Cessation

in Tobacco Prevention and Control

U.S. Department of Health and Human Services
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Purpose

The Center for Public Health Systems Science at Washington University in St. Louis is developing a set of user guides funded by the Centers for Disease Control and Prevention (CDC), contract 200-2015-87568, for the ***Best Practices for Comprehensive Tobacco Control Programs—2014*** (*Best Practices 2014)*, an evidence-based tool to help states develop and sustain comprehensive tobacco control programs.

The purpose of the user guides is to help tobacco control staff and partners implement evidence-based best practices by translating research into practical guidance. The guides focus on strategies (*e.g.*, programs and interventions) that have shown strong or promising evidence of effectiveness. Recommendations in this guide are suggestions for programs helping people quit tobacco. Programs can follow these recommendations according to their needs, goals, and capacity. In the user guides, tobacco refers to the use of manufactured, commercial tobacco products.

Content

This user guide focuses on how comprehensive tobacco control programs can promote cessation through population-wide efforts. According to *Best Practices 2014*, "encouraging and helping tobacco users to quit is the quickest approach to reducing tobacco-related disease, death, and healthcare costs."[1] Population-based interventions can dramatically increase access to proven cessation treatment and help more people quit for good. This guide offers program staff and partners information on how to promote health systems change, improve insurance coverage for cessation treatment, and support state quitlines.

Links to More Information

Each instance of italicized, bolded ***blue text*** in the guide indicates a link to an additional resource or a page within the guide with more information. Website addresses for all of the blue resources noted throughout the guide are also included in the Resources section.

Organization

- **Making the Case:** A brief overview of why cessation interventions are an essential part of tobacco control efforts
- **Brief History:** How cessation interventions have changed from treating individual smokers to promoting quitting at the population level
- **How to:** Strategies to plan and carry out cessation interventions
- **Providing Support:** How tobacco control programs can support cessation efforts
- **Case Studies:** Real-world examples of successful cessation interventions
- **Case for Investment:** Information to raise awareness about the importance of cessation interventions
- **Resources:** Publications, toolkits, and websites to help in planning efforts

Best Practices for Comprehensive Tobacco Control Programs–2014[1]

Best Practices 2014 is an evidence-based guide to help states plan, establish, and evaluate comprehensive tobacco prevention and control programs. The report offers recommendations and evidence for five essential components of effective programs:

- State and community interventions
- Mass-reach health communication interventions
- Cessation interventions
- Surveillance and evaluation
- Infrastructure, administration, and management

Making the Case for Cessation

Every year, more than 480,000 Americans die from smoking.[2] Another 16 million Americans live with a serious disease caused by smoking.[2] Helping people quit using tobacco is the quickest way to reduce the disease, death, and immense cost caused by tobacco use.[1] Cessation interventions are an essential part of a comprehensive tobacco control program because they:

Improve health and save lives

Quitting tobacco is not easy, but it is possible. Quitting improves smokers' health almost immediately. Within 20 minutes, blood pressure and heart rate decrease.[3] Within a year, the risk of heart attack drops sharply.[4] In 2–5 years, the chance for stroke can fall to about the same as a nonsmoker's.[5] Although quitting has health benefits at any age, people who quit smoking before age 40 avoid most of the risk of dying early from a smoking-related disease.[6]

Maximize the impact of other effective tobacco control strategies

Comprehensive smoke-free laws, tobacco product price increases, and hard-hitting media campaigns motivate people to try to quit using tobacco and make it easier for them do so.[1,7-9] Combining these efforts with cessation interventions can connect people who use tobacco to evidence-based treatment and help them quit successfully, maximizing the impact on cessation.[1] Supporting people who want to quit can also pave the way for smooth implementation of tobacco control policies and interventions.[10]

Reduce tobacco-related disparities

Some adults who smoke are less likely to quit successfully, including people with less education, those living below the poverty level, and those without health insurance.[11] These disparities may result from factors such as limited financial resources, lack of health insurance, lack of information about cessation treatments, or living in environments less supportive of quitting tobacco.[1,11] Cessation interventions help overcome these barriers by increasing access to evidence-based treatment so people can quit using tobacco for good.

Address other community health priorities

Smoking cessation can help address other community health priorities, such as mental health and substance use recovery outcomes, cancer survival rates, and pregnancy and child health outcomes.[12-16] It also helps people better control diabetes and lowers the risk for heart disease as much as or more than other common treatments like aspirin.[5,17]

Create a return on investment

Helping people quit tobacco is a smart investment. Tobacco use is expensive—people who smoke cost nearly $6,000 more per year to employ than people who do not smoke.[18] Excess costs include healthcare costs and lost productivity due to absenteeism, smoking breaks, and lower on-the-job productivity (presenteeism).[18] In comparison, evidence-based cessation interventions cost only a few hundred to a few thousand dollars for each person who quits.[19] The savings can add up quickly; lower healthcare costs can save employers money in less than two years.[20]

Support state and national healthcare goals

Changes in healthcare delivery and payment models are increasingly being implemented to improve quality of care and population health outcomes, while reducing healthcare costs. Cessation interventions support these goals by increasing access to and use of evidence-based treatments, quit attempts, and successful cessation, which in turn increases patient satisfaction and reduces tobacco-related disease, death, and healthcare costs.[21-23] Because quitting smoking prevents and improves the prognosis for many chronic diseases, it has the potential to dramatically improve health and reduce costs.[19]

A Changing Landscape

By the 1980s, the public health and scientific community had begun to recognize that smoking was an addiction driven by nicotine, not a habit, and had begun to develop effective cessation treatments.[24] In 1984, the U.S. Food & Drug Administration (FDA) approved the first cessation medication, nicotine gum, followed by the nicotine patch (1991–92), the nicotine nasal spray (1996), the nicotine inhaler (1997), buproprion (1997), lozenge (2002), and varenicline (2006).[25,26] In 1990, the Surgeon General released the report, *The Health Benefits of Smoking Cessation* (see **Figure 1** below).[27]

Telephone cessation services also began to grow rapidly. In 1992, California launched the first publicly funded state tobacco quitline.[12] Evidence of effectiveness and leadership from early adopters led to the creation of more state quitlines.[28] In 2004, at the direction of the Department of Health and Human Services, the National Cancer Institute created a toll-free, national quitline portal, 1-800-QUIT-NOW, and CDC began directly funding state quitlines.[29] By 2006, all 50 states, the District of Columbia, and Puerto Rico offered quitlines.[30]

As effective cessation treatments became more widely available, there was also growing recognition of the need for healthcare providers to treat tobacco use.[31] The U.S. Public Health Service released its first clinical practice guideline on tobacco in 1996, with updates in 2000 and 2008. The 2008 update concluded that tobacco dependence is a chronic disease that often requires repeated intervention, counseling and FDA-approved medications are effective cessation treatments, and the combination of counseling and medication is more effective than using either alone.[19]

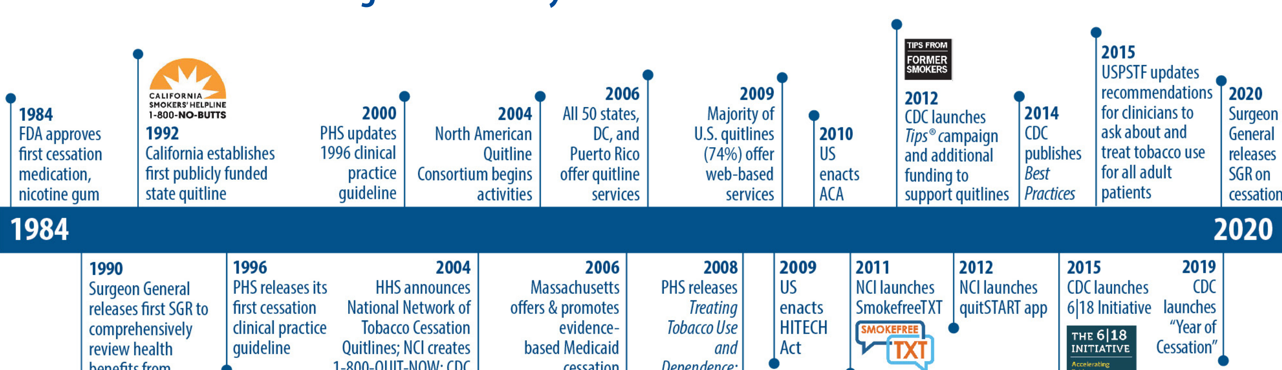
The 2008 update was also one of the first guidelines to recommend that insurers provide comprehensive cessation coverage and that health systems identify and treat every patient who uses tobacco.[19] Other reports also encouraged systems changes, including *Ending the Tobacco Problem: A Blueprint for the Nation*, *Best Practices 2014,* and *Healthy People 2020*.[1,32,33]

Today, the healthcare system is undergoing a transformation to enhance quality of care, improve population health, and reduce costs. Federal legislation such as the 2009 HITECH Act and the 2010 Affordable Care Act have helped improve cessation coverage and encouraged providers to treat tobacco use.[34,35] Health systems are also emphasizing coordinated approaches to manage chronic diseases and collaborating with public health programs. One example is CDC's 6|18 Initiative, which forms partnerships between public health and healthcare stakeholders to address six common and costly health conditions, including tobacco use.[36]

The internet, email, chat, text messaging, and apps are also increasing the potential of cessation services to reach more people who use tobacco.[37] Since 2012, CDC has annually aired ***Tips From Former Smokers®***, the first federally funded national tobacco education campaign. CDC also provides supplemental funding to quitlines to meet increased demand due to the campaign, including Guam. As of 2018, *Tips®* helped over half a million people quit successfully, adding to the evidence that population-wide interventions help people quit tobacco.[38]

In January 2020, the Surgeon General released a new report, *Smoking Cessation*. The report covers the latest scientific evidence on the health benefits of smoking cessation, effective cessation treatments, and broad population-based strategies to help more people successfully quit smoking.

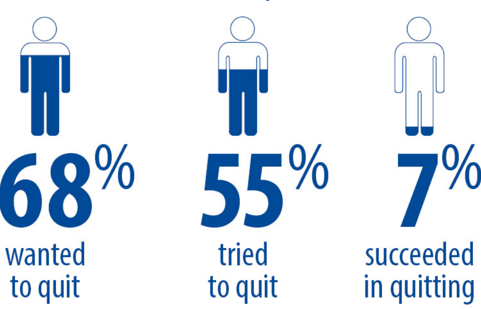
Figure 1. History of Cessation Interventions



Understanding Cessation Interventions

Although many effective tobacco cessation treatments exist, quitting tobacco is not easy. Most people who smoke make many quit attempts before succeeding.[39] Most people try to quit on their own, and overall cessation rates remain low.[11] In 2015, nearly 70% of adults who smoke wanted to quit, more than 50% tried to quit, but less than 10% succeeded (**Figure 2**).[11] People who use tobacco may be unaware that cessation treatment is available, may be unable to afford treatment, or may face other barriers, such as limited insurance coverage for certain treatments.[40] In 2015, only 31% of adults who smoke used evidence-based cessation treatment when trying to quit.[11]

Figure 2. Smoking Cessation Among U.S. Adults, 2015



Source: Babb S, Malarcher A, Schauer G, Asman K, Jamal A[11]

Population-based cessation interventions seek to help people quit successfully by ensuring that barrier-free, evidence-based tobacco use treatments and services are accessible to anyone who wants or needs them. These strategic efforts have the potential to dramatically improve health. They change policies and systems in ways that normalize quitting and institutionalize tobacco use screening and treatment in medical care. Population-level cessation interventions include three approaches:[1]

- Promoting health systems change to integrate tobacco use treatment into routine clinical care
- Improving insurance coverage for evidence-based cessation treatment and increasing use of covered treatments
- Supporting state tobacco quitlines

Improving Cessation Access

Cessation interventions increase access to evidence-based treatment by ensuring that:

- Treatment is offered to every person who smokes via a method they can access and are comfortable using
- Treatment does not have limits or other barriers
- People are aware of treatments available to them

Promoting Health Systems Change

Because 8 in 10 people who smoke see a doctor each year, healthcare providers play an important role in promoting cessation.[1] Yet in 2015, less than three in five smokers received advice to quit from a health professional.[11] Providers often have only a limited amount of time with patients to cover many topics.[41] They may also lack training and confidence in delivering cessation interventions, and are not adequately reimbursed treating tobacco use.[19,41] Providers may also think that patients will resist quitting or do not want to quit.[41,42] It is important, though, that providers talk to their patients about cessation. People who smoke value doctors' advice about quitting, and even brief counseling (under three minutes) is effective.[19]

Health systems change strategies aim to screen every patient for tobacco use and offer every tobacco user help to quit at every visit. Health systems change is focused on making changes throughout the health system. Changes may include revising organizational policies, administrative and clinical processes, information technologies, staff training, performance feedback, and quality improvement initiatives to support tobacco use treatment.[43] The goal is to make screening and treatment automatic, rather than depending on providers to remember to act.

Many healthcare providers can treat tobacco use.[44] For example, providers may work in primary care, emergency medicine, obstetrics and gynecology, dentistry, or behavioral health. Health systems changes

Health Systems Change Components

Health systems change is not "one size fits all."[43] Successful health systems changes are tailored to the characteristics of each health system. They can include many different activities, depending on the system's financial resources, workflow, staffing, patient population, use of electronic health records (EHRs), and quality improvement efforts.[43] Typically, health systems change involves activities in the following areas:

- Educating healthcare leadership, providers, and staff on the importance of treating tobacco use
- Integrating tobacco screening and treatment into the existing workflow
- Referring patients to quitting resources
- Creating reminders for staff to treat tobacco use (*e.g.*, EHR alerts or medical chart stickers)
- Documenting cessation treatment and sharing results with providers and staff as part of quality improvement initiatives
- Reimbursing providers for tobacco use treatment

can be implemented in any setting, including outpatient and inpatient care, public and private practices, and settings with one or many providers. It is best if all staff who interact with patients, including front desk staff, nurses, doctors, and pharmacists, are involved in developing and implementing the changes.[44]

Evidence of the benefits of health systems change is compelling. Although interactions with providers may last only a few minutes, brief tobacco use treatment helps people who smoke quit for good and can even increase the likelihood that people not yet ready to quit will try in the future.[19] Combining strategies increases their overall effectiveness.[19] For example, when training is coupled with reminder systems, providers are more likely to screen patients for tobacco use, help set a quit date, and arrange follow-up.[19] When consistently implemented, these changes can reduce cigarette smoking prevalence.[34] Treating tobacco use can also improve patient satisfaction and help meet federal health priorities, such as improving quality of care and reducing healthcare costs.[21-23,45]

Improving Cessation Coverage

Comprehensive insurance coverage for cessation treatment increases the number of people who try to quit smoking, use evidence-based treatment, and quit successfully.[1,19,46] **Figure 3** describes the elements of comprehensive cessation coverage. Learn more about what is covered under different plans on the American Lung Association web page, ***Tobacco Cessation Treatment: What is Covered?***

Improving coverage also has the potential to give states and insurers a strong return on their investment. In

Figure 3. Elements of Comprehensive Cessation Coverage

Cover individual, group, and telephone counseling

Cover all seven FDA-approved cessation medications*

Eliminate or reduce barriers to treatment, such as copays or prior authorization

Promote available coverage to tobacco users and healthcare providers to increase awareness and use

Monitor and report coverage use

*Five forms of nicotine replacement therapy (patch, gum, lozenge, nasal spray, and inhaler), bupropion, and varenicline
Source: CDC[1]

2006, Massachusetts began offering an evidence-based tobacco cessation benefit for Medicaid enrollees. The state also promoted the benefit heavily to enrollees and healthcare providers. Over 2½ years, smoking prevalence among Medicaid enrollees decreased from 38% to 28%.[47] Hospitalizations for heart attacks and other acute heart disease diagnoses fell by almost half.[48] For every $1 spent on the benefit from 2007 to 2009, Massachusetts saved over $3 in medical costs for cardiovascular conditions alone.[49]

Strategies to improve coverage seek to ensure that all people who use tobacco have access to comprehensive coverage with minimal barriers. Staff can work with employers, health insurers, and state agencies to make tobacco use treatment as easy to access as possible. One way to expand access is to remove barriers such as copays, prior authorization, limits on the duration and number of treatments, and step therapy (requiring people who smoke to try certain treatments before they can try others).[40] Programs can also help raise awareness of cessation coverage and evaluate benefit use.

Supporting State Quitlines

State tobacco quitlines offer free, confidential, evidence-based telephone counseling to help people quit tobacco. Trained quitline coaches provide callers with individual counseling that includes practical advice on how to quit, information on cessation medications and how to use them, and help developing a quit plan.[1] Coaches may also refer callers to quitting resources, send self-help materials, and, in some cases, provide cessation medications.[1] The first state quitlines offered only telephone counseling and mailed self-help information, but many quitlines have expanded services. Quitlines now offer internet, chat, text messaging, and mobile app options, as well as healthcare provider training and support.[50]

Quitlines receive 1.3 million calls per year and operate in all 50 states, the District of Columbia, Puerto Rico, and Guam.[51] The national quitline portal, 1-800-QUIT-NOW, operated by the National Cancer Institute, automatically routes callers to their state quitline based on their area code. Services are also available in languages other than English. 1-855-DEJELO-YA links callers to Spanish-language services from their state quitlines, and the Asian Smokers' Quitline offers services in Chinese, Korean, and Vietnamese.

