledge in their journey to become tobacco free. People can re-enroll with Alaska's Tobacco Quit Line at any time.

What about patients under the age of 18?
Callers under the age of 18 are encouraged in their quit attempt and are referred back to their primary care provider for additional support and services. A Quit Coach will mail out information about quitting tobacco, however the Quit Line does not distribute NRT to minors, but a healthcare provider can prescribe NRT if warranted.

What are the average the quit rates as a result of calling Alaska's Tobacco Quit Line?

- An evaluation[16] of Alaska's Tobacco Quit Line found that 30 percent of survey respondents had not used tobacco for 30 days or more at time of follow up and 35 percent were quit for seven days or more.
- Twenty-three percent had been quit for three months and 15 percent had not used tobacco for 6 months or longer.
- Most survey respondents (85 percent) had used medications to assist in their quit attempt.
- NRT patches were most common at 65 percent, gum was used by 20 percent of respondents, and 13 percent used lozenges.
- Twenty-two percent of respondents reported using two or more medications.

Are Alaskans satisfied with Alaska's Tobacco Quit Line?

The Quit Line evaluation survey responses indicated Alaska's Tobacco Quit Line is a successful support system and a culturally appropriate tool for Alaska Natives. The vast majority (90 percent) of respondents made at least one serious quit attempt after enrolling in the Quit Line, 35 percent made four or more quit attempts. Nearly 60 percent made a quit attempt lasting 30 days or more.

Alaska Native callers had high satisfaction rates. Among Alaska Native respondents, 97 percent agreed that Alaska's Tobacco Quit Line is appropriate for Alaska Natives and Quit Coaches communicated in a culturally sensitive manner. Alaska Natives had significantly lower quit rates than non-Natives. Only 23 percent of Alaska Native respondents had not used tobacco in the last 30 days compared to 31 percent of non-Native respondents.

APPENDIX H

Treatment Guidelines for Specific Populations

The Clinical Practice Guideline recommends the use of the seven FDA-approved first-line tobacco cessation medications in most populations, with the exception of:

- Children and adolescents (not shown to be effective)
- Pregnant women (not shown to be effective, contraindicated)
- Light smokers (not shown to be effective)
- Smokeless tobacco users (not shown to be effective)

The seven medications are:

- Varenicline – available by prescription
- Bupropion SR – available by prescription
- Nicotine gum – available over-the-counter
- Nicotine inhaler – available by prescription
- Nicotine nasal spray – available by prescription
- Nicotine patch – available by prescription and over-the-counter
- Nicotine lozenges - available over-the-counter

Clinical trials show that tobacco dependence medications are safe and effective across most populations, including:

- People with HIV
- Hospitalized smokers
- Lesbian/gay/bisexual/transgender smokers
- Those with low socioeconomic status (SES)/limited formal education
- Smokers with medical comorbidities

- Older smokers
- Smokers with psychiatric disorders, including substance use disorders
- Racial and ethnic minorities
- Women smokers

Tobacco Fact Sheets that can be provided to patients are on Alaska's Tobacco Quit Line website at:
www.alaskaquitline.com/health-professionals/factsheets

- Tobacco Facts for Pregnant Women
- Facts About Smokeless Tobacco
- Tobacco Facts for Oral Health
- Tobacco Facts for Surgery
- Tobacco Facts for Diabetes
- Tobacco Facts for Alaska Natives
- Tobacco and COPD
- Tobacco Use and Asthma

Clinical Practice Guideline Recommendations for Specific Populations

Populations for whom medications are not recommended due to lack of effectiveness or contraindications:

Children and adolescents, tobacco use is a pediatric disease. About 4,000 children and adolescents under age 18 try their first cigarette every day in the U.S., and 1,200 become daily smokers. Among adults who ever smoked daily, 90 percent tried their first cigarette before age 21.

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The Clinical Practice Guideline recommends that clinicians:

- Ask pediatric and adolescent patients about tobacco use and provide a strong message regarding the importance of totally abstaining from tobacco use.
- Provide counseling interventions to adolescent smokers.
- Ask parents about tobacco use and offer them cessation advice and assistance, in order to protect children from secondhand smoke.

Tobacco cessation medications are not recommended. Although safe, there is little evidence that nicotine replacement therapies or bupropion SR are effective among adolescent smokers.

Being pregnant often increases a tobacco user's motivation to quit. Cigarette smoking during pregnancy is the single greatest modifiable risk factor for pregnancy-related morbidity and mortality in the U.S. Cigarette smoking during pregnancy has been linked to cognitive, emotional, and behavioral problems in children and is a causal factor in:

- Stillbirths
- Spontaneous abortions
- Decreased fetal growth
- Premature births
- Low birth-weight
- Placental abruption,
- Sudden infant death syndrome (SIDS)

Whenever possible, pregnant smokers should be offered person-to-person psychosocial interventions that exceed minimal advice to quit. Although abstinence early in pregnancy will produce the greatest benefits to the fetus and expectant mother, quitting at any point in pregnancy can yield benefits. Therefore, clinicians should offer effective tobacco dependence interventions to pregnant smokers at the first prenatal visit as well as throughout the course of pregnancy.

Nicotine replacement therapy (NRT) and other medications are not recommended at this time. Evidence is mixed as to the effectiveness of NRTs during pregnancy. Nicotine may have adverse affects on the fetus including: uteroplacental insufficiency via vasoconstriction: fetal neurotoxicity; inhibited maturation of pulmonary cells; and increased risk of SIDs. The nicotine in NRTs is lower than in cigarettes, which also expose the mother and fetus to over 4000 chemicals including carbon monoxide. The risk of nicotine exposure from NRT must be weighed against the risk of exposure to nicotine and other toxic chemicals from smoking.

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Clinical practice recommendations to help pregnant patients quit smoking	Rationale
Assess pregnant woman's tobacco use status using a multiple-choice question to improve disclosure.	Many pregnant women deny smoking, and the multiple-choice question format improves disclosure. For example: Which of the following statements best describes your cigarette smoking? • I smoke regularly now; about the same as before finding out I was pregnant. • I smoke regularly now, but I've cut down since I found out I was pregnant. • I smoke every once in a while. • I have quit smoking since finding out I was pregnant. • I wasn't smoking around the time I found out I was pregnant, and I don't currently smoke cigarettes.
Congratulate those smokers who have quit on their own.	To encourage continued abstinence.
Motivate quit attempts by providing educational messages about the impact of smoking on both maternal and fetal health.	These are associated with higher quit rates.
Give clear, strong advice to quit as soon as possible.	Quitting early in pregnancy provides the greatest benefit to the fetus.
Use problem solving counseling methods and provide social support and pregnancy-specific self-help materials.	Reinforces pregnancy-specific benefits and increases cessation rates.
Arrange for follow-up assessments throughout pregnancy, including further encouragement of cessation.	The woman and her fetus will benefit even when quitting occurs late in pregnancy.
In the early postpartum period, assess for relapse and be prepared to continue or reapply tobacco cessation interventions, recognizing that patients may minimize or deny smoking.	Postpartum relapse rates are high, even if a woman maintains abstinence throughout pregnancy.

Light smokers are people who smoke less than 10 cigarettes a day, including those who do not smoke daily. This group does not include people who smoke "light" or "low tar/nicotine" cigarettes. Light smoking is becoming more common, accounting for about 25 percent of adult smokers. Light smokers are tobacco dependent and are at increased risk of death from tobacco-related causes, including cardiovascular disease. Many light smokers want to quit. They should be identified, strongly urged to quit, and provided counseling cessation interventions. Treatment with NRT or other medications has not been shown to be effective.

Noncigarette tobacco users include people who use smokeless tobacco (chew, snuff), cigars, pipes, hookah pipes or other noncigarette forms of tobacco. All forms of tobacco use are addictive and harm health. Smokeless tobacco use causes: abrasion of teeth; gingival recession; periodontal bone loss; leukoplakia; and oral and pancreatic cancer. Cigar smoking causes: coronary heart disease; COPD; periodontitis; and cancer (oral, esophageal, laryngeal, lung, and others). Treatment with NRT or other medications has not been shown to be effective. Clinicians, including those delivering dental health services, should identify all tobacco users, strongly advise them to quit, and offering counseling interventions, such as referrals to Alaska's Tobacco Quit Line.

APPENDIX H

Specific Populations for Whom Medications are Recommended

HIV-positive individuals are more likely to smoke than the general population. HIV-positive smokers have higher mortality rates and lower quality of life than HIV-positive nonsmokers.

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HIV-positive smokers are more susceptible to invasive pneumococcal diseases, CNS infections, spontaneous pneumothorax, and other opportunistic infections. Treating tobacco dependence with medication and counseling, such as Alaska's Tobacco Quit Line, may improve quality of life and reduce mortality.

Hospitalized Patients are often motivated to quit tobacco because 1) their illness may have been caused or exacerbated by tobacco use, and 2) hospitals are smoke-free environments under Joint Commission accreditation requirements. Hospitals that adopt and enforce tobacco-free campus policies provide further support to quit. Quitting smoking reduces the chances of a repeat heart attack in cardiac patients and repeat cancer in lung, head, and neck cancer patients. Smoking negatively affects COPD, diabetes, and recovery from surgery.

The Clinical Practice Guideline recommends that hospitals:

- Ask each patient on admission if he or she uses tobacco and document tobacco use status.
- For current tobacco users, list tobacco use status on the admission problem list and as a discharge diagnosis.
- Use counseling and medications to help all tobacco users maintain abstinence and to treat withdrawal symptoms.
- Provide advice and assistance on how to quit during hospitalization and remain abstinent after discharge.
- Arrange for follow-up regarding smoking status. Supportive contact should be provided for at least a month after discharge.

LGBT individuals, both adolescents and adults, are more likely to smoke than the general population. They are targeted by tobacco advertising and are more likely to have other risk factors for smoking, including daily stress related to prejudice and stigma. Tobacco use should be screened, documented, and treated with medication and referrals to counseling, such as Alaska's Tobacco Quit Line.

Individuals with low SES and/or limited formal education, including the homeless, bear a disproportionate burden from tobacco. They are more likely to smoke, have less access to treatment, be misinformed about medications, work in smoky environments, and be targeted by tobacco advertising. Tobacco use should be screened, documented, and treated with medication and referrals to counseling, such as Alaska's Tobacco Quit Line.

People with medical comorbidities such as cancer, cardiac disease, COPD, diabetes, and asthma must be treated for tobacco dependence since these diseases are either caused or exacerbated by smoking. Management of these diseases can be improved by quitting, but not by merely cutting down. Tobacco use should be screened, documented, and treated with medication and referrals to counseling, such as Alaska's Tobacco Quit Line. Tobacco dependence treatment should be incorporated into chronic disease management programs.