State quitlines are highly effective and widely accessible.[1,19] Using quitlines increases the chance of quitting successfully, and combining quitline counseling with medication is more effective than using either alone.[19] Because anyone with a phone can call a quitline, quitlines can reach more people at lower cost than face-to-face interventions. Quitlines may be the only free cessation resource available to tobacco users who are uninsured or live far from a healthcare provider.[40] They are also convenient because they operate during evenings and weekends, reducing transportation and child care barriers.[50]

Despite these advantages, state quitlines only reach about 1% of people who smoke each year.[1] *Best Practices 2014* recommends that state quitlines reach at least 8% of people who use tobacco.[1] Quitlines struggle to reach more people, in part, because of chronic underfunding for operations and promotion.[40] Budget constraints can force quitlines to shorten hours of operation, scale back communications campaigns, or limit proactive calls made by the quitline and provision of medication.[52]

Strategies to support state quitlines focus on securing consistent quitline funding and increasing reach among the uninsured, underinsured (callers whose health insurance does not provide adequate cessation coverage), and other underserved populations. With enhanced resources and promotion, quitlines have the potential to significantly increase their reach and impact.

Taking a Comprehensive Approach

The three cessation interventions described earlier are effective on their own and have an even larger impact when implemented together. For example, comprehensive, barrier-free cessation coverage supports health systems change by making the provider's job easier. State quitlines can also serve as a "treatment extender," reinforcing and enhancing treatment by healthcare providers.

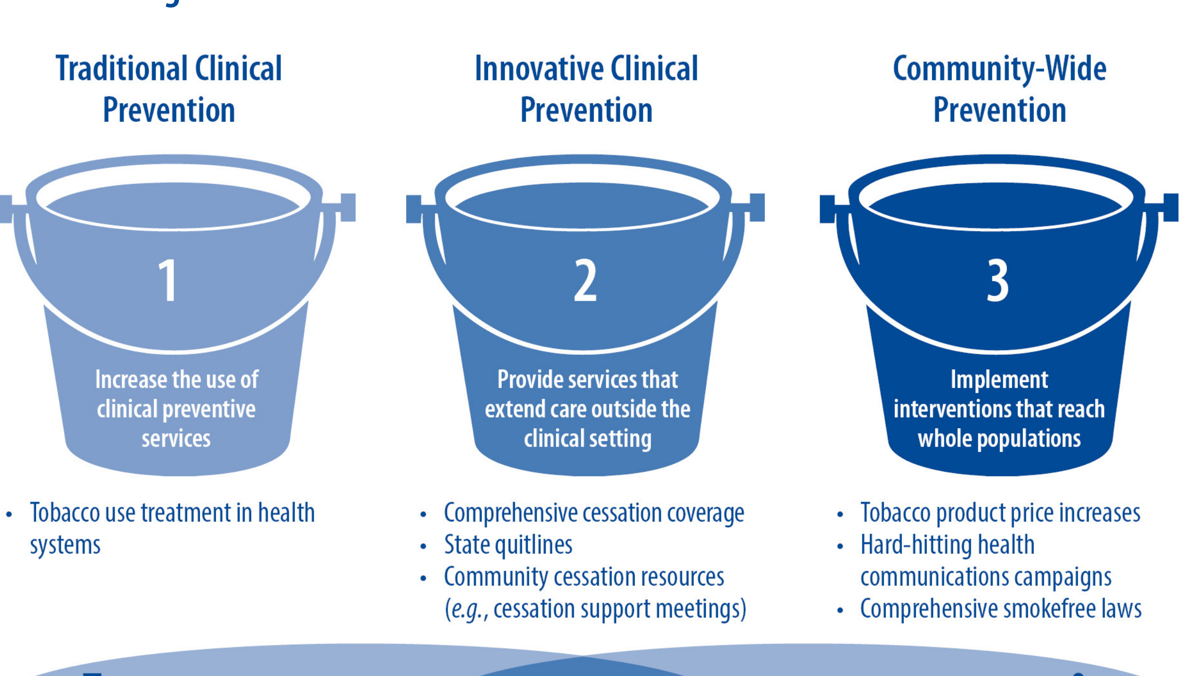
CDC's ***Three Buckets of Prevention*** framework shown in **Figure 4** can help programs map out a comprehensive approach. Bucket 1 includes traditional prevention strategies delivered to patients in clinical settings, such as screening for tobacco use at a doctor's office. Bucket 2 includes innovative strategies delivered outside the clinical setting, such as incorporating tobacco screening into community health programs. Bucket 2 interventions may be implemented by community health workers, nurses, or other healthcare providers.

Bucket 3 includes population-based strategies delivered in the community or workplace, such as implementing and enforcing smokefree laws. These interventions may be led by community members or decision makers. Strategies in Bucket 3 support cessation in several ways:[1]

- Conducting health communications campaigns motivates people who smoke to quit and makes them aware of available treatment.
- Implementing comprehensive smokefree laws creates a supportive environment for quitting and motivates smokers to quit.
- Increasing the price of tobacco products encourages people to quit and could generate revenue for cessation services.

To make the largest gains, it is important to coordinate strategies across all three buckets.[53]

Figure 4. Tobacco Cessation in CDC's Three Buckets of Prevention



Source: Auerbach[53]

Getting Started

A strong tobacco cessation effort begins with a clear understanding of the quality of cessation services and how healthcare systems work in the state. Program staff can use this information to identify areas where the state is doing well and where improvement is needed, select strategies that could make a big impact on cessation, and choose partners.

Understanding Health Care Delivery

Understanding how the healthcare system works is an important first step, especially if tobacco control staff have not worked with health systems or insurers before. These partners may have very different needs, goals, and concerns from those of the program.[53] They may use different terminology and work in different environments.[54] Program staff can review information on the following topics:

- Parts of the healthcare system and how they influence health care delivery (*e.g.*, hospitals and private practices)[44]
- Challenges faced by the healthcare system to improve care and reduce cost[55]
- Quality improvement and its role in health care[44]
- Types of health plans[44]
- The role of federal and state requirements in promoting cessation[56]
- Common terms used by health systems and insurers to talk about cessation[54]
- Key healthcare decision makers[44]

New tobacco control staff can also review information on effective cessation treatments from the Clinical Practice Guideline on ***Treating Tobacco Use and Dependence*** and the U.S. Preventive Services Task Force recommendations for ***Tobacco Smoking Cessation in Adults***. For a complete list of resources, see ***page 52***.

Gathering Information

Programs can start gathering information by identifying the state's largest health plans, employers, and health systems. These organizations are rich sources of information about cessation services in the state. They can provide information on what treatment options are covered and how treatment is provided. The Healthcare Effectiveness Data and Information Set (HEDIS) is also used by more than 90 percent of health plans to track performance.[57]

Information about state employee coverage is also useful, because the state is often one of the largest employers and helps set the standard for private coverage.[1] It is also important to gather information about cessation coverage under other plans, including Medicaid managed care plans and plans offered through the state health insurance marketplace. See ***page 9*** for a list of questions to ask staff of health systems and health plans about cessation services.

Health systems may already collect information about tobacco use and cessation treatment in EHRs and hospital admissions databases. Hospitals also conduct community health needs assessments every three years to identify the community's health priorities and create a plan to meet these needs. Learn more about how these assessments can help inform cessation strategies in the American Lung Association's toolkit, ***Hospital Community Benefits and Tobacco Cessation***. Other helpful data sources on tobacco use trends

include the National Survey on Drug Use and Health (***NSDUH***) and the Behavioral Risk Factor Surveillance System (***BRFSS***).

State agencies such as Medicaid or departments of mental health can also be important resources for information about tobacco use and treatment

Understanding Cessation Services in the State

A complete assessment of a state's cessation services includes questions about tobacco use treatment, cessation coverage, the state quitline, and cessation support for priority populations. Input from many different people may be needed to answer questions, including health plan staff, state Medicaid program staff, employee benefits managers, health systems leadership, and quality improvement staff. Local health and social service organizations are also valuable resources for learning about community assets and needs.

Tobacco Use Treatment

- Do health systems routinely screen patients for tobacco use and advise them to quit?[58]
- How do healthcare staff feel about tobacco use? How many of them use tobacco?[45]
- How often are healthcare staff trained in treating tobacco use? Which staff are trained?[58]
- How supportive is health system leadership of treating tobacco use?[55]
- Is cessation included in health system goals and quality improvement strategies?[55]
- Do health systems record patient tobacco use and cessation treatment in EHRs?[58]

Cessation Coverage

- How many people are covered by each of the state's large health plans?[59] How many people in each plan use tobacco?
- What cessation counseling options are covered?[60]
- Which FDA-approved cessation medications are covered by each health plan, and for how long?[61]
- Is the cessation benefit offered by the health plan standard or an additional benefit with a cost?[61]
- Are there barriers to accessing treatment, such as copays, prior authorization, or coverage limits?[58]
- How do health plans promote cessation coverage to members and providers?[60]

State Quitline Capacity

- Who uses the state quitline?[10]
- What types and quantities of services does the quitline provide?[10]
- Do health systems refer patients to the quitline? How many patients do they refer each year?
- Do health systems use EHRs to refer patients to the quitline?[58]
- How many members from each plan are referred to and use the quitline each year?[60]

Priority Populations

- What is the rate of cessation coverage and treatment use among populations with higher tobacco use?
- Are tailored resources in place to meet the needs of these populations?[62]
- What type of health insurance plan is offered to the Medicaid population (*e.g.*, fee-for-service vs. managed care, or both)?[63]
- What cessation treatments are covered under Medicaid? Are there any barriers to accessing covered treatments?[62]

in the state. Learn more about building successful partnerships with Medicaid agencies on ***page 22***.

Existing data sources may not give enough information, especially about private health plans. Programs may need to conduct their own surveys. See the North American Quitline Consortium's ***Public-Private Partnership Initiative*** for sample coverage surveys and the American Academy of Family Physicians resource, ***Treating Tobacco Dependence Practice Manual***, for a sample health system survey.

Collecting information creates an opportunity to form relationships with organizations who may become key partners later on. It is important to respect potential partners' concerns about sharing information.[64] Letting partners know how data will be used and protected may make them more willing to share information that is not publicly available.[64] Once data have been collected, a small group of partners can help staff organize the information so that it can be used for planning.[64]

Identifying Strategic Opportunities

Information collected from health systems and insurers is vital to identify areas where the state is doing well and where improvement is needed, focusing on efforts that:[65]

- Can have a significant impact on cessation
- Can be easily added to the existing system
- Have demonstrated effectiveness
- Are cost-effective

It may also help to make changes in phases, starting with a small pilot project or lower-cost strategies to build momentum for changes that require more resources.[44] This can be especially useful when health systems or plans are reluctant to make changes. For example, tobacco use screening is widely accepted and generally straightforward to implement.[66] Starting with tobacco use screening can help build support for other changes.[66]

Including multiple approaches (*e.g.*, expanding state quitline reach and promoting health systems change) ensures that all partners have something of interest to work on and can help coordinate efforts if cessation initiatives are already underway. It also avoids internal struggles over how to prioritize efforts.[67] When partners come together, new opportunities to promote cessation may appear. Programs with enough flexibility to take advantage of these opportunities can strengthen partnerships and achieve cessation goals.

It is also important to balance the *reach* and *intensity* of interventions when planning strategies. Both increasing the number of quit attempts (through higher reach interventions) and successful cessation (through more intensive strategies) are important to increase the overall quit rate.

Choosing Partners

Partners, such as health systems, large employers, and state agencies, are critical to successful cessation interventions. Partnerships work best when all partners understand their roles and the expectations of the partnership (*e.g.*, the expected commitment of staff time and resources). The following characteristics are important when choosing partners:[44]

- The size and complexity of the partner organization
- The population served by the organization
- The organization's cessation policies and practices
- Obstacles to implementing cessation interventions (*e.g.*, resource or time constraints)
- The organization's current culture toward tobacco use
- Whether the organization has an existing relationship with the tobacco control program

Organizations that have shown a strong commitment to cessation can lead efforts and serve as models for other organizations. Once programs have selected key partners, they are ready to begin planning and implementing cessation efforts. The following sections describe steps to promote health systems change, improve cessation coverage, and support state quitlines.

Promoting Health Systems Change

Health systems change strategies help clinical settings, such as hospitals, health clinics, or private practices, integrate tobacco use treatment into routine care. Although providers often consider helping patients quit an important part of their job, many lack the time and skills to make cessation a priority.[42] Tobacco control staff provide the knowledge and attention necessary to help organizations make system changes. This section describes how programs can support health systems change, including:

- Forming a health systems change team
- Involving partners in systems change efforts
- Creating an action plan for short-term and long-term goals
- Helping healthcare staff embrace change
- Training staff to provide tobacco use treatment
- Supporting health systems during changes

Forming a Health Systems Change Team

Successful health systems change takes the coordinated efforts of many individuals. A team builds support for cessation and ensures changes happen as smoothly as possible. The health systems change team assesses current tobacco use treatment processes, decides what changes to make, and builds support among providers and other staff who will be making the changes. The makeup of the team may vary depending on the size and structure of the health system. The ideal team is large enough to represent all of the key perspectives of the health system but small enough to work as a group.[45] A health systems change team typically includes the following roles (described in **Table 1**):

- Health system leadership
- Initiative coordinator
- Provider or staff champions
- Information technology (IT) staff
- Quality improvement staff

Support from ***health system leadership*** elevates the importance of cessation within the health system. It is especially important in the early stages of the initiative to secure resources, dedicate staff time for planning and training, and communicate the importance of changes to staff.[68] Highlighting the effectiveness of tobacco use treatment and potential cost savings can engage leaders. Program staff can also share what other health systems are doing in cessation and explain how the changes support other system goals such as quality improvement. Learn how to make the case to health system leadership in the American Lung Association's ***How to Make the Case for Tobacco*** and ClearWay Minnesota's ***Return on Investment for Tobacco Cessation***.

The ***initiative coordinator*** leads day-to-day project activities, such as reaching out to clinical offices and convening team meetings. A public health expert, such as a tobacco control staff member, often holds this position. To help the coordinator succeed in their role, it is important to include health system change tasks in their regular job description.[44]

Table 1. Roles and Characteristics of Health System Change Team Members

Possible Team Members	Health Systems Change Role	Key Qualities
Health System Leadership • Chief Executive Officer • Other members of the leadership team (*e.g.*, Chief Operating Officer, Chief Information Officer, and Chief Medical Officer) • Medical directors (*e.g.*, internal medicine, primary care, pediatrics, and emergency medicine) • Nurse managers	• Secure resources and staff time for health systems change • Find and engage champions • Ensure changes complement health system goals • Communicate the importance of changes to staff • Help scale up changes system-wide • Set performance targets and give feedback	• Authority to make system-level changes • Credibility among health system staff • Commitment to improving tobacco use treatment
Initiative Coordinator • State tobacco control program staff • Cessation staff within the health system	• Convene health systems change team meetings • Regularly communicate with team members • Conduct outreach to potential sites (*e.g.*, clinics and departments) • Provide technical assistance and training to staff • Help set performance targets • Oversee data collection and evaluation	• Cessation knowledge • Experience managing complex projects • Familiarity with the health system's culture and practices • Ability to work effectively with many partners, including healthcare providers
Champions • Doctors, nurse practitioners, and physician assistants • Nurses • Health educators • Clinical office managers • Medical assistants • Pharmacists	• Assess and revise office protocols and clinical workflow • Train staff on changes • Encourage staff in other offices and departments to adopt changes • Deliver tobacco use treatment • Monitor performance and report back to health systems change team	• Passion for helping staff and patients quit • Authority to make changes to office protocols, test implementation, and fix problems • Direct access to providers and office staff
IT Staff • IT manager • Data analysts	• Draft and implement EHR changes • Communicate with software developers on behalf of the larger team • Create periodic reports for health systems change team and providers	• Knowledge of the health system's current capabilities • Technical knowledge and skills
Quality Improvement Staff • Quality improvement manager • Data analysts • Operations staff	• Set performance targets • Manage data collection processes for evaluation • Give performance feedback to staff and health systems change team	• Knowledge of the health system's current quality improvement process and existing data • Experience planning and evaluating efforts to improve related chronic disease outcomes (*e.g.*, diabetes and asthma)

Champions lead the changes "on the ground" in clinical settings. Many people can serve as champions, from providers to office managers. The champion's job title is less important than their commitment to cessation and ability to influence and sustain change within the practice.[69] Some champions may volunteer or be identified early; others may not emerge until changes are underway.[44] Multiple champions can share health systems change responsibilities. The health systems change team can support champions by ensuring they have the time, power, and resources to make sustainable changes.[70]

IT and quality improvement staff are both important members of the health systems change team. IT staff are key if the health system is planning changes to the EHR. Quality improvement staff may be able to streamline efforts by sharing how cessation data are collected for other quality initiatives. The team may also include health system staff from other roles, including marketing, legal, accounting, or pharmacy.

Involving Partners

Partnerships are critical to extend and support the work of the health systems change team. Many different organizations may be able to help make health systems changes:

- Health-related professional associations, such as the American Medical Association, the American Nursing Association, and state medical associations, can provide cessation information and training to their members[64]
- Hospital associations can build support for health systems change and recruit health systems to participate
- Primary care associations can share resources and training with providers serving uninsured or underinsured populations[64]
- Quality improvement organizations can provide technical assistance, IT consulting, and data for planning and evaluation[64]
- Employers and health plans can improve coverage and reimbursement for cessation treatment and promote cessation services to their members[44]
- Local media can inform the public about available cessation services and share patient success stories[44]
- State tobacco quitlines can share data, set up a referral system, and provide materials for patients
- Other health systems can share their successes, challenges, and lessons learned making health systems changes

For a map of Primary Care Associations, visit the ***Health Resources Services Administration*** website. A list of Quality Improvement Organizations is available on the ***Center for Medicare & Medicaid Services*** website.

The strongest partners are those with a clear interest in cessation and systems change, strong credibility with health systems and providers, and resources to support the initiative.[64] When approaching potential partners, it is important to explain the purpose of the initiative, the role of the tobacco control program, and what they would gain from participating. Patient and provider testimonials and endorsements from state healthcare leaders can encourage other partners to join.[64]

Bringing partners and health systems together regularly gives everyone working on health systems change a chance to coordinate activities and learn from each other's experiences. It also helps streamline the work of the tobacco control program by allowing partners to seek answers from each other before turning to tobacco control staff for help. Large initiatives may also consider forming smaller groups of partners focused on particular tasks, topics, or populations, such as a tribal work group. Learn more about forming partnerships in the CDC Division for Heart Disease and Stroke Prevention resource, ***A Guide to Facilitating Health Systems Change***.

Creating an Action Plan

The health systems change team can begin its work by drafting an action plan with clear short- and long-term goals, objectives, and activities.[64] The plan typically includes team member roles, deadlines, and steps to evaluate the initiative.

A critical first step is to understand what is already happening within the health system. For instance, how often are patients advised to quit? Some of this information may have been collected during planning (see the Gathering Information section on ***page 8***).

Engaging Pharmacists as Partners in Cessation

Pharmacists play an increasingly important role in promoting community health, making them a natural partner for cessation. Pharmacists are consistently rated among the most trusted healthcare providers.[71,72] They are also accessible—most Americans live within five miles of a pharmacy and visit a pharmacist up to 10 times more often than primary care providers.[73,74] They often have convenient hours and do not require appointments, making them especially important for vulnerable populations who may face barriers visiting other providers.[75] In some states, pharmacists can provide counseling and cessation medications according to statewide protocols.[76] In other states, pharmacists provide cessation counseling and over-the-counter cessation medications, working with patients' other providers when prescription medications are necessary.[77]

Flyer promoting pharmacists as resource for people who want to quit smoking Source: California Tobacco Control Program

Yet pharmacists can face challenges to providing cessation counseling. Reimbursement concerns and lack of time or training can all be barriers.[75] Tobacco control programs can involve pharmacists in promoting cessation through the following actions:

- Learn what pharmacists can and cannot do in the state—in some states, pharmacists may need to form collaborative practice agreements with providers to deliver cessation services.
- Educate decision makers about the importance of allowing pharmacists to deliver cessation counseling and medication and reimbursing them for treatment.
- Train pharmacists how to ask about tobacco use at prescription intake and give brief advice using a simple, fast framework such as Ask-Advise-Refer (depicted on ***page 15***).
- Offer continuing education credits to pharmacists for tobacco use treatment training.
- Work with pharmacists in inpatient settings, such as hospitals or substance use treatment centers, to treat tobacco use, and include cessation counseling and medication instructions on discharge.
- Encourage pharmacists to support ending tobacco product sales in pharmacies.

Learn more about involving pharmacists in cessation in the Tobacco Control Network resource, ***Access to Tobacco Cessation Medication through Pharmacists*** and get access to free online cessation training for healthcare providers at ***Rx for Change***. Free resources and materials are also available on CDC's ***Tips From Former Smokers®*** website.

A workflow assessment describes in more detail how tobacco use treatment is delivered. Workflow assessments can be completed at the provider, clinic, unit, or department level. Staff input is also essential at this stage. They may have concerns about integrating tobacco use treatment into their practices.[45] See an example of a workflow assessment and staff survey in the University of Colorado online training, ***Foundations and Strategies of Tobacco Control***.

The results of this information gathering phase can help the health systems change team decide what they want to achieve and set short- and long-term goals. An important role of tobacco control staff is to help the team choose evidence-based strategies. Staff can educate the larger team on clinical practice guidelines and encourage them to adopt a tobacco use treatment model like those shown below.

One approach is to create a "menu" of evidence-based strategies that gives health systems some flexibility to choose the option that will work best for their system and available resources, while ensuring high-quality care for each patient.[68] **Table 2** on ***page 17*** outlines a sample menu of strategies and planning questions to guide the health systems change team. For a list of more strategies and tools to integrate tobacco treatment into clinical care, see the Million Hearts® resource, the ***Tobacco Cessation Change Package***.

Completing health systems changes in phases can make the process more manageable, especially when time and resources are limited. Testing changes with a small number of providers or one department can help find and resolve potential problems quickly. This approach can also create buy-in among early adopters whose support can build momentum for more complex

Understanding Tobacco Use Treatment Models

The ***5 As*** brief intervention model is a simple framework to ask about tobacco use and offer help to quit.[78] Yet implementation of all five As is inconsistent, with fewer providers assisting with quit attempts and arranging follow-up.[79] Other models have streamlined the 5As to three steps. ***Ask-Advise-Refer*** guides providers to assess tobacco use, advise patients to quit, and refer them to cessation resources such as quitlines.[78] ***Ask-Advise-Connect*** focuses on connecting patients directly to cessation resources through a link in the EHR.[80]

The 5 As
to help patients quit

ASK about tobacco use
ADVISE to quit
ASSESS readiness to quit
ASSIST in the quit attempt
ARRANGE follow-up

Ask-Advise-Refer
to help patients quit

ASK about tobacco use
ADVISE to quit
REFER to outside help

Ask-Advise-Connect
to help patients quit

ASK about tobacco use
ADVISE to quit
CONNECT to resources

Adapted from: CDC[78] and Vidrine et al[80]

changes.[44] A planning framework like the ***Model for Improvement*** helps staff test changes and learn from the results in small, rapid cycles. The model uses Plan-Do-Study-Act cycles to quickly test small changes:[81]

- Plan: Develop a plan to test the change
- Do: Test the change on a small scale
- Study: Observe the test and learn from the results
- Act: Make changes based on what was learned

Small changes that are likely to be met with little resistance may be appealing to the planning team, but it is important that programs also pursue more significant changes. Ideally, these “small wins” are steps toward adopting more complex changes.

For more guidance on supporting the health systems change team during planning, see the Partnership for Prevention’s action guide on ***Healthcare Provider Reminder Systems, Provider Education, and Patient Education*** and ClearWay Minnesota’s ***Tobacco Health Systems Change Starter Toolkit for Clinics***.

Helping Staff Embrace Change

Successful health systems change depends on all staff making tobacco use treatment a priority. Building support among all clinical team members helps ensure new protocols are actually used in practice.[45] Staff can also provide valuable information about how changes are working and what needs improvement. Healthcare staff are more likely to support changes if they:[70]

- Understand the reason and goals for the changes
- Feel included in the process
- Like and respect the person(s) making changes
- Like the way changes are communicated
- Have a sense of challenge and achievement

The tobacco control program can educate staff on the importance of cessation for their patients. Using data can help show the need for the change. Explaining how treating tobacco use can help meet other goals, such as reimbursement through the Centers for Medicare & Medicaid Services’ ***Quality Payment Program***, can also help build support among providers.

Staff want to know how health systems changes will affect their day-to-day activities. Champions can help explain the changes, describing how roles and responsibilities will be defined and how patient care will be improved.[70] Staff may also be able to identify potential challenges early on and brainstorm solutions. Involving staff in the decision-making process can motivate them to take part and decrease resistance.

Reaching busy providers can be challenging, especially when patient visits and office hours limit opportunities to meet in person. Using multiple communications methods and repeating messages helps spread the word. Phone calls and webinars supplement presentations at staff meetings, one-on-one visits, and online training modules. Email may not be the best way to reach providers; other forms of electronic communication like e-newsletters and posts on the health system’s website or intranet may be more successful.[82]

Table 2. Menu of Health Systems Change Strategies

Strategy	Planning Questions
Identification and documentation: Ask every patient about tobacco use at every visit	• Who will ask patients about tobacco use? • What questions will be asked (*e.g.*, form of tobacco, frequency of use)? • What method will be used (*e.g.*, written intake form, verbal assessment) and how will responses be recorded?
Brief tobacco use treatment: Select a tobacco use treatment model and incorporate it into the clinical workflow	• What evidence-based model will be used (*e.g.*, 5As, Ask-Advise-Refer)? • Who will carry out each step? • When will each step occur? • What information will be needed for each step? • How will treatment be documented?
Provider reminder system: Create a system to remind providers to talk to patients about quitting	• How will reminders be delivered (*e.g.*, chart stickers, EHR alerts)? • Will the reminder system include information to help providers make decisions (*e.g.*, clinical guidelines, talking points)?
Provider education: Train healthcare staff on treating tobacco use and provide supporting educational materials	• What will be the objectives of healthcare provider training? • How will training be delivered (*e.g.*, in-person, online, a mix of formats)? • How often will the training be delivered? • How will training and materials be tailored for providers who treat priority populations?
Referrals: Create a referral system for tobacco users interested in counseling	• Where will patients who use tobacco be referred (*e.g.*, state quitline, community cessation programs, tobacco treatment specialists in the health system)? • How will referrals be made (*e.g.*, fax, EHR)? • How will providers be updated on patient progress?
Follow-up care: Develop a process to follow up with patients who receive tobacco use treatment	• Who will follow up with these patients, when, and how? • What information will be covered (*e.g.*, services used, ongoing needs)? • How will follow-up be documented and tracked?
Reporting and feedback: Create a system to regularly share tobacco use and treatment data with healthcare staff	• How will progress be tracked (*e.g.*, patient chart audits, EHRs) • How will data be shared with leadership and staff, and how often?
Chronic disease integration: Integrate cessation into protocols for managing chronic diseases	• How can cessation be included in group visits or other chronic disease management programs? • How can cessation information be included in health education efforts for patients with chronic conditions?
Quality improvement, accreditation, and standards: Integrate cessation treatment into existing quality improvement, accreditation, and performance efforts	• What cessation measures are currently tracked (*e.g.*, screening, treatment delivery, quit rates)? • What existing performance and accreditation standards relate to cessation (*e.g.*, Joint Commission hospital performance measures)?
Reimbursement: Develop coding and billing practices to reimburse providers for cessation services	• How will providers bill for tobacco use treatment? • What training will be provided on billing and coding for cessation treatment? • Who will be trained (*e.g.*, providers, medical billing staff)?
Population management: Create a tobacco use registry to follow up with patients who have reported current use	• Where will registry information be housed (*e.g.*, spreadsheet, EHR)? • Who will develop and maintain the registry? • Who will follow up with patients?

Adapted from: Jansen, Capesius, Lachter, Greenseid, & Keller[68]

Cessation Training Checklist

Effective cessation training has the following characteristics:

- Includes staff from different roles (*e.g.*, doctors, medical assistants, pharmacists, nurses, health educators, office staff, and volunteers)[45]
- Takes place at convenient times, such as before office hours, at lunchtime, or during regular meetings (*e.g.*, staff meetings or grand rounds)[83]
- Covers all forms of tobacco use, including e-cigarettes
- Stays up to date on the latest evidence and adapts as provider needs change[45]
- Occurs periodically to refresh skills[45]
- Offers continuing education credit to encourage participation[45]

Training Healthcare Staff

Providers with cessation training are more likely to advise patients to quit and refer them to the state tobacco quitline, especially when training is combined with a reminder system.[19] Yet surveys reveal that most providers have not been trained to talk to patients about tobacco use and are not aware of clinical practice guidelines.[42]

Cessation training is typically delivered through in-person lectures, role play, and discussion led by trained specialists (often tobacco control staff).[44] Training increasingly includes hands-on technical assistance, such as help developing office protocols. However, in-person training is more costly and a greater time commitment for program staff than other formats, such as online training. Online training is a convenient, low-cost alternative to in-person training but usually cannot be tailored to the health system's specific context or local resources.[43] Online training also does not generally include technical assistance. Including a mix of formats can help keep costs down while customizing some information. For example, providers might watch an online tutorial on the 5As and use face-to-face training to practice what they have learned. Learn more about online training at ***Rx for Change*** and the University of Wisconsin's ***Tobacco Treatment Training***.

A "train-the-trainer" model may also help reduce training costs. In this approach, providers are trained on the curriculum and then teach other providers. Peer training may be easier to integrate with existing training and be better received than training by outside staff.[68] Since quitting tobacco helps prevent other chronic diseases such as heart disease and cancer, training costs could also be shared across other chronic disease programs.[19,84]

Supporting Health Systems during Changes

Tobacco control programs become health systems' biggest supporters as they begin to make changes, making sure that project activities keep moving forward. Programs can help make health systems changes by meeting regularly with healthcare staff and discussing performance data with staff and leadership.

Scheduling regular meetings or calls with staff builds in time to evaluate progress, plan activities, and deal with barriers that may occur during implementation, such as staff resistance or turnover. Tobacco control staff can also use meeting time to brainstorm solutions and give more training when needed. Periodic outreach (*e.g.*, newsletters with updates on the latest research, resources, and training opportunities) can also keep providers engaged in cessation activities, even as different priorities may compete for their attention.

Staff are more likely to support changes if they feel a sense of progress and achievement. Health systems can prepare reports using EHR data to show progress toward project benchmarks and identify areas for improvement. Sometimes called "performance feedback," reports can be shared with individual providers, clinics, departments, or across the whole system. Posting results on clinic performance boards or including data from multiple sites can spark friendly competition and motivate staff to make changes.[85] More frequent performance feedback is useful at the start of the initiative so staff can make adjustments.[44] Periodic reports are helpful later on as staff maintain changes.[44] Learn more about sustaining health systems changes on ***page 42***.

A CLOSER LOOK: Electronic Health Records (EHRs)

EHRs are digital versions of paper patient charts.[86] They contain medical histories and can also include other features, such as templates to save time and evidence-based tools to help providers make decisions about patient care.[86] As of 2015, most providers used some form of EHRs, although many only have a basic system that may not include extra features.[87] EHR use is also lower among rural and specialty hospitals.[88]

As health systems adopt and improve EHRs, tobacco control programs have an opportunity to encourage changes that make it easier to deliver cessation treatment. EHRs can include fields to document tobacco use status, alerts that remind providers to counsel patients, and guidance on how to talk about tobacco use with patients. They can also be used to give healthcare staff performance feedback and document health systems change outcomes. When EHRs include cessation information, rates of screening and referrals increase.[89,90]

It is important that EHRs are easy to use and include current, evidence-based information on treating tobacco use.[43] EHRs will vary depending on the needs of the health system but are most useful when they mirror the provider's workflow and include fields for every step of tobacco use treatment (*e.g.*, documenting tobacco use status, advising to quit, offering counseling and medication, and creating a follow-up plan).[43] Check boxes, drop-down lists, and pre-populated fields (*e.g.*, provider notes and medication order sets) can simplify data entry.[91] Cessation information can also be programmed to appear at all wellness visits and when patients have related health conditions, such as a cough, diabetes, or depression.[92]

EHR changes require input from many partners across the health system. Tobacco control staff can help coordinate efforts to include cessation in EHRs by:

- Asking the health systems change team to assess current system capabilities, including existing cessation-related EHR features, available financial resources, high-speed internet access, IT staff capacity, and data entry skills of healthcare staff[93]
- Meeting with health system leadership to get their support for EHR changes[93]
- Ensuring IT staff is involved early in planning to answer technical questions[94]
- Forming partnerships with the state quitline to add electronic referrals to the EHR[95]
- Consulting medical billing staff to ensure the EHR includes the right billing codes[96]
- Asking healthcare staff to test EHR changes to ensure that they match the patient visit workflow and include clear recommendations[45]
- Training all staff on how to use new EHR functions for treating tobacco use[45]

Visit HealthIT.gov's ***Health IT Playbook*** and the American Academy of Family Physicians resource, ***Integrating Tobacco Cessation Into Electronic Health Records***, for examples and more on EHRs.

Improving Cessation Coverage

Comprehensive coverage makes tobacco cessation treatment more accessible and affordable and supports healthcare providers' efforts to treat tobacco use.[1] Tobacco control programs can help improve cessation coverage by:

- Working with employers and health insurers
- Improving Medicaid cessation coverage
- Working with state and local health benefit agencies to improve cessation coverage for state and local government employees
- Raising awareness of coverage through health communications campaigns

Working with Employers and Health Insurers

As of 2018, more than two-thirds of U.S. adults had private health insurance, and more than half got insurance through their employer.[97] State programs can help improve private coverage by educating employers and health insurers about the benefits of cessation coverage and tobacco-free workplaces.

Educating Employers and Insurers on Benefits of Cessation Coverage

People who smoke have higher health and life insurance costs, more missed days of work, and lower productivity than people who do not smoke.[18,98,99] Yet employers and health insurers may hesitate to offer comprehensive cessation coverage because of misunderstandings about its costs and benefits. In fact, cessation coverage is actually saves employers and insurers money by lowering healthcare costs.[19,100] **Figure 5** describes key messages about cessation coverage that staff can communicate to employers and health plans.

Online return-on-investment (ROI) calculators can also help estimate potential cost savings. Tools such as the America's Health Insurance Plans ***ROI Calculator*** compares the cost of usual care to the cost of providing cessation coverage. It also takes into account healthcare cost savings and productivity increases when people who smoke quit. Examples from other employers and insurers can also show the positive financial impact of investing in cessation coverage.