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Adults age 45 and older, account for an estimated 41 percent of all adult smokers in the U.S. Older smokers, even those over the age of 65, who quit can reduce their risk of death from coronary heart disease, COPD, and lung cancer; decrease their risk of osteoporosis; improve recovery from illnesses; and improve cerebral circulation. Many older smokers want to quit, and telephone counseling is particularly effective in this population. Medicare has expanded benefits for tobacco cessation counseling and prescription medications (through Medicare Part D) for tobacco dependence treatment.

People with psychiatric disorders, including substance use disorders, smoke at over three-times the rate of the general population (i.e., over 70 percent). Many smokers with behavioral health/substance abuse issues want to quit. Quitting may take repeat interventions because relapse rates are higher. All smokers with psychiatric disorders, including substance use disorders, should be offered tobacco dependence treatment by their healthcare providers as well as within chemical dependence or mental health clinics. Quitting smoking does not interfere with recovery from other substance abuse. However, quitting smoking or nicotine withdrawal may affect psychiatric conditions (e.g., depression, schizophrenia) as well as the pharmacokinetics of psychiatric medications, so patients should be closely monitored.

Racial and ethnic minorities, such as Alaska Natives and American Indians, African Americans, Asian Americans, Pacific Islanders, and Hispanics experience a disproportionately greater burden of tobacco-related diseases and death, such as cancer, cardiovascular disease, and Sudden Infant Death Syndrome (SIDS). SIDS rates are highest among Alaska Natives and American Indians. Many of these populations suffer multiple risk factors, including targeting by tobacco advertising; low socioeconomic status; and inadequate access to healthcare. They are also less likely to receive advice to quit or to be offered tobacco dependence treatment by healthcare providers. Smokers in racial and ethnic minority groups attempt to quit as often or more often than nonminority smokers, but are less likely to use effective treatments and quit successfully. Providers should make special efforts to screen, document and treat tobacco dependence with medication and referrals to counseling, such as Alaska's Tobacco Quit Line.

Women are more likely to seek assistance in their quit attempts than are men, but may face different stressors and barriers to quitting that may be addressed in treatment, such as: depression, weight control concerns, hormonal cycles, and social motives to smoke. Tobacco use should be screened, documented, and treated with medication and referrals to counseling, such as Alaska's Tobacco Quit Line.

APPENDIX H

APPENDIX I

Tobacco Cessation Medications: Prescribing Guidelines[17]

Medication	Dose	Instructions	Pros	Cons		Availability
				Cautions and Warnings	Side Effects	
Sustained-release bupropion (Zyban®, Wellbutrin SR®)	Days 1–3: 150 mg each morning; Day 4–end: 150 mg twice daily	Start 1–2 wk before quit date; use for 2–6 mo	Easy to use Few side effects	Do not use with monoamine oxidase inhibitors or bupropion in any other form or in patients with a history of seizures or eating disorders; see FDA black-box warning on serious mental health events: www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm170100.htm	Insomnia, dry mouth, vivid or abnormal dreams	Prescription only generic or brand-name (Zyban®, Wellbutrin SR®)
Nicotine gum (Nicorette®)	1 piece every 1–2 hr initially, then taper; Up to 24 pieces/day; 2 mg if patient smokes ≤24 cigarettes/day 4 mg if patient smokes ≥25 cigarettes/day	Use up to 12 weeks	Easy to use Faster nicotine delivery	Patients with dentures should use with caution; patients should not eat or drink 15 min before or during use	Mouth soreness, heartburn	Alaska's Tobacco Quit Line Over-the-counter generic or brand-name (Nicorette®)
Nicotine inhaler (Nicotrol inhaler®)	6–16 cartridges/day; Inhale 80 times/cartridge	Use up to 6 mo; taper at end	Easy to use Few side effects Addresses physical and behavioral dependency	May irritate mouth and throat	Mouth and throat irritation	Prescription only (Nicotrol inhaler®)
Nicotine lozenges (Commit®)	1 piece every 1–2 hr initially, then taper; 2 mg if patient smokes 30 min or more after waking and 4 mg if patient smokes <30 min after waking	Use 3–6 mo	Easy to use Faster nicotine delivery	Patients should not eat or drink 15 min before or during use	Hiccups, cough, heartburn	Over-the-counter generic or brand-name (Commit®)
Nicotine nasal spray (Nicotrol NS®)	1 dose is 1 squirt/nostril; 1–2 doses/ hr; up to 40 doses/day	Easy to use Fastest nicotine delivery of all NRT options	Easy to use Few side effects	Not for patients with asthma; may irritate nose; may cause dependence	Nasal irritation	Prescription only (Nicotrol NS®)

Medication	Dose	Instructions	Pros	Cons		Availability
				Cautions and Warnings	Side Effects	
Nicotine patch (Nicoderm CQ® Nicotrol®)	If patient smokes—≥10 cigarettes/day, 21 mg/day for 4 wk, then 14 mg/day for 2 wk, then 7 mg/day for 2 wk; if patient smokes <10 cigarettes/day, start with 14 mg/day	Use 3–6 mo	Easy to use Few side effects	Do not use if patient has severe eczema or psoriasis; patch can be removed at night if sleep is disrupted	Local skin reaction, insomnia	Alaska's Tobacco Quit Line Over-the-counter or prescription generic or brand-name (Nicoderm CQ® Nicotrol®)
Varenicline (Chantix®)	Days 1–3: 0.5 mg every morning; days 4–7: 0.5 mg twice daily; days 8–end: 1 mg twice daily	Start 1 wk before quit date; use 3–6 mo	Easy to use	Use with caution in patients with clinically significant renal impairment, patients undergoing dialysis, and patients with serious psychiatric illness; see FDA Web sites for black-box warning on serious mental health events and statement on risk of cardiovascular adverse events among patients with cardiovascular disease: www.fda .gov/NewsEvents/Newsroom/ /PressAnnouncements/ucm170100.htm and www.fda.gov/Drugs/DrugSafety/ucm259161.htm	Nausea, insomnia, vivid or abnormal dreams	Prescription only (Chantix®)
Patch plus bupropion (Zyban®)	See individual medications above	See individual medications above	Only combination approved by FDA Combination is more effective than either alone	See individual medications above	See individual medications above	See individual medications above
Patch plus gum, spray, inhaler, or lozenge	See individual medications above	See individual medications above	Combining two forms of NRT may be more effective for highly dependent smokers	See individual medications above	See individual medications above	See individual medications above

APPENDIX I

APPENDIX J

Reimbursement: Billing and Coding

Tobacco cessation counseling is covered by Alaska Medicaid, Medicare, IHS and many private health insurance plans. Billing and coding requirements and benefit eligibility should be confirmed with health insurance plans. Additional details about benefits and coding for Medicaid, Medicare, and IHS are in *Appendices K, L,* and *M*.

Make Reimbursement Easy:
Program the tobacco-related diagnosis and billing codes below into your medical records system. A sample electronic medical records template is in *Appendix E*.

ICD-9 Diagnosis Codes

305.1*: non-dependent tobacco use disorder

V15.82: history of tobacco use

649.0x: Tobacco use disorder complicating pregnancy, childbirth, or puerperium

*Some health insurance plans may require an additional diagnosis of a tobacco related condition or interference with the effectiveness of medication.

Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) Codes

Counseling less than 3 minutes delivered as part of a visit:
Use the Evaluation and Management Codes:

99201-99215: illness/problem codes

99241-99245: consultation codes

99401-99404: preventive counseling codes

99384-99387 and **99394-99397**: comprehensive preventive medicine services include counseling, anticipatory guidance, and risk factor reduction interventions

If the E/M service is provided on the same day as intermediate or intensive tobacco use cessation counseling, append the E/M code with modifier 25 to show that it was a separate service.

Counseling 3-10 minutes (Intermediate Intervention):
Medicare uses a new code, G0436, for Counseling to Prevent Tobacco Use, with no out-of-pocket costs for asymptomatic beneficiaries. Otherwise, use the CPT code 99406.

G0436: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than three minutes, up to 10 minutes. Short Descriptor: Tobacco-use counsel 3-10 min

99406: Smoking and tobacco-use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes. Short descriptor: Smoke/Tobacco counseling 3-10

APPENDIX K

APPENDIX K

Counseling 10 or more minutes (Intensive Intervention):
Medicare uses a new code G0476 for Counseling to Prevent Tobacco Use, with no out-of-pocket costs for asymptomatic beneficiaries. Otherwise, use the CPT code 99407.

G0437: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes. Short Descriptor: Tobacco-use counsel >10 min

99407: Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes. Short descriptor: Smoke/ Tobacco counseling greater than 10

Cessation Classes/Group Counseling:

99078: Physician educational services in a group setting

S9453: Smoking Cessation Classes, non-physician provider, per session

99411-99412: Group counseling codes

Other codes:

96150-96155: Health & Behavior Assessment/Intervention (Non-physician only)

90804-90862: Psychiatric codes (substance abuse)

Alaska Medicaid Coverage for Tobacco Treatment

In Alaska, all Medicaid beneficiaries are covered.

- The benefit includes both counseling and medication.
- Medicaid reimburses tobacco cessation counseling delivered by:
  - Physicians
  - Mid-level practitioners (Physician Assistants, Advanced Nurse Practitioners)
  - Pharmacists

Under the Affordable Care Act, Medicaid Now Covers Cessation Counseling and Medication for Children, Adolescents, and Pregnant Women:

- Pregnant women:
  - No out-of-pocket costs
  - Medication can be prescribed if the healthcare provider decides the benefits outweigh the risks of continued tobacco use
- Children and adolescents under age 21:
  - Included in Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit as "anticipatory guidance/ risk-reduction counseling" during routine well-child visits.
  - In addition to routine visits, additional counseling and medication must be provided when medically necessary and appropriate.