Hosting summits, or meetings that bring together key leaders, is another way to raise awareness about the importance of improving cessation coverage. Summits teach representatives from large employers, business coalitions, and insurance companies what is included in comprehensive cessation coverage and the benefits of providing coverage.[101] Participants can explore partnerships, learn from others' experiences, and share resources.[101] Surveying health plans and employers

Web banner from Oklahoma's "Tobacco Stops with Me" campaign Source: Oklahoma Tobacco Settlement Endowment Trust

Figure 5. Key Messages for Employers and Insurers

Key Messages

Cessation coverage is a low-cost health insurance benefit.
The estimated cost for cessation coverage at levels under the Affordable Care Act is $0.10 or less per member per month.[100]

Employees who quit tobacco save employers money.
After quitting tobacco, employees have increased productivity and lower healthcare costs.[19]

Savings from quitting tobacco add up quickly.
Lower healthcare costs alone can save employers money in less than two years.[20]

Quitting tobacco is easier with help.
The nicotine in tobacco products is highly addictive.[12] Employers and insurers can support people who want to quit smoking by covering evidence-based cessation treatment and creating a tobacco-free workplace.

Charging people who smoke higher insurance premiums than nonsmokers does not increase cessation.[102]
Higher premiums could also lead smokers to misrepresent their tobacco use status, avoid seeking help to quit, or forego insurance.[1]

about their cessation coverage before the summit allows them to discuss the results when they meet. See the North American Quitline Consortium's ***Resource Center*** for sample surveys.

Encouraging Tobacco-Free Workplaces

Workplace policies and practices that support cessation make quitting tobacco easier for employees and encourage them to use cessation coverage.[103]

Employers can take the following steps to create tobacco-free workplaces:[104]

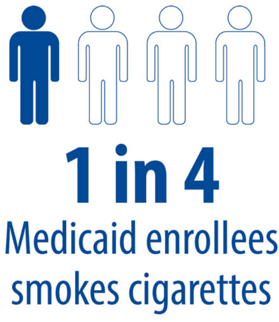
- Implement and enforce written policies for a tobacco-free workplace
- Promote available cessation coverage to employees to increase awareness and use
- Form a cost-sharing partnership with the state tobacco quitline to provide employee cessation services (learn more on ***page 27***)

- Recognize and reward employees who successfully quit tobacco
- Ask employees who have quit tobacco to share their stories in employee newsletters or on company websites
- Regularly evaluate cessation policies and practices to ensure they still meet employees' needs

Improving Medicaid Cessation Coverage

Medicaid provides health insurance coverage to millions of low-income Americans.[105] One in four Medicaid enrollees smokes, more than twice the rate of adults with private health insurance (see **Figure 6**).[106] Although they express similar interest in quitting as people with private insurance who smoke, Medicaid enrollees who smoke are less likely to quit successfully.[11] Improving tobacco cessation coverage among Medicaid enrollees can help reduce these disparities.[4]

Figure 6. Smoking among Medicaid Enrollees, 2016



Source: Jamal[106]

According to *Best Practices 2014*, "providing comprehensive state Medicaid cessation coverage is one of the most important steps a state can take to increase cessation and reduce tobacco use."[1] **Figure 7** lists what is included in comprehensive cessation benefits. Helping people enrolled in Medicaid quit smoking can also save states money. One study found that reducing adult smoking prevalence by just 1% saved states an average of $26 million in Medicaid costs the following year ($2.5 billion total across all states).[107]

Since 2014, traditional state Medicaid programs have been required to cover all seven FDA-approved cessation medications for all adult enrollees. Programs do not have to cover cessation counseling and may allow cost-sharing or prior authorization requirements.[108] Since 2010, programs have had to cover all FDA-approved cessation medications plus counseling for pregnant women, without cost-sharing.[108] States that choose to expand Medicaid eligibility under the Affordable Care Act must cover tobacco use as preventive service with an A rating from the U.S. Preventive Services Task Force.[109] Learn more about Medicaid coverage requirements on the American Lung Association web page, ***Tobacco Cessation Treatment: What is Covered?***

Figure 7. Cessation Benefit Checklist

Comprehensive cessation benefits include ALL of these:

- ✓ Nicotine replacement therapy (NRT) gum
- ✓ NRT patch
- ✓ NRT lozenge
- ✓ NRT inhaler
- ✓ NRT spray
- ✓ Buproprion
- ✓ Varenicline
- ✓ Individual counseling
- ✓ Group counseling
- ✓ Phone counseling

Source: American Lung Association[110]

Figure 8. Medicaid Cessation Coverage in 50 States and Washington, DC

Washington, DC

- Covers all 7 FDA-approved cessation medications* AND phone and group counseling, without barriers†
- Covers all 7 FDA-approved medications* AND phone and group counseling, with some barriers*
- Covers all 7 FDA-approved cessation medications*
- Does not cover all 7 FDA-approved cessation medications*

Five forms of nicotine replacement therapy (patch, gum, lozenge, nasal spray, and inhaler), bupropion, and varenicline

† Barriers include copayments, prior authorization requirements, counseling requirements for medications, limits on the duration of treatment and number of quit attempts, and stepped-care requirements. These barriers may vary among a state's different Medicaid managed care plans.

Source: Centers for Disease Control and Prevention[111]

As of March 2019, most state Medicaid programs did not offer comprehensive cessation coverage.[111] Only two states (Kentucky and Missouri) did so without added cost or other barriers (see **Figure 8**).[111] Tobacco control programs can help improve and increase use of Medicaid cessation coverage by forming partnerships with state Medicaid agencies and educating healthcare providers about available cessation benefits.

Medicaid is administered by the states according to broad federal requirements.[105] Traditionally, states have operated Medicaid under a fee-for-service system, in which healthcare providers are paid at set rates for each service they provide.[112] To manage costs and use of services, many state Medicaid agencies contract with managed care organizations (MCOs) that are paid per member per month rather than by service. Building relationships with both state Medicaid agencies and MCOs is crucial to improve Medicaid tobacco cessation

coverage. These partners can help state programs by sharing tobacco use and cessation data, improving benefits, and promoting coverage to Medicaid recipients.

Programs can begin discussions with Medicaid organizations by talking about the health and economic benefits of improving cessation coverage. Information about Medicaid enrollees' tobacco use, tobacco-related healthcare costs, and use of evidence-based treatment are important talking points. To learn more, read the CDC fact sheet, ***STATE System Medicaid Coverage of Tobacco Cessation Treatments***. State Medicaid staff may also be unaware that there is an opportunity for federal funding to cover some of the cost to provide cessation counseling to Medicaid recipients through the state quitline (learn more on ***page 44***).[113]

In states where Medicaid and the tobacco control program do not have an existing partnership, tobacco control staff can take the following steps to form a strong working relationship:

- Understand where Medicaid's priorities align with and differ from those of the tobacco control program (*e.g.*, Medicaid is focused on a single population rather than the population as a whole)[114]
- Conduct cross-training to learn about state Medicaid processes, vocabulary, and cessation requirements and teach state Medicaid staff about tobacco control[114]
- Build support among tobacco control program leadership for state Medicaid partnerships, since communication between the programs may happen at the director level[114]
- Take and distribute notes on any decisions made during planning to help keep things moving if a champion on either side unexpectedly leaves[114]
- Once agencies are ready to begin a partnership, develop a written memorandum of understanding to clarify the purpose, scope, and responsibilities of each partner[63]

Learn more about forming successful partnerships between tobacco control and state Medicaid programs in the CDC ***case study*** on Massachusetts' efforts to increase use of cessation treatment and successful cessation among Medicaid enrollees. CDC's 6|18 Initiative, described on ***page 25***, also focuses on bringing together partners such as state tobacco control and Medicaid programs to improve health and control healthcare costs.[36]

Improving Coverage for State Employees

Because state governments are among the largest employers in the state, improving coverage for state employees could expand access to tobacco cessation treatment. State plans often serve as an example for other health plans.[1]

As of 2018, only nine states—Illinois, Iowa, Massachusetts, Michigan, Minnesota, Mississippi, North Dakota, Rhode Island, and South Carolina—provided comprehensive cessation coverage for all state employees.[115] Tobacco control programs can help state agencies improve coverage by surveying insurers about coverage and sharing the results.[101] They can also help state benefits directors find coverage gaps, educate insurers about the health and economic benefits of coverage, and answer questions.[101]

A CLOSER LOOK: CDC's 6|18 Initiative

Launched in 2015, CDC's 6|18 Initiative was designed to focus on 6 common and costly health conditions, including tobacco use, and 18 evidence-based interventions that can improve health and control costs.[35] Tobacco control goals of 6|18 include improved coverage, barrier-free treatment, and increased use of covered treatments.[36] By strengthening collaboration between public health and health care, 6|18 seeks to put these interventions into practice more quickly to reach the greatest number of people.

The first phase of the initiative brought together federal partners, public health departments, and Medicaid agencies in nine states: Colorado, Georgia, Louisiana, Massachusetts, Michigan, Minnesota, New York, Rhode Island, and South Carolina. The initiative now includes healthcare partners, such as providers, private insurance purchasers (employers responsible for employee health coverage), and payers (public and private health insurers).[116] Bringing many partners together to improve access to evidence-based interventions requires open communication and dialogue.[116] 6|18 partners are working together to:

- Leverage partners' skills to accelerate use of best practices[116]
- Share knowledge among the public health community, insurers, and healthcare providers[54]
- Help the public health community learn the culture and vocabulary of healthcare insurers and providers[54]
- Find common interests and overcome barriers to building effective partnerships[54]

State health department and Medicaid staff report that 6|18 has increased communication, resource sharing, understanding, and accountability among partners.[116] It has also raised awareness of program activities among other stakeholders.[116] Next, 6|18 partners plan to evaluate the initiative and expand to include employers and other states and insurers.[116] To learn more about applying 6|18 strategies to reduce tobacco use, visit the Center for Health Care Strategies' ***Resource Center***.

Similar to how the state offers health insurance to its employees, city and county governments also provide health benefits to their employees.[101] Tobacco control staff can also educate local governments about the importance of comprehensive cessation coverage.

Raising Awareness of Coverage

Comprehensive, barrier-free cessation coverage is only effective if tobacco users and healthcare providers are aware of coverage and use it.[1] Health communications strategies encourage people who smoke to quit, use evidence-based treatments, and turn to providers as a resource. It is important that messages describe which treatments are covered, point out any coverage limits, and explain how to access treatment.[117]

Promotion is especially important when insurers improve coverage. Providing information in multiple ways makes it easy for members to find coverage information and understand how to use it. For example, programs can encourage state Medicaid agencies and health plans to send emails and mailings, post flyers in provider waiting rooms, and include information in member handbooks, newsletters, and websites.[117]

Communications can also include messages for providers urging them to treat tobacco use and explaining how to get reimbursed. For example, New York's *Don't Be Silent About Smoking* campaign emphasized the important role that providers play in helping patients quit. Campaign materials appeared in print, online, and outdoors.[118] Later phases of the campaign sought to increase cessation among low-income New York residents by encouraging providers to educate patients about Medicaid cessation coverage.[118] Learn more about New York's efforts at the ***Talk To Your Patients*** website.

Communications campaigns can also help people enrolled in Medicaid quit smoking. For example, when Wisconsin improved Medicaid cessation coverage, it launched the *Medicaid Covers It* campaign to raise awareness and increase use of covered benefits. Cessation medication claims increased from 1.5% of Medicaid smokers at the beginning of the campaign to 4.4% at the end.[119] Quitline registrations also dramatically increased.[119] Medicaid agencies facing tight budgets may hesitate to promote coverage.[120] Highlighting the potential healthcare cost savings when people enrolled in Medicaid quit smoking may help encourage Medicaid agencies and MCOs to publicize coverage.

Healthcare providers who treat Medicaid patients are also important partners to increase use of cessation benefits among Medicaid enrollees. Providers are trusted by Medicaid patients to deliver cessation messages and can refer patients to quitting resources.[121] It is important for these providers to know what Medicaid covers and understand how to code and bill Medicaid for services. Staff can make sure providers receive training and information on these topics. For example, the Vermont tobacco control program informed medical and dental providers about Medicaid cessation coverage and new reimbursement codes through mailings, webinars, newsletters, and a website.[122]

Wisconsin's "Medicaid Covers It" campaign informed people who smoke about new cessation coverage available through Medicaid Source: University of Wisconsin Center for Tobacco Research and Intervention

Supporting State Quitlines

State tobacco quitlines provide evidence-based, cost-effective cessation services to hundreds of thousands of people each year over the phone, web, and other communications channels.[123] Despite these advantages, quitlines are underfunded and only reach 1 out of 100 people who smoke on average in any given year.[1] To support state quitlines, programs can:

- Form cost-sharing partnerships
- Use new communications technologies
- Promote the quitline through health communications campaigns

Forming Cost-Sharing Partnerships

Partnerships with health insurers and large employers can help offset quitline costs and reach more people. These public-private partnerships can use several different cost-sharing models:[56]

- Triage and transfer: the state quitline receives all incoming calls, and the partner pays for callers to be transferred to cessation services provided by the partner
- Independent contract: the partner contracts directly with the quitline vendor, expanding the reach of the quitline with little to no involvement by the state program
- Reimbursement: the state quitline provides all services and the partner reimburses the quitline for some or all of the cost
- Cooperative fax referral: the state quitline and health insurance plans share costs for a single fax referral system, which may provide all services through the state quitline or transfer insured callers to services operated by the health plans

Which model will work best depends on the capacity of both the state quitline and the potential partner. The triage and transfer model can work well when the partner offers its own high-quality, evidence-based cessation services.[56] In other cases, a reimbursement model where the quitline provides all services may work best. This approach ensures high-quality services for every caller, but the state quitline must be able to serve a large number of callers.[56]

Programs can start the work of forming partnerships by finding out who uses the quitline and where gaps in cessation coverage exist.[101] This can help identify insurers and employers that may make good partners. It also lays the groundwork for strong relationships as programs work with potential partners to collect information about how their members and employees use quitlines.[101] Focusing on large health plans and employers helps partnerships have the greatest impact by expanding quitline reach to many people at once.[101]

Making the Case for Cost-Sharing

Supporting the state quitline helps employers and health plans provide highly effective cessation treatment. To make a strong case to potential partners for sharing costs, tobacco control staff can emphasize the following points:

- Quitlines increase the likelihood of quitting successfully.[19]
- Quitlines are widely accessible and offer convenient hours.[19,50]
- Supporting quitlines is a smart investment: people who quit smoking have greater productivity, reduced absenteeism, and lower healthcare costs.[19]
- Partnering with the quitline can help plans meet federal requirements.[124]
- Partner support is important to maintain consistent, high-quality quitline service for all callers.[1]

Health insurance purchasing groups or unions can also be potential cost-sharing partners. Learn more about gathering coverage information from partners on ***page 8***.

Once programs have identified potential partners, they are ready to reach out to partners about the possibility of cost sharing. Effective strategies to bring partners to the table include:

- Educating partners about the health and financial benefits of cost-sharing[101]
- Building support among state health department leadership, who can communicate with leaders at partner organizations[101]
- Participating in partnership initiatives, such as CDC's 6|18 Initiative[101]
- Leading by example to form cost-sharing partnerships with the state Medicaid agency and the state employee benefits program[56]

Financial constraints may sometimes require quitline services to be limited to certain groups of callers, such as Medicaid enrollees or those without insurance. However, limiting services can also limit the reach of services and potential for future partnerships. States have found that potential partners appreciate the program working with partners first, rather than requiring cost-sharing or strategically limiting services.[56]

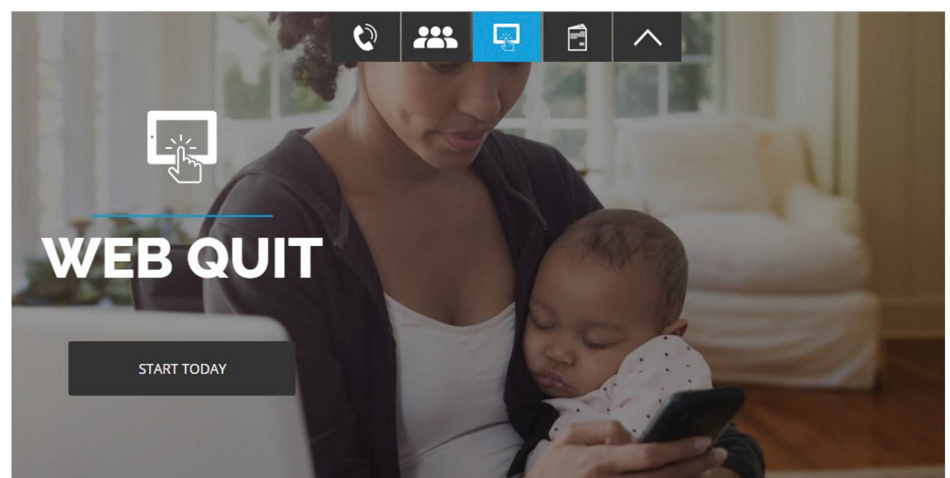
Once insurers and employers are ready to develop a partnership, a written cost-sharing agreement can help clearly define roles and how costs will be shared.[63] An ideal agreement is formed through consensus, requires partners to promote the quitline to their members, includes data sharing, and maintains quality services.

Learn more about developing partnerships from the North American Quitline Consortium's ***Public-Private Partnerships Initiative***.

Using New Quitline Technologies

The way that people communicate has changed drastically over the past decade.[125] As of 2019, almost every U.S. adult has a cell phone and 8 out of 10 own smartphones.[125] A growing number of quitlines offer cessation services through digital channels in addition to telephone-based services.[50] Text-messaging programs send messages to a user's phone with quitting advice and encouragement, and some can tailor messages based on responses from users.[126] Smartphone apps offer interactive features, such as progress trackers and customized reminders, to support people who want to quit using tobacco.[127] Cessation services can also be delivered through websites and other online tools. These web-based services may simply share information or include interactive features like personalized quit plans and online chat tools.[128]

These new technologies are promising because they could expand the reach of telephone quitlines, especially among young people who might not seek more traditional methods of treatment.[129] They can also be used at times that telephone services and clinics are not operating.[130] Despite these potential advantages, evidence of effectiveness for new quitline technologies varies greatly and is not yet equal to that of telephone quitlines.[50] New technologies work best when used to supplement, rather than replace, telephone quitlines. As programs add these technologies, they can contribute to the evidence base by carefully evaluating their use. It



Screenshot from Tobacco Free Florida's ***Quit Your Way*** *website designed to help visitors quit tobacco*
Source: tobaccofreeflorida.com/quityourway

is important that programs use new technologies with the following characteristics:[50]

- Follow clinical practice guidelines
- Connect users to other cessation services, such as telephone quitlines
- Feature interactive elements like group chat or real-time messaging with a counselor
- Deliver frequent, customized quitting messages based on the user's tobacco use history, current health information, and reasons for quitting

Learn more about the pros and cons of new cessation technologies in **Table 3** below.