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Medications

- Must be prescribed by a physician or mid-level practitioner (advanced nurse practitioner, physician assistant)
- Covered for up to six months (three months of daily utilization, three months of tapering)

Nicotine Gum	2,079 units
Nicotine Patches	180 patches
Nicotine Lozenges	2,520 units
Chantix®	360 tablets
Bupropion SR	No limit

Tobacco Cessation Counseling Billing Codes and Reimbursement Rates

Intermediate Counseling (3-10 minutes)

Provider Type	ICD-9 Diagnosis Code	CPT Code	Reimbursement Amount
Physician	305.1 or V15.82	99406	$18.75
Physician Assistant	305.1 or V15.82	99406	$15.93
Advanced Nurse Practicioner	305.1 or V15.82	99406	$15.93
Pharmacist	305.1		$19.40

Intensive Counseling: (Over 10 minutes)

Provider Type	ICD-9 Diagnosis Code	CPT Code	Reimbursement Amount
Physician	305.1 or V15.82	99407	$36.57
Physician Assistant	305.1 or V15.82	99407	$31.08
Advanced Nurse Practicioner	305.1 or V15.82	99407	$31.08

Pharmacists can now be reimbursed for tobacco cessation counseling if they:

1. Receive an order from a prescriber for tobacco cessation medication; and
2. Receive an order from a prescriber for tobacco cessation counseling; and
3. Have documentation (at the pharmacy) of having participated in continuing education presentation on tobacco cessation; and
4. Provide the counseling in person, at time that medication is being dispensed; and
5. Counsel for at least three minutes and no more than 10 minutes; and
6. Keep readily retrievable notes including the recipient's name, date of birth, date of counseling, and details of the counseling in a SOAP (Subjective, Objective, Assessment, and Plan) note format.

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Billing for Tobacco Cessation Counseling

Pharmacies may use a point-of-sale transaction to bill Alaska Medicaid for tobacco cessation counseling services no more than once monthly; use the following fields to submit a claim for this service:

Field Description	NCPDP Field	NCPDP Code Required
Incentive amount submitted	438-E3	$19.40 (maximum allowed)
Gross amount due	430-DU	Be sure to add the "Incentive amount submitted" to the sum of all charges in order to receive payment

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Medicare Coverage for Tobacco Treatment

Medicare now covers cessation counseling and medication for all beneficiaries who use tobacco, regardless of whether they have a tobacco-related illness.

Medicare Prescription Drug Program (Part D) continues to cover tobacco cessation medications prescribed by a physician.

"For too long, many tobacco users with Medicare coverage were denied access to evidence-based tobacco cessation counseling. Most Medicare beneficiaries want to quit their tobacco use. Now, older adults and other Medicare beneficiaries can get the help they need to successfully overcome tobacco dependence."

-HHS Secretary Kathleen Sebelius,
Press Release: HHS Announces Medicare Expands Coverage of Tobacco Cessation Counseling. August 25, 2010.

Medicare reimburses:

- Intermediate (3-10 min) or Intensive (>10 min) cessation counseling sessions provided by a Medicare-recognized provider
- Up to eight counseling sessions per 12-month period
- Four sessions per cessation attempt
- Two attempts per year

Counseling may be provided to outpatient or hospitalized beneficiaries, in-person or through distant site telehealth services.

Beneficiaries must be competent and alert at the time of counseling.

Out-of-Pocket Costs Waived for Counseling to Prevent Tobacco Use

Section 4104 of the Affordable Care Act provided for a waiver of the Medicare coinsurance and Part B deductible requirements for counseling to prevent tobacco use services, codes G0436 and G0437, effective on or after January 1, 2011.

No other tobacco cessation codes are eligible for waiver of coinsurance/deductible at this time. For beneficiaries who use tobacco and have a tobacco-related illness (diagnosed or symptomatic), Medicare Part B coinsurance and deductible apply.

Coding and Billing

Minimal interventions (<3 min) are included in Evaluation and Management (E/M) visits and are not billed separately. If a medically necessary E/M service is provided on the same day as cessation counseling service, append the E/M service with Modifier 25. CMS created two new HCPCS "G" billing codes for Counseling to Prevent Tobacco Use in asymptomatic individuals, **G0436** and **G0437.**

Claims must include both the "G" code and ICD-9 Diagnosis Code 305.1 or V12.82 in order to get reimbursed and to ensure that the patient's out-of-pocket costs are waived.

Distant-site Telehealth Codes

Effective January 1, 2012 distant-site telehealth providers can use codes G0436, G0437, 99406, and 99407.

CMS revised the initial inpatient telehealth consultation code descriptors to allow practitioners to report these services furnished to emergency department patients. The new HCPCS codes are:

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G0425: Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth

G0426: Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth

G0427: Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth

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Cessation Counseling Service		Counseling Session Length	
		Intermediate (3-10min)	Intensive (>10 min)
Counseling to Prevent Tobacco Use (asymptomatic beneficiaries)	ICD-9 Diagnosis Code	**305.1** (non-dependent tobacco use disorder) **V15.82** (history of tobacco use)	
	HCPCS Billing Code	**G0436** Long Descriptor: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes up to 10 minutes Short Descriptor: Tobacco-use counsel 3-10 min	**G0437** Long Descriptor: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes Short Descriptor: Tobacco-use counsel >10 min
Tobacco-use Cessation Counseling Services (symptomatic beneficiaries)	ICD-9 Diagnosis Code	**305.1** (non-dependent tobacco use disorder) and ICD-9 of condition adversely affected or condition for which treatment is adversely affected by tobacco use.	
	CPT Billing Code	**99407** Long Descriptor: Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes. Short Descriptor: Smoke/ Tobacco counseling greater than 10.	**99406** Long Descriptor: Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. Short Descriptor: Smoke/ Tobacco counseling 3-10.

Additional Resources

- MLN Matters® Number: MM7133, Counseling to Prevent Tobacco Use: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//MM7133.pdf
- MLN Matters® Number: MM7504, Expansion of Medicare Telehealth Services for CY 2012: https://www.cms.gov/MLNMattersArticles/downloads/MM7504.pdf
- CMS IOM Pub. 100-04, Chapter 18, Section 150: https://www.cms.gov/manuals/downloads/clm104c18.pdf
- Conditions of coverage for counseling to prevent tobacco use are located in the Medicare National Coverage Determinations (NCD) Manual, Pub. 100-03, Chapter 1, Section 210.4.1: http://www.cms.gov/medicare-coverage-database/
- Tobacco-use Cessation Counseling Services. Medicare Learning Network, Centers for Medicare and Medicaid Services, Department of Health and Human Services. ICN 006767 February 2012. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//smoking.pdf
- HHS Announces Medicare Expands Coverage of Tobacco Cessation Counseling. Press Release. Wednesday, August 25, 2010. http://www.cms.gov/apps/media/press/release.asp?Counter=3830&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=tobacco&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=1&pYear=&year=0&desc=&cboOrder=date

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Indian Health Services Billing for Tobacco Dependence Treatment Services

Definitions:
Diagnosis Code: Codes used in medicine to group and identify diseases, health signs and symptoms, and disorders. Current codes are catalogued in the International Statistical Classification of Diseases and Health Problems 9th edition.

Referred to as ICD 9

- Code for Tobacco Use Disorder: 305.1
- Other tobacco caused health problems might also be coded. i.e. 162 for lung cancer, 410-414 for coronary heart disease
- Psychological problems are also catalogued in the Diagnostic and Statistical Manual for Mental Disorders volume IV Text Revision (DSM IV TR). These codes are a subset of the ICD 9 codes.

Current Procedure Terminology (CPT) Code: A numeric code developed by the AMA that provides a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians, and other healthcare providers, patients, and third parties.

CPT Codes for Tobacco

- 99078 Physician education in a group setting
- 99406 Behavior change, smoking 3-10 minutes
- 99407 Behavior change, smoking >10 minutes
- 99411 Preventive counseling, group
- 99412 Preventive counseling, group
- 4000F Tobacco use treatment, counseling
- 4001F Tobacco use treatment, pharmacologic treatment
- D1320 Counseling for the control and prevention of oral disease
- S9453 Smoking cessation class

Tribal System Codes for Tobacco Use Found in RPMS are as Follows:
Tobacco Use Assessment/Screening ICD 9 Coding Equivalents:

Code Type	Code	Screening Tool Option	Detailed Meaning
Diagnosis	305.1	Smoke, Chew or Quitting Now	Uses tobacco daily-Current user
Diagnosis	V15.82	Already quit	Has not used tobacco for > 6 (maintenance- Current behavioral definition of stopped is > 6 months)
Diagnosis	V65.49	Counseling delivered	Counseling general delivered (must be used w/ clinic 94)

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Tobacco Use Assessment Health Factor Screening Coding Equivalents:

Code Type	Code	Screening Tool	Detailed Meaning
RPMS HF	Non-Tobacco User	None	Never used tobacco or not used > 6 months
RPMS HF	Current Smoker	Smoke	Currently smokes
RPMS HF	Current Smokeless	Chew	Currently uses spit tobacco or snuff
RPMS HF	Current Smoker and Current Smokeless	Both	Currently uses smokes and uses spit tobacco
RPMS HF	Smokefree Home		No ETS exposure in the home
RPMS HF	Smoker in Home		A smoker lives in the home
RPMS HF	Exposure to ETS	Secondhand	Exposed to second hand smoke at work or at home
RPMS HF	Cessation Smoker or Smokeless	Quitting now	Has used tobacco in the past and has since quit or is trying to quit < 6 months
RPMS HF	Previous Smoker or Smokeless	Already quit	Quit > 6 months

Patient Education Tobacco Counseling Coding Equivalents:

Code Type	Code	Topic	Detailed Meaning
*RPMS Patient Ed	TO-LA	Lifestyle Adaptations	Patient Education provided on behavior change
*RPMS Patient Ed	TO-QT	Quitting tobacco	Patient is receiving tobacco cessation counseling
*RPMS Patient Ed	TO-M	Medications Discussed	Patient counseled on smoking cessation medications (HEDIS) Indicator
*RPMS Patient Ed	TO-SM	Stress Management	Patient counseled on stress management and how to deal w/ stressful situation that may lead to relapse
*RPMS Patient Ed	TO-C	Complications	Patient counseled on tobacco related health complications
*RPMS Patient Ed	TO-CUL	Cultural/Spiritual Aspects of Health	
*RPMS Patient Ed	TO-DP	Disease Process	Patients counseled on the disease process of tobacco use.
*RPMS Patient Ed	TO-EX	Exercise	Patient counseled on how exercise will aide in tobacco cessation
*RPMS Patient Ed	TO-FU	Follow up	Patient informed of the follow up schedule for tobacco cessation
*RPMS Patient Ed	TO-L	Patient Information/ Literature	Appropriate patient literature delivered to his/ her specific tobacco related health problems
*RPMS Patient Ed	TO-SCR	Screening	Patient screened for tobacco use
*RPMS Patient Ed	TO-SHS	Secondhand Smoke	Patient counseled on adverse effect of second hand smoke
*RPMS Patient Ed	TO-IR	Information and Referral	