Table 3. Pros and Cons of New Cessation Technologies

Platform	Pros	Cons	Example
Text Messaging	• Can be used by anyone with a basic cell phone • Can reach large audiences at low cost[131] • Strong evidence of effectiveness[132] • Can support telephone quitlines with reminder texts[50]	• Communication limited to text and simple graphics[127] • High participant dropout rates[133] • Some may offer only automated messages with no interactive chat feature[50] • Messages may only be delivered for a set period of time • Requires users to have a data or texting plan	***https://smokefree.gov/SmokefreeTXT***
Smartphone Apps	• Can deliver customized support based on users' mood, smoking history, or triggers[127] • Can include interactive progress trackers and challenges[127] • Can include games and videos to distract from cravings[133] • Can deliver messages at certain locations or times of day when extra support is needed[134]	• Require a smartphone data plan • Most do not follow U.S. clinical practice guidelines[135] • Evidence of effectiveness is still emerging[127] • Require user to open app regularly[133] • Users may be able to turn off notifications	***https://smokefree.gov/tools-tips/apps***
Web-based Services	• Can reach large audiences at low cost[50] • Can include interactive tools such as online chat, blogs, or build-your-own quit plan[50] • Can be accessed from anywhere with a computer, such as public libraries or internet cafes[50]	• Require internet access • May be challenging to keep participants engaged[136] • Website maintenance can be time consuming[137]	***http://tobaccofreeflorida.com/quityourway***

Promoting State Quitlines

Quitlines are more likely to be effective if people are aware of available services and how to reach them.[138] Three strategies are effective to promote state quitlines:[123]

- Implement health communications campaigns featuring quitline contact information
- Promote the availability of free cessation medication for quitline callers
- Generate referrals from healthcare providers and community organizations

Implementing Health Communications Campaigns

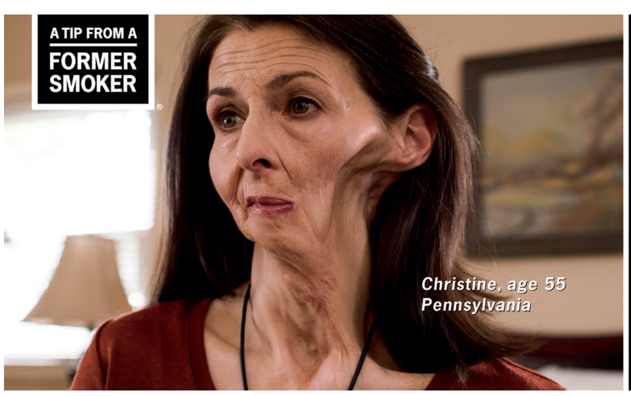
Health communications campaigns increase cessation by motivating people who smoke to try to quit.[123] Campaigns can also motivate people to contact the quitline and educate providers on the importance of helping patients quit.[123] The most effective messages combine hard-hitting information about the negative health consequences of smoking with how to contact the quitline.[139] For example, the *Tips From Former Smokers®* campaign features adults who have quit smoking and are living with the serious health effects of tobacco use. Campaign messages also included the quitline portal telephone number, 1-800-QUIT-NOW, and the National Cancer Institute website http://www.smokefree.gov. The campaign led to over nine million quit attempts and over a half million successful quits in only three years.[38] From just March to June 2012, the campaign increased quitline calls by 132% and visits to the website by 428%.[140]

Programs may also choose to develop campaigns on other issues, such as raising awareness about a new comprehensive smokefree law. It is important that all campaigns are tagged with quitline contact information so people who decide to try to quit smoking know where they can get help.

Paid ads on TV, radio, billboards, transit, newspapers, magazines, and the internet are one of the best ways to raise awareness of the quitline.[141] Paid media allows programs to reach large audiences, but some channels are expensive.[142] Incorporating other strategies, such as news coverage or social media, can help keep costs down. News coverage is free, but it can be harder to control the timing and content than with paid ads. Social media allows programs to communicate directly with people about quitting tobacco. Posting on social media can also be free but takes time and staff resources to manage. Learn how to select the best mix of communications strategies in CDC's ***Best Practices User Guide: Health Communications in Tobacco Prevention and Control***.

Ideally, the goal of quitline promotion is to generate a steady flow, rather than a large spike, of calls. Programs can air ads in "pulses" strategically throughout the year to allow time to catch up on outgoing calls.[139] Providing quitlines at least 90 days' notice before a campaign begins also gives them time to adjust staffing levels and plan for an increase in calls.[143] In general, programs should give quitlines as much advance notice and information as possible about upcoming campaigns.

Throughout the year, other local and national partners may run their own communications campaigns that reach tobacco users in the state. It is important that



Billboard ad from the 2018 Tips From Former Smokers campaign® featuring Christine, who was diagnosed with oral cancer at age 44 after smoking for 28 years
Source: Tips From Former Smokers® Download Center

programs are aware of these campaigns so that they can be prepared for increased call volume. They may also adjust their own media placements. For example, programs can choose to air ads when no other campaigns are running or create social media posts to extend the reach of a national TV campaign.

Promoting Free Cessation Medication

Providing free cessation medication is another strategy to increase quitline calls. Quitlines sometimes offer a 2-week starter supply kit of nicotine replacement therapy (NRT) medications, such as the nicotine patch or gum. The amount and type of NRT distributed may vary based on the state's resources and restrictions.

To promote free NRT, tobacco control programs have included the details in campaign ads and mailings. Free medication can also generate news coverage of the quitline.[144] These promotions are even more successful when paired with other major campaigns or events. For example, during CDC's *Tips From Former Smokers®* campaign in 2012, the Florida Quitline provided free cessation medication to callers. The promotion led to the greatest spike in quitline enrollment and web-based cessation services during the campaign.[145]

Using free NRT with quitline counseling may also increase the number of calls and successful quits, especially for those who may not be able to afford medication or lack coverage.[1,123] Quitlines may be hesitant to provide starter kits because of concerns about their cost, but evidence shows that the small added cost is more than offset by their effectiveness in helping people quit.[146] In fact, using cessation medication can double the chance of quitting for good.[19]

Generating Referrals

Compared to media campaigns and NRT promotions, referrals from healthcare providers and other community organizations can be a lower-cost and more sustainable way to increase state quitline calls.[142] In bi-directional referral systems, quitlines can also send information back to providers, letting providers know whether the quitline reached the patient, if the patient enrolled in quitline services, and whether the patient succeeded in quitting.

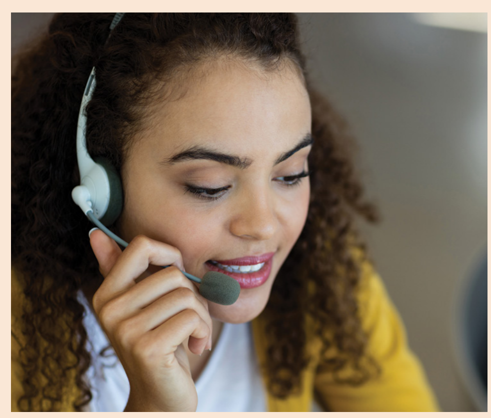
Most states already use fax referral systems and many are developing electronic referrals (e-referrals).[1]

Print ad from New York City Department of Mental Health & Hygiene's "Suffering Every Minute" campaign urging people who smoke to contact the quitline and promoting a nicotine patch and gum giveaway Source: CDC Media Campaign Resource Center

E-referrals allow healthcare providers to send referrals electronically through electronic health records (EHRs) and potentially receive feedback from the quitline. E-referrals can save time for healthcare and quitline staff and increase the number of quitline referrals.[90]

Developing e-referrals takes a joint effort. The quitline service provider develops the capacity to accept e-referrals, and health systems develop the capacity to send e-referrals to the quitline. Putting the necessary relationships in place with health systems can require a lot of time and staff resources. The tobacco control program can support both partners by identifying health systems, helping create quitline referral forms, and training healthcare staff on quitlines and the referral process.[95] To learn more about developing e-referral systems, see the North American Quitline Consortium's resource, ***Quality Improvement Initiative Issue Paper: Quitline Referral Systems***.

A CLOSER LOOK: Counseling About E-cigarettes



E-cigarettes are electronic devices that heat a liquid usually containing nicotine, flavoring, and additives into an aerosol inhaled by users.[147] Quitline callers may ask about these products, either as cessation aides or because they want to quit using e-cigarettes.

E-cigarette aerosol generally contains fewer toxic chemicals than the deadly mix of 7,000 chemicals in cigarette smoke.[148] E-cigarettes have the potential to benefit adults who smoke and are not pregnant, if used as a complete substitute for cigarettes and other smoked tobacco products.[149] But many adult e-cigarette users continue to smoke cigarettes (dual use), which does not provide a meaningful health benefit.[150] Smoking even a few cigarettes a day has significant health risks.[151] E-cigarettes have not yet been approved as safe and effective for cessation.[152] E-cigarette aerosol is also not harmless.[153] It can contain heavy metals, small particles that can be inhaled deep into the lungs, and cancer-causing chemicals.[153] E-cigarettes are not safe for youth, young adults, pregnant women, or adults who do not currently use tobacco products.[149]

Patients and quitline callers may ask providers and quitline coaches about using e-cigarettes as part of an attempt to quit smoking cigarettes, or they may ask about quitting e-cigarettes. Providers and quitline counselors can follow these steps to talk about e-cigarettes:

- **Ask about e-cigarette use**
  It is important to ask all patients and quitline callers, particularly youth and parents, about e-cigarette use and exposure. Because e-cigarettes go by many names, it is important to ask using popular terms for these products (*e.g.*, JUUL, vape pens, and e-hookah).[154]
- **Counsel about the known and unknown risks of e-cigarette use**
  E-cigarettes typically contain nicotine, a highly addictive chemical.[153] Nicotine is harmful to the developing brain.[152] E-cigarette aerosol may also contain other harmful chemicals.[153] The long-term health effects of heating and inhaling these chemicals is still not well understood.[153]
- **Emphasize the importance of quitting completely**
  Reducing daily smoking by substituting some cigarettes with e-cigarettes is not an effective way to reduce the health risks of smoking. Using e-cigarettes can prolong nicotine addiction and make quitting more difficult.[153] The only way to meaningfully reduce risk is to quit smoking completely.
- **Reinforce proven cessation treatment**
  FDA-approved cessation medications can double or triple the chances of successfully quitting.[19] These medications are even more effective if combined with counseling.[19] While there is limited evidence about treatment for e-cigarette use, a similar approach using counseling and FDA-approved medication could be considered when assisting individuals quit e-cigarette use.

Learn more about e-cigarettes in the CDC resources, ***About Electronic Cigarettes*** and ***E-cigarettes Shaped like USB Flash Drives***. More information is also available at the Surgeon General's website, ***The Facts on E-cigarette Use among Youth and Young Adults***.

Reducing Tobacco-Related Disparities

Most people who smoke are interested in quitting.[12] Yet some groups face more challenges accessing cessation treatment than others and struggle to quit. These priority populations are based on socially determined circumstances and characteristics such as age, disability, education, income, occupation, geographic location, race, ethnicity, sex, sexual orientation, gender identity, behavioral health status, and military status.[1,155]

For example, people with low income and education levels and those without health insurance are just as likely as other people who smoke to be interested in quitting but are less likely to succeed.[11,12] Use of evidence-based cessation treatment is also lower among certain groups, including racial and ethnic minorities; lesbian, gay, or bisexual smokers; and people without health insurance.[11]

People from certain racial, ethnic, and socioeconomic status groups are also more likely to live in communities with more tobacco advertising.[156] These environmental cues to smoke can make cessation more difficult.[157]

Tobacco control staff can reduce cessation disparities by:

- Considering the needs of priority populations during planning for cessation interventions
- Supporting health systems serving priority populations
- Improving coverage and use of cessation treatment among priority groups
- Expanding state tobacco quitline reach to these groups

Preparing to Reach Priority Populations

An important first step to reduce cessation disparities is to assess whether current strategies are effective for the population and fit with their culture. For example, people who avoid counseling may not want to call quitlines. Other strategies may be needed to reach them.

Members of priority populations and the organizations who serve them are vital to planning efforts. They can provide information about how priority groups use cessation services and what barriers they face to getting help. Including them in planning also ensures that cessation interventions take into account the needs and culture of the population. Programs can ensure that these groups are active participants in discussions and decision making.

To learn more about reducing tobacco-related disparities, see the CDC resource, ***Best Practices User Guide: Health Equity in Tobacco Prevention and Control*** and ***Networking2Save***, a consortium of national networks focused on eight priority populations.

Supporting Health Systems Serving Priority Populations

Despite an overall increase in advising patients to quit using tobacco, healthcare providers are still less likely to advise some groups to quit, such as young adults, certain racial and ethnic minorities, and the uninsured.[11,158] Providers serving these populations may lack the time or training to give cessation advice.[159] Patients from these groups may also face competing health priorities.[159] Tobacco control programs can support providers who work with priority populations by:

- Educating providers on the importance of cessation for the populations they serve
- Helping healthcare staff create procedures to ask about and treat tobacco use at every patient visit

- Providing cessation information tailored to patients' cultures, literacy levels, native languages, and ages
- Incorporating cessation into behavioral health treatment (learn more on *page 37*)
- Training healthcare staff on delivering culturally competent cessation treatment

Smaller health systems may have fewer resources to support systems change, especially for integrating cessation treatment into EHRs. Programs can support smaller organizations by connecting them to resources and partners that can help develop health information technology. It can also help to connect organizations to each other so they can learn from others' experiences. For example, Oklahoma developed a tribal work group to connect health systems change partners working with tribal communities. Learn more on *page 46*.

It is also important to take advantage of every chance to encourage priority populations to quit, including opportunities outside of healthcare settings. For example, Tobacco Free Florida worked with the Florida Workforce Development Association to ask about tobacco use and refer people at employment centers to the state quitline.[160] People were facing challenges finding work because of their tobacco use, so the program was able to capitalize on their motivation to quit.[160]

Improving Coverage for Priority Populations

As of 2015, more than half of people who smoke reported making a quit attempt in the last year.[161] But only one-fifth of uninsured smokers and one-third of smokers with private insurance or Medicaid used proven cessation treatments when trying to quit.[161] Uninsured smokers were also less likely to receive advice to quit from a healthcare provider.[161] Since using evidence-based treatment doubles the likelihood of quitting successfully, providing comprehensive cessation coverage is an important way to increase cessation.[19] Tobacco control programs can work to improve coverage for priority populations by:

- Encouraging state Medicaid programs to remove cost barriers, which are especially challenging for low-income populations
- Creating health communications that educate people about coverage and motivate them to use covered treatments
- Ensuring that messages fit the audience's culture and language preferences
- Placing messages where the population will see them, such as billboards near community health centers
- Supporting use of community health workers and health navigators to enroll people in coverage and educate them about their benefits
- Monitoring how priority populations use cessation coverage

Promoting Cessation Among Priority Populations

Partners can be helpful in promoting cessation to reduce disparities. Potential partners include:

- Behavioral health providers
- Community and tribal health clinics
- Community health workers
- Dentists
- Faith-based organizations
- Free clinics
- Federally qualified health centers
- Homeless shelters
- Lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) organizations
- Local public housing authorities
- Primary care providers
- Pharmacists
- Workforce development organizations

A CLOSER LOOK: Promoting Cessation in Multi-unit Housing

Each year, about 28 million people living in multi-unit housing are exposed to secondhand smoke that came from outside their unit.[162] Because there is no safe level of secondhand smoke exposure and it can spread between apartments to harm nonsmoking residents, many multi-unit properties are becoming tobacco-free.[163] Since August 2018, the U.S. Department of Housing and Urban Development has required most public housing authorities to be smokefree, except for mixed-finance developments and tribal housing.[164,165] These changes mean that residents of multi-unit public housing are especially in need of help to quit smoking.

State tobacco control programs can support multi-unit housing residents by:[166]

- Sharing culturally relevant quitting information through signs, newsletters, and resident forums
- Offering resources that are convenient for residents, such as on-site cessation education
- Connecting property managers with nearby healthcare providers, including community health centers that serve low-income housing residents
- Helping property managers update leases
- Recommending a staged enforcement process that includes offering cessation assistance (*e.g.*, warning for first violation plus quitting information)

Learn more about creating tobacco-free multi-unit housing in the American Lung Association's online course, ***Smokefree Policies in Multi-Unit Housing: Steps for Success***.

Improving Medicaid cessation coverage is one of the most important steps a state can take to reduce cessation disparities.[1] Despite similar interest in quitting, Medicaid recipients are less likely to quit successfully than those with private health insurance.[11] Tobacco control staff can educate Medicaid agencies on the benefits of evidence-based cessation coverage. Learn more about strategies to improve Medicaid cessation coverage on ***page 22***.