*Patients understanding level needs to be documented G (good) F (fair) P (poor) R (refused) or Group

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Readiness to Change Standards:

*RPMS Patient Ed	TO-RTC 1,2,3,4, or 5	Precontemplation Contemplator Preparation Action Maintenance	- Patient not willing to make a quit attempt within the next 6 months - Patient willing to make a quit attempt <6 months - Patient is willing to make a quit attempt <30 days - Patient is actively making a quit attempt - Patient has quit for > 6 months

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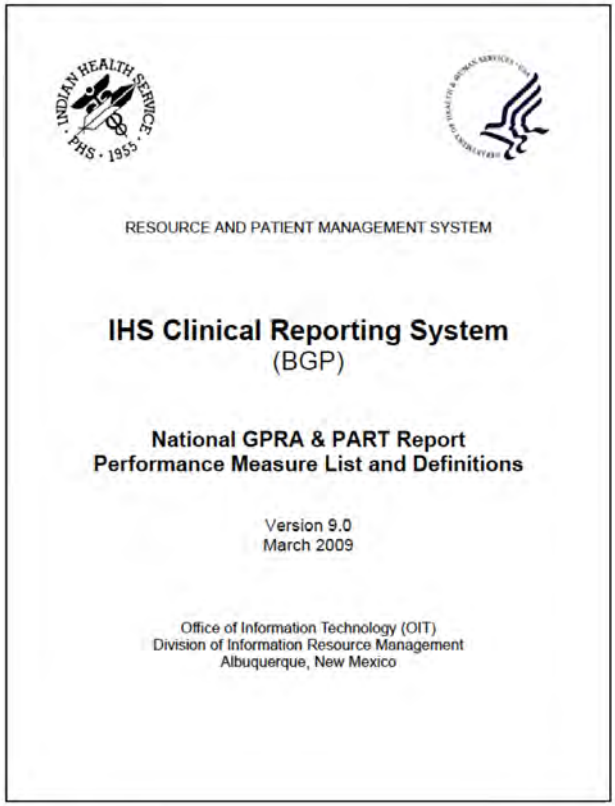
IHS Clinical Reporting System (BGP) v9.0 CRS 2009 National GPRA & PART Report Performance Measure List & Definitions March 2009 39



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Clinical Reporting System
(BGP)

National GPRA & PART Report
Performance Measure List and Definitions

Version 9.0
March 2009

Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico

2.4.4 Tobacco Use and Exposure Assessment

No changes from Version 8.0 Patch 3.

Owner/Contact

Mary Wachacha & Chris Lamer, PharmD/Epidemiology Program, Dr. Nat Cobb

National Reporting

NATIONAL (included in IHS Performance Report; NOT reported to OMB and Congress)

Denominators

1. Active Clinical patients ages five and older.

Numerators

1. Patients screened for tobacco use during the Report Period (during the past 20 months for pregnant female patients denominator).
2. Patients identified during the Report Period (during the past 20 months for pregnant female patients denominator) as current tobacco users.
   - **a.** Current smokers
   - **b.** Current smokeless tobacco users
3. Patients exposed to environmental tobacco smoke (ETS) during the Report Period (during the past 20 months for pregnant female patients denominator).

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Definitions

1. **Tobacco Screening:** At least one of the following:
   - **a.** Any Health Factor for category Tobacco. **b.** POV or Current PCC Problem List 305.1, 305.1* (old codes), 649.00-649.04, or V15.82 (tobacco-related diagnosis).
   - **c.** Dental code 1320.
   - **d.** Patient Education codes containing "TO-", "-TO", "-SHS," 305.1, 305.1* (old codes), 649.00-649.04, or V15.82.
   - **e.** CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (Current Tobacco Smoker), 1035F (Current Smokeless Tobacco User), or 1036F (Current Tobacco Non-User).

2. **Tobacco Users:**
   - **a.** Health Factors: Current Smoker, Current Smokeless, Current Smoker and Smokeless, Cessation-Smoker, Cessation-Smokeless.
   - **b.** POV 305.1, 305.10-305.12 (old codes), or 649.00-649.04.
   - **c.** CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F or 1035F. IHS Clinical Reporting System (BGP) v9.0 CRS 2009 National GPRA & PART Report Performance Measure List & Definitions March 2009 40

3. **Current Smokers:**
   - **a.** Health Factors: Current Smoker, Current Smoker and Smokeless, Cessation-Smoker.
   - **b.** 305.1, 305.10-305.12 (old codes), or 649.00-649.04.
   - **c.** CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F.

4. **Current Smokeless**:

   a. Health Factors: Current Smokeless, Current Smoker and Smokeless, or Cessation-Smokeless.

   b. CPT 1035F.

Environmental Tobacco Smoke (ETS):

   a. Health Factors: Smoker in Home, Exposure to Environmental Tobacco Smoke

Patient List

Patients with no documented tobacco screening. IHS Clinical Reporting System (BGP) v9.0 CRS 2009 National GPRA & PART Report Performance Measure List & Definitions March 2009 41

2.4.5 Tobacco Cessation

Changes from Version 8.0 Patch 3, as noted.

Note: The Other National Measures (ONM) Report contains a set of denominators, numerators, and logic that is developmental for GPRA and may become the GPRA logic in a future GPRA year. This logic is included only in the ONM Report.

Owner/Contact

Mary Wachacha & Chris Lamer, PharmD/Epidemiology Program, Dr. Nat Cobb

National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

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Denominator

GPRA: Active Clinical patients identified as current tobacco users prior to the Report Period, broken down by gender and age groups: <12, 12-17, 18 and older.

Numerators

1. GPRA: Patients who have received or refused tobacco cessation counseling or received a prescription for a smoking cessation aid during the Report Period.
   a. Patients who refused tobacco cessation counseling.
2. GPRA Developmental: Patients who have received tobacco cessation counseling or received a prescription for a smoking cessation aid during the Report Period. NOTE: This numerator does NOT include refusals.
3. Patients identified during the Report Period as having quit their tobacco use.
4. Patients who have received or refused tobacco cessation counseling, received a prescription for a smoking cessation aid, or who quit their tobacco use during the Report Period.

Definitions

1. **Current Tobacco Users**: Any of the following documented prior to the Report Period:
   a. Health Factors (looks at the last documented): Current Smoker, Current Smokeless, Current Smoker and Smokeless, Cessation-Smoker, Cessation-Smokeless
   b. Last documented Tobacco-related Diagnoses (POV or active Problem List): 305.1, 305.10-305.12 (old codes), or 649.00-649.04.

c. Last documented CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F or 1035F.

If any of the above are found, the patient is considered a tobacco user. IHS Clinical Reporting System (BGP) v9.0 CRS 2009 National GPRA & PART Report Performance Measure List & Definitions March 2009 42

2. **Tobacco Cessation Counseling**: Any of the following during the Report Period:
   - **a.** Patient Education codes containing "TO-", "-TO", "-SHS", 305.1, 305.1* (old codes), or 649.00-649.04
   - **b.** Clinic Code 94
   - **c.** Dental Code 1320
   - **d.** CPT code 99406, 99407, G0375 (old code), G0376 (old code), or 4000F
   - **e.** Documented refusal of patient education codes containing "TO-", "-TO", or "-SHS". Refusals will only be counted if a patient did not receive counseling or a prescription for tobacco cessation aid.

3. **Prescription for Tobacco Cessation Aid**: Any of the following:
   - **a.** Medication in the site-populated BGP CMS SMOKING CESSATION MEDS taxonomy;
   - **b.** Any medication with name containing "NICOTINE PATCH", "NICOTINE POLACRILEX", "NICOTINE INHALER", or "NICOTINE NASAL SPRAY";
   - **c.** CPT 4001F.

4. **Quit Tobacco Use**: POV or Current Active Problem List 305.13 (old code) or V15.82; Health Factors Previous Smoker, Previous Smokeless (looks at the last documented health factor).

GPRA 2009 Target

During FY 2009, maintain the FY 2008 rate of 21% for the proportion of tobacco-using patients who receive tobacco cessation intervention.

Patient List Options

- List of tobacco users with documented tobacco cessation intervention or refusal.
- List of tobacco users without documented tobacco cessation intervention or refusal.
- List of tobacco users who quit tobacco use.
- List of tobacco users with documented tobacco cessation intervention or refusal or who quit tobacco use.
- List of tobacco users without documented tobacco cessation intervention or refusal and did not quit tobacco use.

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The Joint Commission Tobacco Measures

The Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 19,000 healthcare organizations and programs in the United States. The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in healthcare. Accreditation and certification by the Joint Commission is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. For more information about The Joint Commission, see their website: www.jointcommission.org

The Joint Commission sets standards for smoke-free healthcare campus policies as well as tobacco treatment measures.

Environment of Care: Smoke-free Campus Policies

The Joint Commission sets standards for the Environment of Care, including performance measures for smoke-free campuses. The Joint Commission Environment of Care standards support, but do not require, smoke-free campus policies in:

- Hospitals
- Critical access hospitals
- Behavioral healthcare
- Ambulatory care
- Home care
- Laboratory services
- Long-term care
- Office-based surgery

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The Joint Commission's rationale for prohibiting smoking is that it will reduce:

- Health risks to people who smoke, including possible adverse effects on care, treatment, and services;
- Health risks of passive smoking;
- Risk of fire.

Ensuring compliance requires the organization to implement a monitoring process and to implement strategies to eliminate the incidence of policy violations, when identified. The organization is expected to be able to demonstrate that it has embraced its policy by:

- Educating staff
- Offering smoking cessation options
- Illustrating measures taken to pro-actively assess compliance with the policy
- Taking steps to deal with policy violations

The Joint Commission standards require that no-smoking signs are prominently and strategically placed at all major entrances. The standards do not establish an acceptable distance from the building for smoking areas, though they note it is important to comply with any local or state requirements that may specify a smoking area's minimum distance requirements from entrances/exits.

The Joint Commission supports smoke-free healthcare campuses.

For healthcare organizations that choose to prohibit smoking within a certain distance of buildings or to create designated smoking areas, the Joint Commission does not establish a minimum distance. However, it recommends that the campus smoking policy is written and enforced in a way that prevents secondhand smoke from entering buildings, using the following questions as a decision-making guide:

- Is it possible for smoke to be drawn into the building as doors operate?
- Take into consideration window air-conditioning units that may be located above a designated outdoor patio and other fresh air intakes that could draw second-hand smoke into the building.
- Does the smoking location cause others to pass through the smoke?
- Does the smoking location cause smokers to extinguish smoking materials directly onto the ground, and then be tracked into the building?
- Does the location identified as a smoking area meet life safety requirements (not near combustibles; appropriate waste receptacles; etc)?
- Is the smoking location arranged to allow staff to view or monitor at-risk patients, clients or residents?

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Tobacco Treatment Measures Set

Joint Commission-accredited hospitals must select four performance measure sets from a list of 14, which now includes the Tobacco Treatment Measures Set.

The Joint Commission now promotes robust smoking cessation measures that include all patients. In the past, Joint Commission tobacco use screening measures were limited to patients with certain conditions. The four recently added Tobacco Treatment Measures are in the Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0. Previously, tobacco use screening measures were limited to patients with certain conditions, such as Myocardial Infarction. However, the Joint Commission and the Centers for Medicare and Medicaid Services (CMS) are encouraging more robust smoking cessation measures that include all patients.

1. **Set Measure ID#:** TOB-1
   Performance Measure Name:
   TOB-1 Tobacco Use Screening
   Description:
   TOB-1 Hospitalized patients who are screened during the hospital stay for tobacco use (cigarettes, smokeless tobacco, pipe, and cigars) within the past 30 days.

   Numerator: Number of patients screened for tobacco use status

   Denominator: Number of hospitalized patients 18 years of age and older

2. Set Measure ID#: TOB-2

Performance Measure Name:

TOB-2 Tobacco Use Treatment Provided or Offered

Description:

TOB-2 Patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the hospital stay.

Numerator: Number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications.

Denominator: Number of hospitalized patients 18 years of age and older identified as current tobacco users

Performance Measure Name:

TOB-2a Tobacco Use Treatment

Description:

TOB-2a Patients who received counseling AND medication as well as those who received counseling and had reason for not receiving the medication

Numerator: Number of patients who received counseling to quit AND received FDA-approved cessation medications.

Denominator: Number of hospitalized patients 18 years of age and older identified as current tobacco users

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3. Set Measure ID#: TOB-3

Performance Measure Name:

TOB-3 Tobacco Use Treatment Provided or Offered at Discharge

Description:

TOB-3 Patients identified as tobacco product users within the past 30 days who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge.

Numerator: Number of patients who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge.

Denominator: Number of hospitalized patients 18 years of age and older identified as current tobacco users

Performance Measure Name:

TOB-3a Tobacco Use Treatment Provided at Discharge

Description:

TOB-3a Patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication upon discharge as well as those who were referred to outpatient counseling and had reason for not receiving a prescription for medication.

Numerator:

Number of patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication at discharge.

Denominator:

Number of hospitalized patients 18 years of age and older identified as current tobacco users

4. Set Measure ID#: TOB-4
Performance Measure Name:
TOB-4 Tobacco Use: Assessing Status after Discharge
Description:
TOB-4 Discharged patients who are identified through the screening process as having used tobacco products (cigarettes, smokeless tobacco, pipe, and cigars) within the past 30 days who are contacted within 30 days after hospital discharge and follow-up information regarding tobacco use status is collected.

Numerator: Number of discharged patients who are contacted within 30 days after hospital discharge and follow-up information regarding tobacco use status is collected.

Denominator: Number of discharged patients 18 years of age and older identified as current tobacco users

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The new Tobacco Treatment Measures require that tobacco users receive treatment for tobacco dependence during hospitalization and at discharge. They are comprehensive and based on the U.S. Public Health Service Clinical Practice Guideline, 2008 Update.

They are available for hospitals to begin data collection beginning with discharges January 1, 2012. They will be publicly reported on the Joint Commission's website "Quality Check" subsequent to endorsement by the National Quality Forum, slated for 2012.

The Tobacco Treatment Measure Set is summarized below. Technical information about collecting and reporting the measures can be accessed at: www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures/

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Meaningful Use: Including Tobacco Use Screening and Interventions in Electronic Health Records

Meaningful Use is determined using Clinical Quality Measures (CQMs). The Meaningful Use program's core objectives are assessed using Core and Alternate Core CQMs. The program's additional objectives are measured using additional CQMs.

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs provide a financial incentive for the "meaningful use" of certified EHR technology to achieve health and efficiency goals.

The program includes required Core Objectives; an optional menu of additional objectives; required Core Clinical Quality Measures; an Alternate Core set of Clinical Quality Measures; and an optional menu of Additional Clinical Quality Measures.

Tobacco-related measures are included in the Core Objectives, Core Clinical Quality Measures, and Additional Clinical Quality Measures, as outlined below.

Meaningful Use Reporting Requirements

Eligible Professionals Must:

- Report all 15 required core objectives and five additional objectives.
- Report at least six specific CQMs to demonstrate meaningful use of EHRs:
  - Three Core or Alternate Core CQMs (report alternate CQM if core CQM has denominator of zero)
  - Three from the list of 38 Additional CQMs

Eligible Hospitals and Critical Access Hospitals:

- Report all 14 required core objectives and 5 additional objectives.
- Report on all 15 of their CQMs to demonstrate meaningful use.

The Meaningful Use Incentive Program requires Eligible Professionals and Hospitals to report on the smoking status of patients 13 years and older (Core Objectives).

Eligible professionals must also report on Tobacco Use Assessment and Intervention (Core Clinical Quality Measures). Eligible Professionals may also choose to report on Smoking and Tobacco Use Cessation, Medical Assistance (Additional set, Clinical Quality Measures).

Tobacco-related Meaningful Use Core Objectives

For Eligible Professionals (EPs):

- Measure Number: 9 of 15
- 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 as structured data.

- Specifications for this objective can be found on the CMS website here: www.cms.gov/EHRIncentivePrograms/Downloads/9_Record_Smoking_Status.pdf

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For Eligible Hospital and Critical Access Hospitals

- Measure Number: 8 of 14
- 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 or admitted to the eligible hospital's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.

Specifications for this objective can be found on the CMS website here: cms.gov/EHRIncentivePrograms/Downloads/8_Record_Smoking_Status.pdf

Tobacco-related Clinical Quality Measures (CQMs)

There are two tobacco-related CQM's. One is a Core (required) measure and one is on the Additional set. To participate in the Electronic Health Records Incentive Program, Eligible Providers must choose three of the 38 measures on the Additional Set.

For the year 2012, Eligible Professionals, eligible hospitals and critical access hospitals seeking to demonstrate Meaningful Use are required to electronically submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States.

- Core CQM
  - Measure Number NQF 0028
  - Title: Preventive Care and Screening Measure Pair:
    a. Tobacco Use Assessment,
    b. Tobacco Cessation Intervention

- Description:
  - **a.** Tobacco Use Assessment: Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months.
  - **b.** Tobacco Cessation Intervention: Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.

- Additional Set CQM
  - Measure Number: NQF 0027, PQRI 115
  - Title: Smoking and Tobacco Use Cessation, Medical Assistance:
    - **a.** Advising Smokers and Tobacco Users to Quit,
    - **b.** Discussing Smoking and Tobacco Use Cessation Medications,
    - **c.** Discussing Smoking and Tobacco Use Cessation Strategies
  - Description: Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.

CQM specifications can be downloaded from the CMS website here: www.cms.gov/apps/ama/license.asp?file=/QualityMeasures/Downloads/EP_MeasureSpecifications.zip

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Additional Resources

- American Academy of Family Physicians. "Integrating Tobacco Cessation into Electronic Health Records." aafp.org/online/etc/medialib/aafp_org/documents/clinical/pub_health/askact/ehrs.Par.0001.File.tmp/AAEHRSheet2010.pdf
- Centers for Medicare and Medicaid Services. "EHR Incentive Programs." cms.gov/EHRIncentivePrograms/
- Centers for Medicare and Medicaid Services. "Clinical Quality Measures." cms.gov/EHRIncentivePrograms/31_ClinicalQualityMeasures.asp#Eligible
- Medicaid Program: Initial Core Set of Healthcare Quality Measures for Medicaid-Eligible Adults.

Calculating Return on Investment (ROI)

Making the Business Case for Tobacco Cessation

"What is the return on investment for this program?"
"We really need to see an ROI before we can make any funding decisions."
"Show us the economic value of your program."

ROI is short for "return on investment." ROI answers the question: Is there a financial return for investing in a program, process, initiative, or performance improvement solution? ROI is an economic indicator – meaning, you are dealing with money and costs. Basically, return on investment shows the financial benefits derived from having spent money on a program, such as tobacco cessation intervention. The intent of ROI is to measure how effectively the organization or program is using its money.[18]

Economic Burden of Tobacco Use in the State of Alaska

Tobacco use creates a large economic burden within Alaska. In 2008, tobacco use cost Alaskans an estimated $325 million annually in direct medical expenditures and an additional $221 million in 2008 in lost productivity due to tobacco-related deaths.

Tobacco-Related Economic Costs, 2008

Direct Medical Expenditures	$
Hospital	193,050,000
Ambulatory	56,160,000
Prescription Drugs	35,100,000
Nursing Home	7,020,000
Other	33,930,000
Total	**325,260,000**

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This sums to an economic cost of $546 million in 2008, yet it underestimates total costs. Lost productivity from tobacco-related illness and costs due to secondhand smoke exposure-related illness or death are not included.[19]

AHIP – Making the Business Case for Smoking Cessation Programs
America's Health Insurance Plans (AHIP) developed a business case for smoking cessation by estimating the ROI of evidence-based cessation interventions.

Extensive research culminated in the creation of a user-friendly, web-based ROI Calculator that estimates the impact of smoking cessation interventions for one to five years.

Employer OR Health Plan Return on Investment
AHIP's research showed clinical interventions to reduce smoking provide a positive return on investment within two to three years for health plans and immediate savings for employers. Researchers found that health plans investing $35-$410 per participant in a one-year program generated a positive ROI within three years.

For the test health plan population, ROI per cessation service recipient for the plan was $750-$1,120 after five years. For employers, ROI was positive in all years, and totaled $100-$200 after five years. The results indicate investments of $.18-$.79 per member per month (PMPM) generate positive net ROI of over $1.70-$2.20 after five years.[20]

What information do you need before using AHIP's calculator? It is important for employers to be able to see exactly what this information means for their company in particular. Gather the following information:

Data Elements for AHIP's ROI Calculator

When these data are entered into an ROI calculator, a table is produced with projected service use, numbers of quits, estimated costs, estimated ROI per recipient and PMPM for the health plan for the selected year.