Expanding Quitline Reach to Priority Populations

Quitline counseling is effective among priority populations.[19] Quitlines are especially effective at reaching Medicaid, African American, and some American Indian and Alaska Native populations.[167,168] State quitline use is lower among Hispanic, Asian/ Pacific Islander, and LGBT populations.[168,169]

Anyone with a phone can reach a quitline. Smartphone apps, text messaging, and web-based services have made quitlines even easier to reach. However, it is also important to consider the unique needs of each population the program intends to reach. For example, quitlines may not be as accessible for American Indians living on tribal lands, which have the lowest number of telephone subscribers in the U.S.[170]

Tobacco control programs can use the following strategies to expand state tobacco quitline reach to diverse groups:

- Offer a free 2-week starter supply of cessation medication to uninsured and underinsured callers[1]
- Work with faith leaders, elders, or other trusted messengers to emphasize the importance of quitting and dispel myths about what happens when a smoker contacts a quitline[171]
- Use universally effective hard-hitting messages about the health consequences of tobacco use to motivate people to contact the quitline[1]
- Place quitline ads where the population is most likely to see and hear messages (*e.g.*, newspapers printed in their native language)[1]
- Strategically promote the ***Spanish-language quitline portal*** (1-855-DEJELO-YA) and the ***Asian Smokers' Quitline***[1]
- Form partnerships with national networks and healthcare providers serving priority populations to promote the quitline[171]
- Monitor how priority populations use quitlines

Many quitlines use special protocols for callers from certain groups, such as pregnant women, people with behavioral health conditions, and American Indian/ Alaska Natives.[171] These protocols are important to prepare quitline staff to help diverse callers. Cultural competence training can also help staff recognize their cultural values and biases, learn about others' cultures, and prevent stereotyping.[171,172] Learn more about communicating with diverse groupsin the Think Cultural Health resource, ***Guide to Providing Effective Communication and Language Assistance Services***.

Print ad from "Keep Tobacco Sacred" campaign about differences between traditional and commercial tobacco Source: ClearWay Minnesota

A CLOSER LOOK: Promoting Cessation in Behavioral Health Treatment

People with behavioral health conditions, such mental health or substance use disorders, make up 25% of the U.S. population but smoke 40% of all cigarettes.[173] Yet many treatment centers do not screen patients for tobacco use. In 2016, 49% of mental health and 64% of substance use treatment centers reported asking patients about tobacco use.[174] Some providers have viewed smoking as a secondary concern to behavioral health conditions, allowing tobacco use to be tolerated among patients and staff.[175]

Web banner ad from 2016 "Tips From Former Smokers®" national tobacco education campaign Source: CDC Media Campaign Resource Center

People with mental illness who smoke are as interested in quitting as other people who smoke, despite myths that they are unmotivated or unable to quit.[175] Quitting tobacco does not interfere with behavioral health treatment. In fact, quitting smoking could reduce symptoms of depression and improve substance use recovery outcomes.[176,177] Tobacco control programs can work with behvaioral health providers such as social workers, psychologists, and psychiatrists to:[178]

- Dispel myths about tobacco cessation among people with behavioral health disorders
- Educate providers and staff on the importance of treating patients' tobacco use during behavioral health treatment
- Develop protocols and reminder systems to help providers and staff ask patients about tobacco use
- Create partnerships with the state quitline, Nicotine Anonymous, or other groups that can serve as resources to patients for tobacco cessation
- Implement tobacco-free campus policies in behavioral health treatment centers that apply to both patients and staff
- Offer counseling and medication to staff who want to quit tobacco
- Reimburse providers for cessation treatment

Tobacco control programs can support these efforts with communications campaigns encouraging people with behavioral health disorders to quit smoking. Messages can also focus on empowering their family members and providers to help.[171] Learn more about promoting cessation in behavioral health treatment in the National Association of State Mental Health Program Directors resource, ***Tobacco-Free Living in Psychiatric Settings*** and the Substance Abuse and Mental Health Services Administration toolkit, ***Implementing Tobacco Cessation Programs in Substance Use Disorder Treatment Settings***. Free resources and materials are also available on CDC's ***Tips From Former Smokers®*** website.

Evaluating Cessation Interventions

Evaluating cessation interventions is vital to show their impact on reducing tobacco use. Evaluation can also help programs:[44]

- Build on successful elements and change things that are not working
- Justify time and resources spent on cessation interventions
- Secure resources
- Show partners the impact of their participation
- Plan for the future
- Share lessons learned with other organizations that are considering cessation interventions

The information collected for evaluation will depend on the program's cessation activities. For example, programs pursuing health systems change can collect patient visit data to determine how tobacco use is being treated. Programs can also gather data from employers and insurers on awareness and use of cessation coverage. Information about state quitline callers can help improve the reach and quality of quitline services. Programs can also track changes in quit attempts, cessation rates, and visits or hospitalizations for tobacco-related diseases over time. These longer-term measures are critical to assess the impact of efforts on increasing cessation and reducing tobacco use. **Table 4** on ***page 40*** includes examples of measures and data sources for all three cessation interventions.

More information is also needed about interest in quitting, cessation rates, and use of evidence-based treatment among those who face the greatest barriers to quitting. For example, questions about LGBT status are often not included in cessation surveys.[179] Data may also be aggregated, masking differences across subgroups. For example, data may reported about Asian people who use tobacco instead of reporting differences among Korean, Vietnamese, and Chinese tobacco users.[179] Collecting cessation data on these groups can help determine if they are being reached by current efforts, understand which interventions work best to help them quit, and decide where to focus efforts.

Learn more about priority populations from the ***Networking2Save*** national networks, which focus on preventing commercial tobacco use and cancer in eight priority populations. For more on including priority groups in evaluation, see the ***Best Practices User Guide: Health Equity in Tobacco Prevention and Control***.

Evaluating Health Systems Change

Data are critical to plan health systems changes and track progress. Health systems can use data from paper and electronic patient charts and patient visit surveys to measure how healthcare staff are treating tobacco use.

Tracking the same data over time can show whether health systems changes are increasing delivery of tobacco use treatment and patient cessation. It can also help identify treatment gaps.

Hospital systems often already collect evaluation data for internal quality improvement programs. For example, the Joint Commission hospital measures include information on cessation interventions.[180] Tobacco use screening and intervention is also listed as a Centers for Medicare and Medicaid Services quality measure in the Quality Payment Program.[180] Using existing data makes data collection easier for health systems and lowers evaluation costs.[182] Showing how changes can help meet other performance goals can also raise the profile of health systems change initiatives.

Cessation data can also help build staff awareness and increase buy-in for health systems changes. Performance feedback can be shared with providers through monthly or quarterly reports or during annual staff performance evaluations to help them set goals and assess their own performance.

Learn more about evaluating health systems change in the Partnership for Prevention's action guide on ***Healthcare Provider Reminder Systems, Provider Education, and Patient Education***.

Evaluating Cessation Coverage

Evaluation can help identify coverage gaps and shows the impact of improving coverage on cessation, health outcomes, and healthcare costs. Evaluating campaigns to raise awareness of coverage is also important. Programs can use these results to design better ways to reach tobacco users and healthcare providers.

Evaluating coverage is easier when states form partnerships with health insurers and employers. With help from tobacco control programs, these organizations may be able to provide critical information about how many people use tobacco, how many use covered cessation treatments, how many quit, and the resulting cost savings. Programs can work with health plans and employers to gather tobacco use and cessation data from personnel records, claims data, or electronic health record (EHR) data. They can also conduct surveys about cessation coverage (learn more on ***page 9***).

Programs can also work with state Medicaid agencies and managed care organizations (MCOs) to track smoking prevalence and use of cessation treatment among Medicaid recipients. Many of these agencies have cessation data, but they may not have the resources to analyze it.[183] Programs can work with partners to track Medicaid enrollees':

- Awareness of coverage[184]
- Knowledge of how to access coverage[184]
- Use of cessation coverage and services such as quitlines[184]
- Cessation rates[184]
- Rates of smoking-related diseases, healthcare usage (*e.g.*, heart attack hospital admissions), and healthcare costs[44]

It is also important to track coverage offered through other insurance plans, such as short-term, limited-duration health plans. These plans are designed to

Learn More about Evaluation from CDC

- Read about using data to improve programs in CDC's ***Best Practices User Guide: Program Infrastructure in Tobacco Prevention and Control***
- Learn how to measure cessation outcomes in CDC's ***Promoting Quitting Among Adults and Young People: Outcome Indicators for Comprehensive Tobacco Control Programs—2015***
- Visit CDC's ***Surveillance and Evaluation*** web page to learn about planning tobacco control evaluations and sharing results

fill temporary gaps in coverage that may occur when transitioning from one type of coverage to another, such as when changing jobs.[185] They do not have to meet Affordable Care Act cessation requirements, and many do not cover cessation treatment. Monitoring what these and other plans cover can help give programs a fuller picture of the cessation benefits available to insured populations.

Evaluating State Quitlines

All state tobacco quitlines conduct some evaluation, which usually includes collecting information from quitline users during intake and conducting follow-up surveys with some users after they receive treatment.[10] Careful staff records at intake can gather most of the necessary information for quitline evaluation. When first speaking with a caller, quitlines may collect

Table 4. Sample Measures for Evaluating Cessation Strategies

Strategy	Sample Measures	Examples of Data Sources
Promoting Health Systems Change	• Percentage of patients asked about tobacco use • Percentage of tobacco users who have been advised to quit • Percentage of tobacco users who have been assisted in quitting by a healthcare professional • Percentage of patients who were followed up with after visit • Adoption of health system campus tobacco-free policies • Patient quit attempts and cessation rates • Visits and hospitalizations for tobacco-related diseases	• Healthcare Effectiveness Data and Information Set (HEDIS) • Joint Commission standards • Physician Quality Reporting System • Health Resources and Services Administration Core Clinical Measures • Patient records (paper or electronic) • Patient visit surveys • Health system billing data
Improving Coverage	• Percentage of insured population with coverage for all recommended evidence-based cessation treatments • Percentage of insured population without health insurance-related barriers to accessing cessation services • Awareness of cessation coverage among health plan members and providers • Number of health plan members using cessation coverage • Employee health indicators (*e.g.*, productivity, absenteeism, tobacco use, tobacco-related illness) • Quit attempts and cessation rates among health plan members	• Insurance claims • Health plan surveys • Medicaid and MCO enrollee data and claims information • Employee surveys • Personnel records
Supporting State Quitlines	• Quitline call volume • Types and quantities of services provided • Percentage of tobacco users who have used mobile cessation services (*e.g.*, text messaging or smartphone apps) • Percentage of quitline users from priority populations • How tobacco users heard about the quitline • Satisfaction with quitline services • Quit rate at 7-month follow-up	• Quitline intake surveys • Follow-up surveys of quitline users • National Quitline Data Warehouse

information about the caller's demographics, tobacco use, past quit attempts, and referral source. They may also document the quitline services provided to the caller. At follow-up, quitlines often ask a sample of callers about their success in quitting and satisfaction with the quitline.

Evaluating quitlines helps programs:

- Improve quitline operations[10]
- Track effectiveness of health communications campaigns and nicotine replacement therapy (NRT) promotions and make changes if necessary[138]
- Find potential cost-sharing partners[95]
- Assess effectiveness of health systems change referrals process[95]
- Show the value of quitlines to funders and potential partners[10]
- Determine whether services are reaching priority populations[10]

Although evaluation data are standardized across most quitlines, new technologies such as web services and smartphone apps are not consistently evaluated. It is important that programs measure how well these technologies follow cessation best practices, which features are most effective, and how they compare with telephone quitlines in terms of quit rates. Program staff may also need to rethink how they traditionally measure quitline reach to include these technologies.

Another important consideration for quitlines is the effect of cost-sharing partnerships on evaluation. When health plans and employers contract directly with quitline service providers, it may be harder for state programs to get data about quitline callers and calculate reach. Data use agreements can help preserve state access to data by requiring partners to share data about quitline reach with the tobacco control program.[101] Some states have made agreements directly with the partner; others have set up foundations to manage these agreements.[101]

All state quitlines use the standard intake and follow-up measures in the North American Quitline Consortium's Minimal Data Set to evaluate quitlines.[186] State quitline data are also reported to the National Quitline Data Warehouse. These tools make it easier to compare performance across states and improve services for priority populations.[186] Learn more at the ***Minimal Data Set*** web page and CDC's ***National Quitline Data Warehouse*** web page.

Sustaining Cessation Interventions

Quitting tobacco is not easy, but it is possible. Tobacco use and dependence is a chronic, relapsing condition that often requires repeated intervention.[19] Most people who smoke make multiple quit attempts before succeeding, and the average person may try 30 or more times before quitting successfully.[39] Long-term support is important to help people quit using tobacco.[19] Sustaining efforts also ensures that cessation interventions reach as many people as possible, including new tobacco users. Each day, more than 3,200 young people try their first cigarette and another 2,100 become daily smokers.[12] By continuing to promote and improve cessation interventions, programs can help more people quit using tobacco for good.

Sustaining Health Systems Change

Health systems change is easier to sustain when all staff view cessation as a vital part of health care. State programs can keep healthcare staff involved by organizing regular meetings to identify potential problems, review progress reports, and discuss ways to improve delivery of tobacco use treatment.[44] Programs can also help health systems make cessation part of their culture by:

- Identifying a dedicated backup champion in each provider office in case of staff turnover[187]
- Training new health system employees and volunteers and offering refresher sessions for existing staff[44]
- Updating training resources and materials to stay current with tobacco use trends, new tobacco products, and new cessation developments[45]
- Recommending health systems build alerts into EHRs that remind staff to screen all patients for tobacco use and offer cessation interventions to tobacco users at every visit[43]
- Working with health systems to add cessation treatment to staff job descriptions and include it in employee performance reviews[44]
- Sharing new cessation research, emerging trends, and resources regularly through email or newsletters[138]
- Encouraging health systems to implement tobacco-free campus policies[44]

*Web banner from **Talk to Your Patients** website Source: New York State Department of Health*

Taking the time to recognize success is also important to show healthcare staff that their hard work is appreciated. Programs can encourage health systems to highlight successes in website posts, internal employee newsletters, patient communications, and the news media.[44] Personal stories from staff champions and patients who have quit can be especially compelling. Hearing these success stories can sustain staff commitment and encourage others to help their patients quit.[44] Involving health systems staff in presenting results to other staff members or stakeholders also strengthens their commitment to maintaining the changes.

The Clinical Sustainability Assessment Tool (CSAT) can also help sustain health systems changes. Health care providers, staff, and evaluators can use this free, online tool to rate the sustainability capacity of a practice or intervention (*e.g.*, a new surgical procedure or protocol for treating tobacco use). Learn more at ***sustaintool.org/csat***.

Other chronic diseases such as asthma, cancer, diabetes, and heart disease can be caused and worsened by smoking.[13] Integrating tobacco use treatment into healthcare visits for these diseases can also help sustain momentum. For example, providers can screen for tobacco use and offer cessation treatment during cancer screenings and asthma and diabetes visits. Chronic disease programs often include health education, which can share information about the dangers of tobacco use and how to quit.[45] Tobacco use data can also be included in clinical dashboards used for other chronic diseases.[68] Competing priorities, busy schedules, and communications issues can make integration more challenging.[66] In Oklahoma, the state's health systems change initiative began a chronic disease integration workgroup aimed at increasing communication among different chronic disease partners. Learn more about Oklahoma's health systems change efforts on ***page 46***.

Maintaining Strong Cessation Coverage

Lasting relationships with insurers, employers, Medicaid agencies, state government, and healthcare providers are critical to keep tobacco cessation coverage strong. Dedicating staff to work with these partners helps ensure that messages are consistent.[101] Regular meetings with partners sets aside time to update them on progress and discuss opportunities and challenges.

Economic, political, or other changes can also impact cessation coverage. It is important that programs respond to these outside influences so that cessation coverage stays as comprehensive and accessible as possible.

The characteristics of the population who uses coverage may also change. This is especially true for Medicaid, where people often move in and out of the program due to changes in eligibility status.[188] Over time, the tobacco use patterns, use of cessation services, demographic characteristics, and media preferences of Medicaid recipients may change. Staying aware of these changes can help programs work more effectively with Medicaid agencies and refocus health communications to better reach their audience.

Sustaining State Quitlines

Since most people try to quit using tobacco multiple times before succeeding, consistent tobacco quitline service is critical.[39] Outside influences can create surges in calls that may challenge quitlines to offer the same level of service to each caller. For example, national media campaigns or new referral systems can increase calls.[189] Without planning and budgeting to handle the increased volume, call lines can get overloaded, callers may have to wait longer to be connected, or the quitline may be forced to cut back services or temporarily suspend operations.[190] Unexpected funding changes may also cause service interruptions. To develop a long-term quitline funding strategy, programs can take the following steps:

- Start planning for potential change during normal operations, instead of waiting until unexpected changes occur.[190]
- Estimate how much funding is needed to support ideal quitline service levels and consider ways to increase staff levels or adjust services during other times.[190]
- Explore cost-sharing partnerships with health insurers and employers or other funding sources such as universities or business health coalitions.[1]
- Dedicate funds collected from tobacco taxes to the state quitline.[191]
- Arrange for flexible funding that can be split between providing and promoting quitline services as demand changes.[189]
- Work with Medicaid agencies to secure federal matching funds for quitline services provided to Medicaid recipients.[1]

In 2011, the Centers for Medicare and Medicaid Services announced that the federal government would cover 50% of the cost for quitline counseling to Medicaid recipients.[113] To get this funding, tobacco control programs have to work with the state Medicaid agency to set up a process to bill Medicaid for quitline services.[114] Although securing Medicaid matching funds can be a time-consuming process, it can also help strengthen vital relationships with Medicaid agencies.[192] These partnerships are an important foundation for improving Medicaid cessation coverage and promoting coverage to enrollees.