State of Residence	>	Select Alaska
Population Covered by Health Plan	>	Enter type of Health Plan (%HMO, %PPO, %FFS). Note: IHS facilities are considered 100% HMO,
Male/Female Age Distribution	>	Ages are broken down into the following age groups: 18-34, 35-64, and 65.
Male/Female % of Smokers by Age	>	Ages are broken down into the following age groups: 18-34, 35-64, and 65.
Employee Turnover by Age	>	Ages are broken down into the following age groups: 18-34, 35-64, and 65.
Employer Benefit Allowance/Participant	>	Costs for medication, counseling, and Rx and phone
Other Program Costs	>	Costs for provider training and tobacco treatment staff

A Few Things to Remember

Do *Use Caution When Comparing the ROI in Public Health Programs with ROI in Other Areas*

Although the calculation for ROI in public health programs uses the same basic formula as in the business world, some decision-makers or stakeholders may not fully understand ROI within the context of public health. ROI in public health focuses on the value of the benefits and the total cost of the program instead of profits and investments. As a result, the ROI calculation method and meaning should be clearly communicated to decision-makers and stakeholders so that unreasonable assumptions or comparisons are not made.

Do *Fully Disclose Assumptions and Methodology*
When discussing the ROI process and communicating data, it is very important to fully disclose all the steps and assumptions used. Strengths should be clearly communicated as well as weaknesses and short comings. The audience should fully understand what is being presented and the assumptions on which it is based. Any adjustments made to the data should be highlighted. Be clear that the costs are comprehensive and accurate.

Don't *Try to Use ROI on Every Program*
Some programs are difficult to quantify, and an ROI calculation may not be feasible. Other methods of presenting the benefits or value of a program might be more appropriate. Program staff should set targets for the percent and types of programs in which ROIs are developed. Also, specific criteria should be established to select programs for ROI analysis.[18]

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Sample Employee Survey: Tobacco-Free Policy

[ORGANIZATION] is considering a tobacco-free policy for the facility and grounds, and would like to hear your opinion. This survey should take less than five minutes.

Questions about this survey or the possible policy should be directed to: [Contact].

Thank you!

How strongly do you agree or disagree?	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion
1. Secondhand smoke is a problem on the grounds of [ORGANIZATION].					
2. Secondhand smoke is a problem near entryways of [ORGANIZATION].					
3. The use of tobacco products is a problem at [ORGANIZATION].					
4. Secondhand smoke is a health hazard.					
5. Secondhand smoke bothers me.					
6. A tobacco-free policy on the grounds of [ORGANIZATION] would support our mission as a healthcare organization.					
7. Patients should not have to be exposed to secondhand smoke when they visit [ORGANIZATION].					

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How strongly do you agree or disagree?	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion
8. A tobacco-free policy on the grounds of [ORGANIZATION] would help patients quit tobacco.					
9. A tobacco-free policy on the grounds of [ORGANIZATION] would help employees quit					
10. I think it would be a good idea to have a tobacco-free policy inside [ORGANIZATION].					
11. I think it would be a good idea to have a tobacco-free policy outside at					

12. Have you ever smoked or chewed tobacco? Yes No

13. Do you smoke or use tobacco products currently? Yes No

14. If yes, would you be interested in quitting? Yes No

15. Please write your comments regarding eliminating the use of tobacco products on at [ORGANIZATION]:

Sample Tobacco-Free Policy Timeline

Activities	Description	Timeline
Gain top-level commitment	1. Written memo to middle management signed by organization CEO or physician-in-chief and labor-management partnership representative announcing new policy	1 year prior to target
Create Workgroup	2. Recommended members: MD champion and assistant (co-chairs), coordinator, representatives from: primary care, health education, addiction medicine, personnel, security, facilities, environmental services, pharmacy, public affairs, key employee groups (union representatives, smokers)	9 –10 months prior to target
	3. Revise tobacco policy and procedure	
	4. Survey employeees	
	5. Develop implementation plan and timeline	Plans completed 8 months prior
Facilities Planning	6. Signage location and placement	Signage placed 6 months prior
	7. Eliminate ash urns	
Communication to physicians and employees	8. Send written memo from middle management announcing the new policy	7 months prior
	9. Communicate details of phasing-out of designated areas, enforcement, cessation resources and timeline	

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Activities	Description	Timeline
Positive promotion to members	10. Parking lot banners, lobby banners and posters	7 months prior
	11. Employee brochure	
	12. Appointment card announcement	
	13. Newsletter articles	
	14. Other internal publications	
	15. External publications/new media	
	16. Train security, etc., to communicate policy	
	17. Begin enforcement during phase-out of designated areas/ offer cessation resources (free, if possible)	6 months prior to target "kick-off" date
Going "live"	19. Kick-off celebration	Target date
	20. Enforcement with employees/ members (per policy)	
	21. Maintain grounds	
	22. Prevent relapse with communication	
	23. Evaluate effectiveness and modify as needed	6 months after

Adapted with permission from the Smoking Cessation Leadership Center "Destination Tobacco-Free" toolkit; Original source: Kaiser Permanente, Northern California

Tobacco-Free Policy Sample Talking Points

On *DATE*, *ORGANIZATION* will become completely tobacco-free, both indoors and outdoors--for all properties. This includes our parking areas and the vehicles parked there. This ban covers all tobacco products, including chewing tobacco, and extends to everyone who smokes--patients, visitors, employees, students and vendors.

Why are we doing this?
We believe *ORGANIZATION* leads the community in health promotion and staff wellness. As an institution dedicated to improving the health of our patients and community, we must "walk the talk" and show our commitment and leadership in tangible ways. Tobacco-free and smokefree property is the standard for many healthcare institutions and companies. Organizations in Alaska that are already 100 percent smoke-free include Alaska Airlines, Southeast Alaska Regional Health Consortium (SEARHC), Alaska Native Medical Center (ANMC), Providence Hospital, and hundreds of businesses, hospitals and healthcare organizations across the region and nation.

Don't we have a right to smoke?
There is no legal right to smoke. On the other hand, this *ORGANIZATION* has a right to create a tobacco-free environment within our buildings and grounds. This initiative is consistent with our goals of supporting good health and wellness.

How will patients, visitors and others learn of the ban?
We will announce the ban through the media and post signs around our property. We will send information to physicians and

other healthcare providers, asking that they tell patients about our tobacco-free policy. We will tell every patient about the policy. We ask that managers begin discussing this policy with employees as soon as possible so all of us can prepare for this change.

Doesn't this policy punish tobacco users?
Our new policy isn't intended to punish anyone. It is designed to provide all staff with a healthy and safe workplace and to treat patients in a healthy and safe environment. Our tobacco cessation programs and related activities show our commitment and leadership in health promotion and disease prevention for our staff, patients and communities. We hope we provide the kinds of support that staff, patients and visitors need to take steps toward health.

What about other kinds of tobacco products, like iqmik, chew or pipes?
The new policy will also ban use of other forms of tobacco, including chewing tobacco, cigars, pipes and tobacco alternatives, such as clove cigarettes. Nicotine replacement therapy products (patches, gum, lozenges) are allowed.

Does this new policy comply with union contracts?
ORGANIZATION's union contracts allow us to implement general staff policies like this one. We have informed union leaders of our new policy and we will work with them as we implement this policy and other policies and changes.

How will the policy be enforced?
Our hope is that we can work together to enforce this policy through friendly interactions. All employees seen smoking or

using tobacco on the premises after *DATE* will be asked to stop, reminded of the new policy and informed of tools that can ease symptoms while they are at work. If they are ready to quit, we can provide resources to help them. If you find staff who do not wish to comply with our policies, we ask that you talk with them or their supervisor to let them know you're concerned about supporting a tobacco-free campus. Repeat offenders are subject to disciplinary action.

We recognize that we also will deal with visitors who may be under stress and are unfamiliar with our policies. If you see visitors smoking or chewing tobacco on our grounds, kindly inform them of the policy and request that they stop. We will provide you sample scripts and information cards. If a visitor refuses to comply, walk away. Inform security if they pose a safety threat.

What about visitors or patients who must stay on our property for lengthy periods of time?
We want to deliver a clear message to all of our patients and visitors that, 'While you are here, you and those around you have every right to breathe smokefree air and every opportunity to make healthy choices.' This applies to our psychiatric, chemical-dependency treatment units and long-term care as well as our tertiary care.

Experience shows that psychiatric, chemical-dependency treatment centers and long-term care facilities can implement tobacco-free policies without the upheaval skeptics predict. We will provide training to our staff on treating nicotine addiction along with other psychiatric or chemical-dependency issues.

(For information and sample policies for long-term care facilities, see tcsg.org/tobacco/smokepolicies.htm)

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Will staff or visitors be able to smoke on public property adjoining our property, such as a public sidewalk?
Yes, but we ask that our employees respect our neighbors and their property.

If I have to walk farther to reach public property where I can smoke, will I get more break time?
No. That would be unfair to co-workers and hurts our ability to treat patients. Failure to return from break on time will be treated as a violation of our standards of employee conduct.

Can I smoke inside my car?
If your car is parked in the *ORGANIZATION* parking lot, you cannot smoke in it because the lot is part of our tobacco-free zone. Additionally, the use of tobacco products is not allowed in any *ORGANIZATION*-owned vehicles.

Won't there be more litter around the campus because of cigarette butts?
All staff act as *ORGANIZATION* ambassadors during working hours at our campuses. As ambassadors and good neighbors, we expect that employees will treat surrounding public areas and private properties with respect. This means that staff is expected to avoid littering, including cigarette butts and other trash, on all properties adjoining our buildings.

Can an employee be disciplined for carrying cigarettes or chew?
The tobacco-free policy is intended to cover the use of lighted cigarettes, cigars, pipes or other tobacco products on *ORGANIZATION* campuses.

If you are carrying unlit cigarettes or other tobacco products in your purse or on your person going to and from a break, you will not be disciplined. You will be subject to progressive disciplinary action if you light up or smoke a lighted cigarette or other tobacco product or use chewing tobacco on *ORGANIZATION* property.

Can I use nicotine-replacement therapy products, like gum, lozenges, or patches, at work?
Yes. Some smokers may choose to use NRT products—particularly gum or the patch—to manage their nicotine cravings during work hours. If you are still smoking or using tobacco, please be cautious if you choose to use nicotine-replacement therapy at work. Taking too much nicotine by using nicotine-replacement therapy while you still use tobacco can cause unpleasant side effects. If you want to use NRT at work, you may want to talk to your physician about appropriate dosing and use.

How do I learn more about what will happen at my work site, or otherwise get more information on our Tobacco-Free Campus?
You can get more information from your manager or from the Tobacco-Free Campus Web Page at _____ You can also ask questions or offer suggestions by e-mailing or calling _____.

Who enforces the no-tobacco requirement for contract workers who are outside employees?
We have notified our contracted vendors of the Tobacco-Free Campus policy and its *DATE*, effective date. All vendors and contracted employees are expected to comply with this policy.

APPENDIX S

I'm uncomfortable talking with members or visitors about smoking on campus. What am I supposed to do?
You may need to educate patients, employees and visitors about the new policy when you see someone smoking or using tobacco on campus.

Managers and security staff have the primary responsibility for enforcement. This means they will talk with employees or visitors who do not wish to stop smoking or using tobacco after being educated about our policy. We anticipate that most employees, patients and visitors will comply with the policy once they know about it.

We understand that conversations about personal behaviors, like smoking, can be uncomfortable. We hope you'll help *ORGANIZATION* create a healthier environment by educating people about the new policy. Gently inform them of the policy. Something like:

"Hi. I need to let you know that for the health of our patients, employees and visitors, ORGANIZATION does not allow tobacco-use on campus. Please put out your cigarette and dispose of it. Here's a card that explains our policy and offers some other options."

If the member, visitor or staff member continues smoking, walk away. If you believe the smoker poses a safety threat, report the person to security right away.

How will ORGANIZATION help tobacco-users who want to quit?

- ORGANIZATION's health plan and wellness program covers NOTE CESSATION HELP for employees.
- Refer tobacco-users to Alaska's Tobacco Quit Line phone number 1-800-QUIT NOW.

I'm a smoker. How can I get help?

We know that quitting is a process that doesn't happen the same way for everyone. Research shows that you will be most successful with a combination of support, coaching and medications.

1. Employees can *DEFINE BENEFITS OR SERVICES*.
2. Talk with your doctor.
3. Call Alaska's Tobacco Quit Line, 1-800 QUIT NOW. The Quit Line can offer you information, coaching, and free Nicotine Replacement Therapy.

Adapted with permission from the Smoking Cessation Leadership Center "Destination Tobacco-Free" toolkit; Original source: Group Health Cooperative, University of Massachusetts Medical School, Centers for Disease Control & Prevention

APPENDIX T

Sample Tobacco-Free Policy Communication Plan

Include this intro for the tobacco-free policy communication form:

The success of your tobacco-free policy is contingent upon the widespread and thorough delivery of an aggressive advertising campaign. Policy objectives must be accurately and consistently communicated to target audiences, beginning with the official announcement of the new tobacco plan and continuing throughout its duration. It is essential that information regarding your facility's new tobacco policy reaches a broad range of audiences, including patients, visitors, and employees of your facility, as well as regional sites and partner organizations with which your facility is affiliate. In addition to conveying policy objectives, it will be important to inform your facility's patients, visitors, and employees of the tobacco cessation services that will be available to them.

Audience	Communication Tool	How to Disseminate	Who is Responsible?	By When Will This Be Completed?
Employees	Presentation on: Policy Role-play on policy enforcement Health education programs	Staff meetings		
Employees	Card to be given to smokers indicating "no smoking" (may print as tear-off pads)	Staff meetings		
Employees	Announcements	E-mail to all employees and other appropriate distribution lists E-mail to managers E-mail to providers		
Employees	Flyers	Paychecks		
Employees	Policy	New employee orientation		

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Audience	Communication Tool	How to Disseminate	Who is Responsible?	By When Will This Be Completed?
Employees	Town Hall Meeting	Lunch time meeting for all interested employees		
Employees	Article and calendar section	Employee newsletter		
Employees	Training staff on talking points for policy	Staff meetings		
Unions	Letter	Sent to unions		
Patients and Community	Banner	Placement in facility		
Patients and Community	Recorded message	Patient packet		
Patients and Community	Patient information	Patient packet		
Patients and Community	Reminder Cards	Through scheduling		
Patients and Community	Press Release	All media		
All	Flyers	Facility information desks and waiting areas		
All	Signs	Through facility services		

Adapted with permission from the Smoking Cessation Leadership Center "Destination Tobacco-Free" toolkit; Original source: Kaiser Permanente's Santa Rosa Medical Center's Smoke-Free Campus Communication Plan

[Insert Logo]

APPROVED BY:

_____

CEO/President

_____

Chairman of the Board of Trustees

TOBACCO-FREE POLICY

Effective DATE, ORGANIZATION will maintain a 100% tobacco-free environment. This policy applies to employees, patients, residents, visitors, vendors and anyone who enters ORGANIZATION-owned property or off-campus employee worksites.

PURPOSE

As a healthcare provider, ORGANIZATION is committed to providing a healthy and safe environment for employees, patients, staff, and visitors and to promoting positive, healthy behaviors.

With this policy, we hope to:

- Eliminate secondhand smoke so everyone on our grounds can breathe smokefree air
- Demonstrate our commitment to improve the health of patients, employees and the community
- Increase ORGANIZATION involvement in treating nicotine addiction
- Set an example that other organizations and businesses can follow

APPENDIX U

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PRODUCTS COVERED BY THE POLICY

Tobacco products include, but are not limited to:

- Cigarettes
- Cigars or cigarillos
- Dip, chew, snuff, snus or any other smokeless tobacco
- Pipe smoking
- Nicotine delivery devices, such as the electronic cigarette, excluding FDA-approved nicotine replacement therapy for the purpose of tobacco cessation

PHYSICAL BOUNDARIES OF THE POLICY

Please refer to attached map for the boundaries of ORGANIZATION's campus. This policy shall apply to all indoor and outdoor spaces owned or leased by ORGANIZATION, including:

- Parking lots and driveways that are used by ORGANIZATION
- ORGANIZATION vehicles
- Vehicles on property that is owned, leased or used by ORGANIZATION
- Adjoining sidewalks to ORGANIZATION owned or leased property

SALE AND PROMOTION OF TOBACCO PRODUCTS

- ORGANIZATION will not sell or allow to be sold any tobacco products on property grounds.
- ORGANIZATION prohibits the advertising or promotion of any tobacco product on ORGANIZATION'S property.

1. Employee Responsibilities
For purposes of this policy only, "employee" refers to employees, contract employees, volunteers and students.

All ORGANIZATION employees must observe and promote compliance with the tobacco-free policy. ORGANIZATION employees are encouraged and expected to be good neighbors and refrain from using tobacco products on the property of nearby businesses and residences.

Employees are not allowed to leave the workplace property while "on the clock." Leaving campus during work time is subject to disciplinary action.

Hourly employees, who leave ORGANIZATION property for non-work matters, must clock-out upon leaving and clock-in upon returning. Unauthorized breaks are subject to corrective action. Employees carpooling to attend training classes or work-related functions paid for by ORGANIZATION may not smoke unless all parties agree that smoking is acceptable. This applies for travel where mileage is reimbursed by ORGANIZATION.

All employees are responsible for ensuring compliance by fellow employees. Employees observing a co-worker violating the policy are requested to courteously remind the employee of the policy and ask that the tobacco product be extinguished or removed.

Employees are encouraged to make a confidential, "good faith" report to a supervisor, manager or human resources when they observe an employee violating this policy.

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If the tobacco violation involves a potential threat to health or safety, such as smoking near combustible supplies, flammable liquids, gases or oxygen, management and security staff must be contacted. If the tobacco materials are not extinguished or dispensed of or if the patient/resident repeats the activity, security will remove the tobacco materials from the room until dismissal. You may dial "0" to request security for assistance.

As outlined in the Dress Code Policy, employees are asked to pay special attention to personal hygiene. This includes not having a strong odor of smoke when working.

Employees who violate this policy are subject to disciplinary action, up to and including termination. These consequences are based on a 12-month rolling calendar:

1st VIOLATION	>	VERBAL COACHING
2nd VIOLATION	>	WRITTEN WARNING
3rd VIOLATION	>	SUSPENSION
4th VIOLATION	>	TERMINATION

Employees who smoke or use other tobacco products are encouraged to avail themselves of the tobacco cessation programs offered.

2. Visitors

Informational cards are available for staff to give visitors who are observed smoking or using tobacco on ORGANIZATION property. Staff can use the card to inform the visitor of ORGANIZATION's policy and options to relieve withdrawal symptoms or quit tobacco.

Staff is encouraged not to confront visitors, but rather to respectfully ask those who refuse to comply to please dispose of tobacco products in the appropriate receptacle. Should a tobacco-use violation pose a potential safety threat to the property or to another person, employees are asked to contact security.

3. Patients and Residents
At the time of admission or registration, patients and residents will be given information regarding the tobacco-free policy. Patients will be informed that leaving the campus while admitted will not be allowed. Leaving campus while admitted is classified as leaving "against medical authorization."

Patients and residents will not be permitted to use tobacco or smoke under any circumstances. If an employee observes a patient/resident using tobacco products the employee needs to remind the tobacco-user of the policy and provide an informational card. Patients' and residents' tobacco items will be placed in a secure location until dismissal.

Additional remedies are the responsibility of the management team responsible for the safety and well-being of the patient/resident. Tobacco cessation materials will be given to the patient/resident and their physician may be contacted to request tobacco cessation products.

If the use of tobacco products continues after the first verbal reminder, management and security may be contacted for additional assistance and to reinforce the policy.

APPENDIX U

4. Security
Security is available to assist with a patient or resident who is not compliant with ORGANIZATION's tobacco-free policy. If tobacco materials are not extinguished or if the patient/resident repeats the activity, security will remove the materials from the room to be stored in a safe place until dismissal.

5. Contractors and Vendors
All contractors and vendors will be informed of ORGANIZATION's tobacco-free policy as part of the contractual agreement. Vendors who sign-in at shipping and receiving to deliver items will be reminded of the policy. If you observe a contractor or vendor violating this policy you may inform them of ORGANIZATION's policy or contact security.

Senior leadership is responsible for monitoring compliance with this policy.

Adapted with permission from the Smoking Cessation Leadership Center "Destination Tobacco-Free" toolkit; Original source: Group Health Cooperative, Seattle, Washington

Tobacco-Free Policy Enforcement Scripts

Be friendly and respectful when informing employees, patients, or visitors about the tobacco-free policy. Remember, tobacco-use is an addiction, which can be triggered by stress.
Our tobacco-free policy is designed to provide a safe and healthy environment and model healthy behaviors. As you enforce the policy, provide as much help as possible:

- Educate people about the policy
- As appropriate, offer symptom relief for tobacco-users during their stay
- Encourage tobacco-users to quit when they are ready

Keep discussions about the tobacco-use policy brief and non-confrontational.