Cost-sharing partners also play a vital role in sustaining quitlines. Strong relationships with these partners are important to ensure they stay invested in supporting the quitline. Regular communication can build trust and program credibility. Staff can be available by phone, email, or in person to answer any questions and hold conference calls or webinars to highlight the impact of the partnership. Programs can also share data on quitline services, such as how many people have called, how many tried to quit, and how much money was saved.[63] Sharing this information publicly can also lead to new partnerships.

Supporting a Comprehensive Approach to Tobacco Control

Other population-wide interventions like smokefree laws, tobacco product price increases, and health communications campaigns can motivate people to quit using tobacco and increase cessation.[7-9] Encouraging partners to support a comprehensive approach to tobacco control can maximize the impact of cessation efforts and strengthen partners' commitment to help people quit.

How Can Tobacco Control Programs Support Cessation Interventions?

Tobacco cessation interventions require the coordinated efforts of many partners. Programs can help support cessation interventions by taking the following actions:

Administrative Support

- Gather information about the quality of cessation treatment and coverage in the state from the largest health systems, employers, and health plans
- Build support for cessation interventions among state health department leadership, who can help communicate with leaders at partner organizations
- Ensure staff and funding are in place to promote health system change, improve cessation coverage, and support state quitlines
- Evaluate cessation interventions and share results with partners

Coordination & Collaboration

- Lead by example, forming partnerships with the state Medicaid agency and the state employee benefits program
- Engage diverse healthcare partners, such as health system leadership, primary care providers, specialists, nurses, dentists, pediatricians, and pharmacists, making the case for the importance of cessation for their patients
- Reach out to health insurers and employers about the benefits of improving and promoting cessation coverage and supporting the state quitline
- Take part in state and national partnership initiatives to bring new partners to the table, such as CDC's 6|18 Initiative
- Implement health communications campaigns to promote cessation help available through providers, cessation coverage, and quitlines

Training & Technical Assistance

- Train healthcare providers and staff on best practices for delivering tobacco use treatment, including initial trainings for new staff and refresher courses for staff already trained once
- Offer hands-on technical assistance to health systems, such as helping providers develop office protocols for treating tobacco use
- Incorporate cultural competence and treating tobacco use among diverse populations into trainings for quitline counselors and healthcare providers

Oklahoma Case Study

Hospital initiative refers 26,000 to state quitline

Oklahoma identifies health care as an ideal setting to reach people who use tobacco

In 2009, Oklahoma's smoking prevalence was one of the highest in the United States (25.5%).[193] Knowing that Oklahoma hospitals admitted about 120,000 people who use tobacco each year, the Oklahoma tobacco control program saw an opportunity to reach more tobacco users by forming partnerships with health systems.[194] In 2010, the state program collaborated with the Oklahoma Tobacco Settlement Endowment Trust (TSET) and the Oklahoma Hospital Association (OHA) to form the Hospitals Helping Patients Quit initiative. TSET funds the initiative as part of its Health Systems Initiative grant, which also promotes health systems change among Medicaid providers and state-funded mental health and substance use treatment centers. OHA serves as the initiative's main contact with hospitals and works closely with them to make systems changes. To date, the initiative has worked with more than 50 hospitals throughout the state to systematically treat tobacco use. For example, the initiative has helped hospitals and clinics to:

- Screen every patient for tobacco use
- Integrate tobacco use treatment into clinical protocols
- Adopt and use electronic health records (EHRs) to treat tobacco use and refer patients to counseling
- Help health systems implement tobacco-free campuses

Tobacco control program creates statewide infrastructure to support health systems change

The tobacco control program knew it could best support the work of Hospitals Helping Patients Quit by developing a strong cessation infrastructure at the state level. They created a statewide cessation leadership team to oversee efforts, such as coordinating available cessation benefits and aligning cessation messaging. The leadership team includes the tobacco control

Logo for the Hospitals Helping Patients Quit program

program, TSET, and the Oklahoma Tobacco Research Center, a state quitline partner. The program also created a health systems change workgroup to bring all organizations working on health systems change to the same table, including those working in chronic disease. The workgroup has increased communication between groups, improved coordination, and prevented duplication of services. A separate workgroup for partners working with tribal nations shares resources and best practices.

The tobacco control program also holds monthly technical assistance meetings for OHA and health system partners. Tobacco control staff review work plans and strategies, discuss successes and challenges, and help the hospitals and clinics plan future activities. The initiative's evaluator, Oklahoma University Health Sciences Center, also attends these meetings to help programs as they collect data and track outcomes.

Oklahoma Hospital Association recruits hospital partners

The tobacco control program partnered with the Oklahoma Hospital Association to recruit hospitals to take part in the initiative. OHA had existing relationships with more than 135 hospitals across the state, built on nearly 100 years of strong support. OHA was able to leverage the trust it had built with hospitals to encourage them to join the initiative. Hospitals represented on its board were among the first to make systems changes. Eric Finley, OHA Health Improvement Coordinator,

says, “When you do health systems change, trust is absolutely paramount. When you have that, it knocks down a lot of barriers and a lot of walls.”

OHA took every opportunity to start conversations with hospitals about promoting cessation. When programs reached out to OHA with other requests, such as help meeting clinical performance measures, OHA suggested they make health systems changes to reduce tobacco use too. Promoting successes also helped OHA recruit hospitals. They presented early results at state and national conferences, involving hospital representatives in presentations when possible. The presentations showed potential partners that their peer hospitals were making changes to promote cessation, that the model works, and that OHA is an experienced partner who can help them succeed. Highlighting past successes also helped ease concerns voiced by some partners about time commitment and workload.

Oklahoma tailors strategies to needs of diverse health systems

Oklahoma’s hospital partners each had different levels of readiness and priorities for health systems change. Finley says, “When you’ve worked with one healthcare system, you’ve worked with only one healthcare system.” To meet the needs of each hospital, Oklahoma began with a recommended approach and then tailored strategies as needed. This also helped prevent hospitals from having to start over from scratch after making partial changes. For smaller clinics and health centers unable to adopt all of the recommended changes right away, OHA staff helped create a timeline and make changes in stages. OHA also encouraged hospitals to pursue their own health systems change ideas.

Customizing health systems change was especially important to Oklahoma’s work with tribal health systems. Oklahoma also focused on practicing cultural sensitivity and finding key champions. For example, the tobacco control program collaborated with the Office of the Tribal Liaison, which has helped the department understand tribal hierarchy and find the best people to engage. Their efforts paid off—health systems change partner Chickasaw Nation Medical Center was the first tribal hospital in the U.S. to implement bi-directional quitline referral, enabling providers to refer patients to the quitline and receive information back to follow up with patients.

> “When you do health systems change, trust is absolutely paramount. When you have that, it knocks down a lot of barriers and a lot of walls.”
>
> — Eric Finley

Oklahoma plans to expand health systems changes to new partners

The Hospitals Helping Patients Quit initiative has helped over 50 Oklahoma hospitals and clinics refer more than 26,000 patients to the state quitline. It is estimated to have saved millions of dollars in healthcare costs.[195] Finley credits Oklahoma’s success to building trust with health systems and considering their individual needs and resources for systems change. He recommends that other states look for a partner that has credibility with healthcare partners and take the time to understand each health system’s strengths and weaknesses.

Looking ahead, OHA is developing a quality improvement tool to help hospitals sustain health systems changes. The tobacco control program is also focused on increasing health systems change coordination within the state health department. For example, the program is also partnering with the state chronic disease division and hopes to incorporate tobacco use questions into cancer screenings.

Oklahoma also plans to expand Hospitals Helping Patients Quit to rural health systems. Because rural providers often lack staff and information technology resources for systems change, the tobacco control program has collaborated with a health information technology (IT) contractor to help smaller health systems build tobacco use treatment into EHRs. Former Oklahoma Tobacco Use Prevention Manager Christin Kirchenbauer says, “We realize that smaller health systems may not have the resources or capacity to make these large-level changes, but we want to make sure we are serving all of Oklahoma.”

Rhode Island Case Study

Rhode Island increases access to cessation treatment through diverse partnerships

State law requires health plans to cover cessation

In 2009, Rhode Island began requiring by law that private health plans cover cessation counseling and all FDA-approved cessation medications. Plans also had to include clinical practice guidelines in the definition of cessation treatment and report to the Department of Health on cessation coverage every year.[196] It also opened an opportunity for the Rhode Island tobacco control program to form partnerships with the state Medicaid program, the state's major health plans, and the state Employee Benefit Office to close gaps in cessation services. To further strengthen these partnerships, Rhode Island's tobacco control program joined the CDC's 6|18 Initiative and the Centers for Medicare and Medicaid Services' State Innovation Models (SIM) Initiative.

Rhode Island forms partnerships to improve cessation coverage

The tobacco control program began work to improve cessation insurance coverage by focusing on coverage for state employees. The program formed a partnership with the state employee benefits office to promote the quitline and the availability of employee cessation coverage. The program also formed the Rhode Island Tobacco Cessation Council, bringing together health plan representatives, community stakeholders, and healthcare professionals to focus on cessation issues. The program also developed a cessation coverage survey to learn more about coverage offered by the state's largest health plans and help them meet the new state regulations. View the survey on the Department's ***web page***.

Having a broad group of partners helped the program make sense of the complicated data collected from the survey. With input from the partners, the program used the data to create tables of the cessation coverage offered by major private plans, traditional fee-for-service Medicaid plans, and Medicaid managed care plans. The tables also describe barriers to accessing coverage, such as deductibles, limits on length of treatment, and copays. The tobacco control program made the information publicly available online and in print (links to the tables are available on the Department's ***web page***). They also shared it with community health organizations, providers, and federally qualified health centers.

Rhode Island adopts a State Innovation Model and joins CDC's 6|18 Initiative to expand partnerships

Although the program's early work with the Council created momentum for cessation, Rhode Island wanted to do more. Tobacco Cessation Manager Dana McCants Derisier said, "We were at our limit on where we were taking cessation. There are so many opportunities that we have when we really look for them." In 2015, Rhode Island received a SIM test grant from the Centers for Medicare and Medicaid Services to improve the way health care is delivered and paid for. SIM partners included state agency leaders, insurers, community agency staff, and representatives from health systems. The partners identified cessation as a priority intervention and helped the tobacco control program connect with stakeholders, take part in statewide meetings, and coordinate cessation services statewide.

The tobacco control program also successfully applied to become part of CDC's 6|18 Initiative. The Initiative works with healthcare insurers and providers to collaboratively implement evidence-based interventions for common, costly health conditions, including tobacco use. The 6|18 Initiative helped the program turn occasional contacts into active partnerships to help reduce tobacco-related disparities. For example, before joining 6|18, the program had only a loose relationship

with state Medicaid staff, meeting with them yearly to discuss immediate needs. The Initiative brought the state tobacco control program and the state Medicaid program together to develop a joint action plan to improve access to cessation treatments among state Medicaid enrollees. Joint participation in this effort fostered a much closer relationship between the two agencies.

These stronger partnerships taught Rhode Island the importance of broadening its network of partners and reaching out to people and organizations with common goals. McCants Derisier recommends other state programs look for partners that are doing similar work: “On a statewide level, align with what is already being done so you don’t have to reinvent the wheel.” She added that national partnerships like 6|18 “took us to another level,” helping Rhode Island get a sense of what is happening around the nation. State-level groups that support tobacco control have also played an important advisory role, providing input from concerned citizens, youth, and public health colleagues. Rhode Island’s program meets regularly with members of the Tobacco Free Rhode Island network to stay updated on trends and innovative projects.

Program plans to expand partnerships to support state quitlines and promote health systems change

According to McCants Derisier, strong partnerships are critical to sustain and grow cessation interventions. As health care continues to evolve, Rhode Island’s tobacco control program is focused on maintaining strong relationships with partners. Using information from the coverage tables, the program plans to work with partners to create an infographic to promote available cessation coverage to the public. The program is also working with the state Medicaid program to collect data on why Medicaid cessation services are underused. They hope to use the data to identify trends and ways to improve use of evidence-based cessation treatments.

Rhode Island also plans to work with partners to increase the use of electronic health records (EHRs) in cessation treatment. The program plans to develop an e-referral system between the state quitline and health systems.

> “There are so many opportunities that we have when we really look for them.”
>
> — Dana McCants Derisier

The Rhode Island tobacco control program meets regularly with state and national partners to identify common interests, plan strategies, and stay updated on trends

Why Invest in Cessation Interventions?

Cessation interventions make it easier for people to get the help they need to quit using tobacco. They are the fastest way to reduce the disease, disability, and death caused by tobacco use.[1] They also maximize the impact of other tobacco control strategies and promote national healthcare goals to improve quality and reduce cost. Tobacco control programs and partners can use the information in this section to educate decision makers and other leaders about why promoting health systems change, improving cessation coverage, and supporting state quitlines are essential strategies of a comprehensive tobacco control program.

History and Adoption

By the 1980s, the public health and medical community had recognized smoking as an addiction driven by nicotine and had begun to develop effective cessation treatments.[24] Telephone cessation services also began to grow rapidly. California launched the first publicly funded state telephone quitline in 1992, and by 2006, all 50 states, the District of Columbia, and Puerto Rico offered quitlines.[12,30]

As effective cessation treatments became more widely available, there was also growing recognition of the need for healthcare providers to treat tobacco use.[31] The 2008 U.S. Public Health Service clinical practice guideline concluded that tobacco dependence is a chronic disease that often takes repeated intervention.[19] It was also one of the first guidelines to recommend that insurers cover cessation and that health systems identify and treat every patient who uses tobacco.[19] Today, the healthcare system is undergoing a transformation to improve quality of care and reduce costs. Federal healthcare reforms have increased the use of electronic health records (EHRs) and improved insurance coverage for cessation.[34,35]

The internet, email, chat, text messaging, and mobile apps have also created more ways to reach tobacco users with cessation interventions.[37] Since 2012, CDC has aired *Tips From Former Smokers®*, the first federally funded national tobacco education campaign, and provided supplemental funding to quitlines to meet the resulting increased demand for cessation services. Designed to motivate people who smoke to quit and direct them to cessation assistance, the campaign has resulted in over nine million quit attempts and over a half million successful quits in just three years.[38]

Scientific Evidence

Promoting health systems change, improving cessation coverage, and supporting state quitlines are proven strategies to help people who smoke quit. Even brief cessation interventions by healthcare providers (less than three minutes) can increase quit rates.[19] They can also increase the likelihood that people not yet ready to quit smoking will try in the future.[19] Systems changes, such as integrating cessation reminders into EHRs, make it more likely that providers will treat tobacco use.[19]

Comprehensive cessation coverage increases the number of people who try to quit smoking, use evidence-based treatment, and quit successfully.[1,19,46] It can also support health systems change by making it easier for patients to access treatment.[1] Improving coverage, especially for Medicaid enrollees, can also increase cessation and reduce tobacco use among those who face the greatest barriers to quitting.[1]

State quitlines are highly effective and widely accessible.[1,19] Using quitlines increases the chance of quitting successfully.[19] Combining quitline counseling with medication is more effective than using either alone.[19] With adequate and sustained resources, state quitlines also have the potential to reach large numbers of tobacco users.[1] They are especially important to reach those who might face challenges getting help in other ways, such as people without health insurance or with inadequate coverage.

Cost

Tobacco use is the leading cause of preventable death and disease in the United States.[12] Smoking-related illness in the U.S. costs approximately $300 billion a year, including nearly $170 billion in medical care for adults and more than $156 billion in lost productivity.[163,197] Quitting smoking lowers healthcare costs. If just 1 in 10 people who smoke cigarettes quit, healthcare spending would drop by $63 billion the following year.[198]

Helping people quit using tobacco is a smart investment for employers and states. Cessation coverage costs employers very little—less than $0.10 per member per month.[100] In fact, covering cessation treatment saves employers money by lowering healthcare costs, improving productivity, and reducing missed work days.[19,20] The savings can add up quickly; lower healthcare costs alone can save employers money in less than two years.[20]

Massachusetts's experience shows how investing in cessation can improve health and reduce costs. In 2006, Massachusetts began providing evidence-based cessation coverage with reduced barriers for all adult Medicaid enrollees. For every dollar spent on program costs, the state saved $3.12 in medical expenses.[49] Within the first two years, hospitalizations for heart attacks and other heart disease diagnoses also decreased by nearly half among Medicaid smokers who used the benefit.[48]

Sustainability

Investing in cessation can have a lasting effect on public health. Population-wide cessation interventions are able to reach many people to make the greatest impact on health.[1] They also address many other critical community health needs, such as substance use, mental health, pregnancy and child health, and cancer.[13]

Cessation interventions create a strong infrastructure of trained staff, dedicated resources, and lasting health systems changes to support quitting. As programs pursue cessation interventions, they form partnerships with health care, insurance, and business that bring new perspectives and resources to tobacco control efforts. These partnerships raise awareness about the importance of tobacco control efforts and create champions that can carry out tobacco control work for years to come.

Cessation interventions also help pave the way for smooth implementation of population-wide strategies such as comprehensive smokefree laws and tobacco product price increases.[1] By maximizing the impact of tobacco control programs, cessation interventions help make the case for continuing tobacco control efforts.