Schedulers, registration and physician offices to patients:

"I'd like to let you know that for the health of patients, employees and visitors, ORGANIZATION does not allow tobacco-use on campus. That includes all property, grounds and parking area. Under our policy, a patient cannot leave the hospital to smoke. However, if you are interested, we can provide nicotine-replacement therapy to relieve your symptoms. We also can provide nicotine replacement therapy for family members and visitors who request it."

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Employees to patients, visitors, contractors, paramedics, police officers, firefighters, tenants, vendors, or volunteers:

Scenario: Someone lights up on campus:

"Hi. I need to let you know that for the health of our patients, employees and visitors, ORGANIZATION does not allow tobacco-use on campus. Please put out your cigarette and dispose of it. Here's a card that explains our policy and offers some other options."

Scenario: Someone is smoking in a car, truck or other vehicle in the parking lot.

"Hello. I just wanted to let you know that this parking lot is part of our tobacco-free campus. Here is an information card that explains our policy and gives you some other options."

Employee to employee:

Scenario: Employee says, "If I can't smoke on campus, I'll just leave when I need a smoke."

"That's probably something you need to talk about with your supervisor."

Employee to patient:

Scenario: Patient says, "If I can't smoke on campus, I'll just leave your campus."

"I'm sorry, but for your safety, patients are asked not to leave ORGANIZATION's property. If you'd like, we can assist you with other options for your nicotine cravings."

Scenario: Patient has been told, "If you cooperate with this procedure, I'll let you chew."

"I'm sorry you got that information. ORGANIZATION now has a tobacco-free campus. We can see about providing you with a patch or some gum to help you with your cravings."

Potential challenges with employees, patients, or visitors:

Scenario: Smoker becomes irate and out of control, saying, "I need a cigarette."

"It sounds like things are tough for you right now. We don't make exceptions to our policy, for the health and safety of everyone. I can offer you nicotine gum or lozenges that will make it easier for you not to smoke. Or, if you prefer, I can show you the quickest way off our smoke-free area. Is there anything else I can do?"

(Have nicotine gum and lozenges available for staff members, families and visitors on each nursing unit or at another designated site.)

Scenario: Smoker, reminded of the policy, declares: "I'm going to smoke here anyway!"

"Sorry you're having a rough time. Could you please put out your cigarette? Here is an informational card that explains our policy and gives you some other options." Then contact security or other enforcement.

Scenario: Smoker responds: "Then where am I supposed to smoke?"

"In order to provide a healthier environment, ORGANIZATION no longer permits smoking anywhere on the campus. I can show you where you can get some free nicotine lozenges, but if you wish to smoke, you will need to leave the campus. I can show you the quickest way off our tobacco-free campus if you like. Here is an information card that explains our decision and gives you some other options."

Scenario: Tobacco-user rants about the tobacco-free policy.

"Perhaps you should tell a manager how you feel about this policy. I suggest you call NAME OF MANAGER IN CHARGE.

Scenario: Smoker says, "If I can't smoke here, I'll go to another hospital."

"I'd hate to see you leave. Our policy is designed to protect the health of patients, employees and visitors and (depending upon the locale...) is similar to other hospitals in this area. While you're here, we can make it easier for you not to smoke by giving you nicotine gum or lozenges. Here is an information card that explains our policy and gives you some options."

APPENDIX V

Adapted with permission from the Smoking Cessation Leadership Center: "Destination Tobacco-Free" toolkit.

[HOSPITAL NAME]

Leaving the Unit for Smoking/Tobacco Use Form

RELEASE

I have been informed that [HOSPITAL NAME] has a tobacco-free policy. It is my desire to leave the unit to smoke or use tobacco.

I understand that my physician has been notified, and that certain medications and/or treatments will be discontinued until my return to the floor.

I understand that leaving to smoke or use tobacco is against medical advice.

I assume all risk of injury that may occur to me, the patient, while smoking or using tobacco.

I assume all risk of delayed treatments that may occur due to my absence to smoke or use tobacco.

I understand and accept the risks and/or any complications that may arise as the result of leaving the unit to smoke or use tobacco.

I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE [HOSPITAL], its agents, employees, and physicians from any and all liability, claims, demands or injury, including death, that may be sustained by me in leaving the unit to smoke.

_____

(Patient Name) (Date and Time)

_____

(MD/RN Signature) (Date and Time)

__*Patient has been informed of hospital policy and refuses to sign form.*

APPENDIX W

Adapted with permission from the Smoking Cessation Leadership Center: "Destination Tobacco-Free" toolkit. Original Source: UAMS Medical Center

Sample Press Release

For Immediate Release: DATE

ORGANIZATION Announces New Tobacco-Free Policies

(CITY) - ORGANIZATION today announced plans to implement a new tobacco-free policy at all facilities, effective DATE.

ORGANIZATION leaders say the new policy reflects the health system's mission: "We are eliminating tobacco-use on our properties to provide a healthy and safe environment for employees, patients and visitors and to promote positive health behaviors," said NAME, chief executive officer at ORGANIZATION.

The new policy bans the use of all tobacco products, including cigarettes, cigars, pipes and smokeless tobacco, within all properties owned, leased, or occupied by ORGANIZATION. This includes parking lots, hospital vehicles, and employees' personal vehicles parked on the premises. Employees are prohibited from using tobacco products during working hours.

The US Surgeon General's Office in 1964 declared that smoking is hazardous to health. Yet smoking remains the number one cause of preventable death and disability, according to the Centers for Disease Control & Prevention.

APPENDIX X

APPENDIX X

ORGANIZATION views tobacco-use as a quality concern: "We can no longer turn a blind eye to on-campus smoking when we know that continued tobacco-use can cause serious health effects for a patient," said chief medical officer, NAME. "Smoking slows wound healing, increases infection rates in surgeries, and is the most common cause of poor birth outcomes."

Furthermore, three-fourths of all tobacco-users say they want to quit. But the ORGANIZATION medical director recognizes the challenges of breaking the addiction to nicotine and respects an individual's quitting process. "We are not telling anyone, 'you must quit smoking.'" said NAME OF MEDICAL DIRECTOR. "We are saying, 'Don't use tobacco at our ORGANIZATION.' While you are a patient or visitor at this hospital, we can suggest ways to ease nicotine withdrawal symptoms. And if you are ready to quit, we have trained professionals and community partners who can help you."

ORGANIZATION hopes employees will help inform visitors and patients about the new policy, said NAME OF CEO. "This will not be easy," he said, "but it's central to our continuing efforts to make an excellent place to work and to receive healthcare." In implementing the new tobacco-free campus, the ORGANIZATION plans to offer symptom relief or tobacco-cessation treatment to interested staff, visitors and patients.

Adapted with permission from the Smoking Cessation Leadership Center "Destination Tobacco-Free" toolkit

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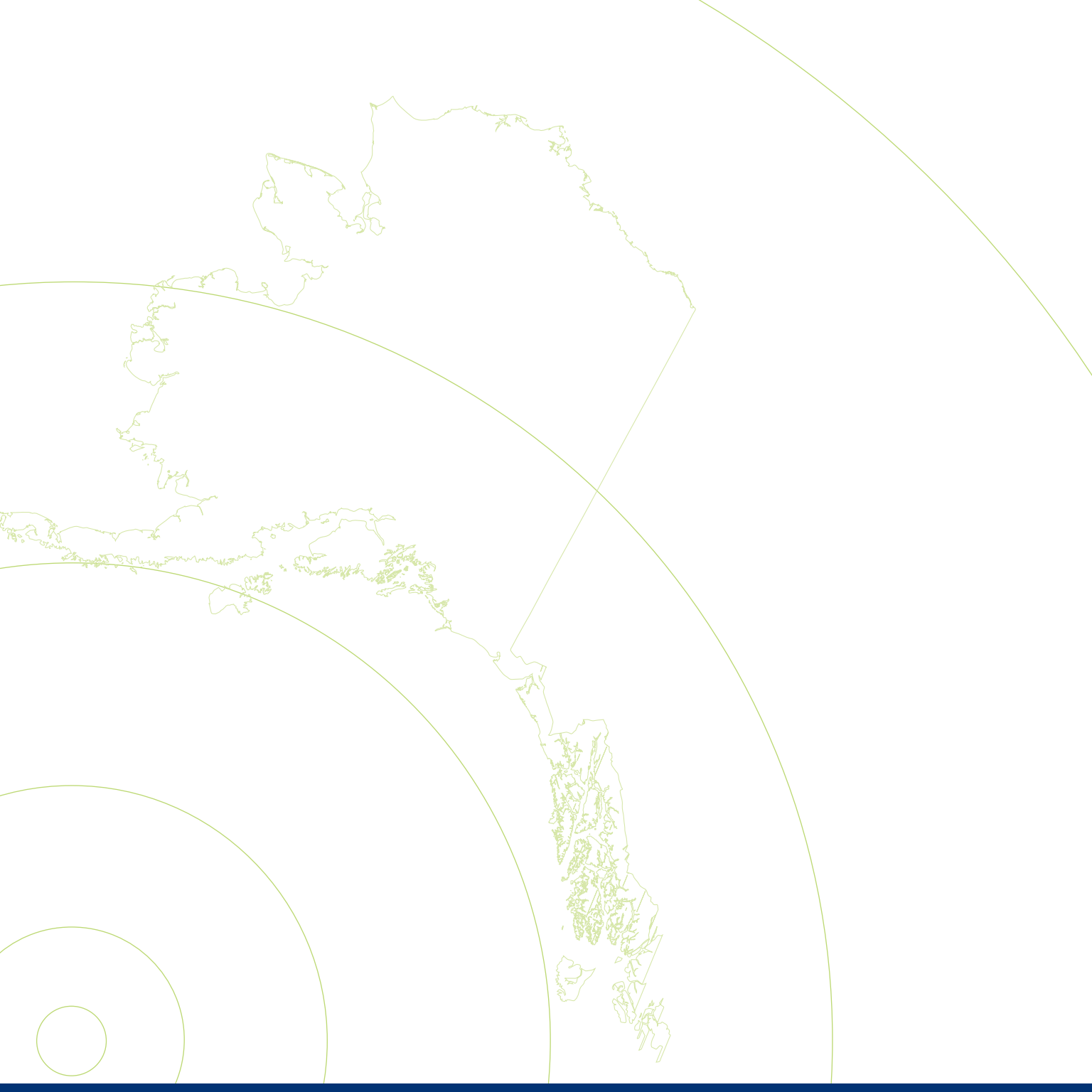

STATE of ALASKA
Department of Health and Social Services

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