Tobacco Prevention and Control

About Electronic Cigarettes (E-Cigarettes)

Publisher: Centers for Disease Control and Prevention

Summary: Information on e-cigarette components, health risks, and potential use as a quit smoking aid

http://bit.ly/cdc_aboutecigarettes

Best Practices for Comprehensive Tobacco Control Programs—2014

Publisher: Centers for Disease Control and Prevention

Summary: Strategies and funding recommendations to plan and implement state tobacco control programs

http://bit.ly/bp_2014

Best Practices User Guide: Health Communications in Tobacco Prevention and Control (2018)

Publisher: Centers for Disease Control and Prevention

Summary: Steps that state tobacco control staff and partners can take to develop effective health communications

http://bit.ly/cdc_communications

Best Practices User Guide: Program Infrastructure in Tobacco Prevention and Control (2017)

Publisher: Centers for Disease Control and Prevention

Summary: Steps that state tobacco control staff and partners can take to build strong program infrastructure

http://bit.ly/cdc_programinfrastructure

Best Practices User Guide: Youth Engagement in Tobacco Prevention and Control (2019)

Publisher: Centers for Disease Control and Prevention

Summary: Steps that state tobacco control staff and partners can take to create meaningful opportunities for youth to contribute to tobacco control efforts

http://bit.ly/cdc_youthengagement

Behavioral Risk Factor Surveillance System (BRFSS)

Publisher: Centers for Disease Control and Prevention

Summary: Tobacco use prevalence and other health data collected from the BRFSS annual nationwide telephone survey

https://www.cdc.gov/brfss

Electronic Cigarettes – What's the Bottom Line?

Publisher: Centers for Disease Control and Prevention

Summary: Graphic summary on the health effects of e-cigarettes

http://bit.ly/cdc_bottomline

E-cigarettes Shaped Like USB Flash Drives: Information for Parents, Educators, and Health Care Providers

Publisher: Centers for Disease Control and Prevention

Summary: Graphic summary on the history and health effects of USB-shaped e-cigarettes

http://bit.ly/cdc_ecigarettesUSB

Electronic Nicotine Delivery Systems (2019)

Publisher: American Academy of Pediatrics

Summary: Facts about e-cigarettes and links to resources for healthcare providers

http://bit.ly/aap_ends

The Facts on E-cigarette Use Among Youth and Young Adults (2019)

Publisher: U.S. Surgeon General

Summary: Findings from the 2016 U.S. Surgeon General Report on e-cigarette use among youth and young adults

https://e-cigarettes.surgeongeneral.gov

The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General (2014)

Publisher: U.S. Department of Health and Human Services

Summary: Overview of the progress made to reduce tobacco use over the last 50 years and the continued burden of tobacco-related death and disease

http://bit.ly/sgr_2014

National Survey on Drug Use and Health

Publisher: Substance Abuse and Mental Health Services Administration

Summary: Health data on tobacco, alcohol, and drug use, mental health topics

http://bit.ly/nsduh

Program Sustainability Assessment Tool (2012)

Publisher: Center for Public Health Systems Science

Summary: Tool to assess programs' sustainability and create a sustainability action plan

https://sustaintool.org

Public Health Consequences of E-cigarettes (2018)

Publisher: The National Academies of Sciences, Engineering, and Medicine

Summary: Comprehensive report examining the use of e-cigarettes, their health consequences, and recommendations for future research

http://bit.ly/nasem_ecigarettes

Surveillance and Evaluation Resources (2018)

Publisher: Centers for Disease Control and Prevention

Summary: Resources to plan, carry out, and communicate findings from tobacco control evaluations

http://bit.ly/cdc_surveillanceandeval

The Three Buckets of Prevention (2016)

Publisher: Journal of Public Health Management and Practice

Author: Auerbach J

Summary: Overview of the CDC's Three Buckets of Prevention population health and prevention framework

http://bit.ly/cdc_3buckets

Cessation

Ask-Advise-Connect

Publisher: JAMA Network

Authors: Vidrine J, Shete S, Cao Y, et al.

Summary: Evaluation of the Ask-Advise-Connect model for brief tobacco use treatment

http://bit.ly/vidrine_AAC

The Brief Tobacco Intervention

Publisher: Centers for Disease Control and Prevention

Summary: Pocket guide for healthcare providers describing two tobacco use treatment models: the 5As and Ask-Advise-Refer

http://bit.ly/cdc_briefintervention

Cessation Materials for State Tobacco Control Programs (2018)

Publisher: Centers for Disease Control and Prevention

Summary: A comprehensive list of resources to promote health systems change, improve cessation coverage, and support state quitlines

http://bit.ly/cdc_statematerials

Promoting Quitting Among Adults and Young People: Outcome Indicators for Comprehensive Tobacco Control Programs—2015

Publisher: Centers for Disease Control and Prevention

Summary: Outcome indicators for tobacco control programs to plan and evaluate cessation interventions

http://bit.ly/cdc_outcomes

Quitting Smoking Among Adults—United States, 2000–2015 (2017)

Publisher: Morbidity and Mortality Weekly Report

Authors: Babb S, Malarcher A, Schauer G, Asman K, Jamal A

Summary: National data on smokers' interest in quitting, receipt of advice from a health professional, use of evidence-based treatments, and cessation

http://bit.ly/babb_quitting

Return on Investment for Tobacco Cessation (2016)

Publisher: ClearWay Minnesota

Summary: Fact sheet on the cost-effectiveness of cessation treatment for health systems, employers, insurers, and states

http://bit.ly/clearway_ROI

Smokefree.gov

Publisher: U.S. Department of Health and Human Services

Summary: Tools and resources for people trying to quit smoking or stay tobacco free, with links for veterans, women, teens, senior citizens, and Spanish-speakers

https://smokefree.gov/

Smoking Cessation: A Report of the Surgeon General (2020)

Publisher: U.S. Department of Health and Human Services

Summary: The importance of tobacco cessation and the Surgeon General's recommendations for cessation services

http://bit.ly/SGR_Cessation

Tips From Former Smokers® (2018)

Publisher: Centers for Disease Control and Prevention

Summary: Stories and materials from *Tips From Former Smokers®*, the first national tobacco education campaign

https://www.cdc.gov/tobacco/campaign/tips

Tobacco-Free Living in Psychiatric Settings: A Best-Practices Toolkit Promoting Wellness and Recovery (2010)

Publisher: National Association of State Mental Health Program Directors

Summary: Step-by-step guidance to create smokefree mental health treatment centers

http://bit.ly/samhsa_tobaccofreeliving

Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions (2015)

Publisher: U.S. Preventive Services Task Force

Summary: Updated recommendations on clinical interventions to treat tobacco use

http://bit.ly/uspstf_cessation

Treating Tobacco Use and Dependence Clinical Practice Guideline: 2008 Update

Publisher: Agency for Healthcare Research and Quality

Summary: 2008 update to the Clinical Practice Guideline on treating tobacco use

http://bit.ly/ahrq_guideline

Promoting Health Systems Change

Academic Detailing: Frequently Asked Questions (2014)

Publisher: Centers for Disease Control and Prevention

Summary: Answers to common questions about using academic detailing to train health care staff to treat tobacco use

http://bit.ly/cdc_academicdetailing

Access to Tobacco Cessation Medication through Pharmacists (2017)

Publisher: Tobacco Control Network

Summary: State approaches to engage pharmacists in promoting cessation

http://bit.ly/tcn_pharmacists

Billing Guide for Tobacco Screening and Cessation (2018)

Publisher: American Lung Association

Summary: An overview of cessation coverage and how to bill for cessation treatment

http://bit.ly/ala_billing

Clinical Sustainability Assessment Tool (2019)

Publisher: Center for Public Health Systems Science

Summary: Free online tool to assess the sustainability capacity of clinical practices, such as integrating tobacco use treatment into routine care

https://sustaintool.org/csat

Clinical Tobacco Cessation Resources (2019)

Publisher: American Academy of Pediatrics

Summary: Resources for healthcare providers to talk to patients about tobacco use, understand cessation billing and coding, and find training opportunities

http://bit.ly/aap_clinicalcessation

Electronic Health Records (EHR) & Tobacco

Publisher: University of Wisconsin Center for Tobacco Research & Intervention

Summary: Information and links to more resources about integrating tobacco use treatment into EHR systems

http://bit.ly/uw_ehr

Facilitators of Health Systems Change for Tobacco Dependence Treatment: A Qualitative Study of Stakeholders' Perceptions (2014)

Publisher: ClearWay Minnesota

Authors: Jansen A, Capesius T, Lachter R, Greenseid L, Keller P

Summary: Results of ClearWay Minnesota's efforts to promote cessation in four health systems

http://bit.ly/clearway_facilitators

Foundations and Strategies of Tobacco Control

Publisher: Colorado State Tobacco Education & Prevention Partnership

Summary: Free online training on a variety of tobacco control topics, including promoting health systems change

https://www.tobaccocontrolco.org

A Guide to Facilitating Health Systems Change

Publisher: Centers for Disease Control and Prevention

Summary: Guidance for states on promoting health systems changes to prevent and manage heart disease and stroke

http://bit.ly/cdc_guidetoHSC

Health IT Playbook (2018)

Publisher: HealthIT.gov

Summary: Information on how to select and implement EHRs

http://bit.ly/healthit_playbook

Healthcare Provider Reminder Systems, Provider Education, and Patient Education: Working with Healthcare Delivery Systems to Improve the Delivery of Tobacco-Use Treatments to Patients (2009)

Publisher: Partnership for Prevention

Summary: Step-by-step instructions, checklists, and tools to promote health systems change

http://bit.ly/pfp_hsc

HEDIS & Performance Measurement (2018)

Publisher: National Committee for Quality Assurance

Summary: Measures, data, and reports from the Healthcare Effectiveness Data and Information Set (HEDIS)

http://www.ncqa.org/hedis-quality-measurement

Help Your Patients Quit Tobacco Use: An Implementation Guide for Community Health Centers (2013)

Publisher: Legacy and Partnership for Prevention

Summary: Steps to integrate tobacco use treatment into community health centers

http://bit.ly/legacy_implementationguide

How to Make the Case for Tobacco (2017)

Publisher: American Lung Association

Summary: Talking points on the link between reducing tobacco use and addressing other important community health needs

http://bit.ly/ala_makethecase

Hospital Community Benefits and Tobacco Cessation: A Toolkit

Publisher: American Lung Association

Summary: Information on how to use hospital Community Health Needs Assessments to promote cessation

http://bit.ly/ala_benefitstoolkit

Integrating Tobacco Cessation into Electronic Health Records (2015)

Publisher: American Academy of Family Physicians

Summary: Sample tobacco use template for EHRs

http://bit.ly/aafp_cessationehr

The Joint Commission (2019)

Publisher: The Joint Commission

Summary: Standards and reports from The Joint Commission accrediting body for hospitals and healthcare organizations

https://www.jointcommission.org

Model for Improvement (2019)

Publisher: Institute for Healthcare Improvement

Summary: Overview of the Model for Improvement and Plan-Do-Study-Act cycle for testing small changes

http://bit.ly/ihi_modelforimprovement

More Than the 5 A's: Implementing a Commercial Tobacco Cessation Intervention in Tribal Communities (2014)

Publisher: Red Star Innovations

Summary: Step-by-step plan to integrate the 5As model of tobacco use treatment into tribal health promotion programs

http://bit.ly/redstar_tribalcessation

Primary Care Associations (2018)

Publisher: Health Resources & Services Administration Health Center Program

Summary: Map with links to Primary Care Association websites for all 50 states and Puerto Rico

http://bit.ly/hrsa_primarycare

Providers Overview

Publisher: University of Wisconsin Center for Tobacco Research and Intervention

Summary: Educational materials for healthcare providers on tobacco use treatment guidelines, EHRs, billing codes, and other cessation topics

http://bit.ly/uw_providers

Q&A with Harvard Vanguard Medical Associates and Atrius Health about Health Systems Change to Address Smoking

Publisher: Centers for Disease Control and Prevention

Summary: Activities and results from a health systems change initiative in Massachusetts

http://bit.ly/cdc_smokinghsc

Quality Improvement Organizations Directories

Publisher: QualityNet

Summary: List of regional Quality Improvement Organizations

http://bit.ly/cmms_QIO

Quality Payment Program

Publisher: Centers for Medicare & Medicaid Services

Summary: Overview of the Quality Payment Program which reimburses providers for services to Medicare patients, including tobacco use treatment

https://qpp.cms.gov/about/qpp-overview

Rx for Change (2019)

Publisher: University of California, San Francisco

Summary: Free online training for healthcare providers on treating tobacco use

http://rxforchange.ucsf.edu

Tobacco Cessation Change Package: A Million Hearts® Action Guide

Publisher: U.S. Department of Health and Human Services

Summary: Strategies and resources for healthcare professionals to integrate tobacco treatment into clinical care

http://bit.ly/millionhearts_changepackage

Tobacco Health Systems Change Starter Toolkit for Clinics (2018)

Publisher: ClearWay Minnesota

Summary: Tips and tools to make health systems changes

http://bit.ly/clearway_hsctoolkit

Tobacco Treatment Training (2019)

Publisher: University of Wisconsin Center for Tobacco Research and Intervention

Summary: Free online training for healthcare providers on treating tobacco use, including comprehensive training for mental health and substance use providers

http://bit.ly/uw_training

Treating Tobacco Dependence Practice Manual: A Systems Change Approach (2017)

Publisher: American Academy of Family Physicians

Summary: Tips and templates for healthcare providers who want to make tobacco health systems changes

http://bit.ly/aafp_practicemanual

Using Health Systems Change to Increase Tobacco Cessation: What Can State Tobacco Control Programs Do? Frequently Asked Questions (FAQ)

Publisher: Centers for Disease Control and Prevention

Summary: Answers to common questions about how tobacco control programs can support health systems change

http://bit.ly/cdc_hscfaq

Smoking Cessation Leadership Center Webinars

Publisher: University of California, San Francisco Smoking Cessation Leadership Center

Summary: Webinars proving training and technical assistance to enhance cessation efforts in health systems, many of which offer free continuing education credits

http://bit.ly/sclc_webinars

Improving Coverage

Affordable Care Act Tobacco Cessation Guidance Toolkit (2017)

Publisher: American Lung Association

Summary: Fact sheets, templates, and webinar materials to understand federal requirements for cessation coverage

http://bit.ly/ala_acatoolkit

Approaches to Promoting Tobacco Cessation Coverage: Promising Practices and Lessons Learned

Publisher: American Lung Association

Summary: Strategies used by five states to promote Medicaid cessation coverage

http://bit.ly/ala_promotingcoverage

Case Study: The Effect of Expanding Cessation Coverage—The Massachusetts Medicaid Cessation Benefit

Publisher: Centers for Disease Control and Prevention

Summary: Case study of how expanding Massachusetts's Medicaid cessation benefit improved health and saved money

http://bit.ly/cdc_MAcasestudy

Helping Smokers Quit: Tobacco Cessation Coverage 2014

Publisher: American Lung Association

Summary: State trends in comprehensive cessation coverage

http://bit.ly/ala_cessation

Medicaid Managed Care and Comprehensive Cessation Coverage: A Recommended Approach for State Tobacco Control Programs? (2014)

Publisher: North American Quitline Consortium

Summary: Brief of a roundtable on challenges and lessons learned working to improve cessation coverage with Medicaid Managed Care Organizations

http://bit.ly/naqc_comprehensivecoverage

Medicaid Tobacco Cessation Coverage in Oklahoma: A Case Study in Leveraging Systems and Partnerships

Publisher: American Lung Association

Summary: Challenges and lessons learned improving cessation coverage in the Oklahoma Medicaid program

http://bit.ly/cdc_medicaidOK

A Resource Center for Implementing CDC's 6|18 Initiative (2018)

Publisher: Center for Health Care Strategies, Inc.

Summary: Overview of CDC's 6|18 Initiative, state activities, and implementation tools

http://www.618resources.chcs.org

The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts (2012)

Publisher: PLOS ONE

Authors: Richard P, West K, Ku L

Summary: The cost savings of comprehensive Medicaid cessation coverage in Massachusetts

http://bit.ly/richard_roiMA

ROI Calculator

Publisher: America's Health Insurance Plans

Summary: Online tool for health insurers and employers to calculate return on investment for cessation interventions

http://bit.ly/ahip_ROIcalculator

STATE System Medicaid Coverage of Tobacco Cessation Treatments Fact Sheet (2018)

Publisher: Centers for Disease Control and Prevention

Summary: Fact sheet on Medicaid cessation coverage in each state

http://bit.ly/state_medicaid

State Tobacco Cessation Coverage Database (2019)

Publisher: American Lung Association

Summary: Cessation coverage required under public, private, marketplace, and state employee health plans

http://bit.ly/ala_coveragedatabase

Talk to Your Patients

Publisher: New York State

Summary: Information for Medicaid healthcare providers to increase awareness of covered cessation benefits

https://talktoyourpatients.health.ny.gov

Tobacco Cessation Treatment: What is Covered? (2018)

Publisher: American Lung Association

Summary: Cessation requirements of different health insurance plans under the Affordable Care Act

http://bit.ly/ala_cessationtreatment

Tobacco Use and Secondhand Smoke Exposure: Reducing Out-of-Pocket Costs for Evidence-Based Cessation Treatments (2012)

Publisher: Community Guide

Summary: Effectiveness of reducing costs for evidence-based cessation treatment on increasing cessation

http://bit.ly/communityguide_reducingcosts

Supporting State Quitlines

802Quits (2019)

Publisher: Vermont Department of Health

Summary: Quitting resources for healthcare providers and tobacco users from the Vermont quitline

https://802quits.org/

Asian Smokers' Quitline

Publisher: Asian Smokers' Quitline

Summary: Resources for people who smoke, family and friends, healthcare providers, and state programs about the Asian Smokers' Quitline

http://www.asiansmokersquitline.org/

CDC's Guiding Principles for Public-Private Partnerships: A Tool to Support Engagement to Achieve Public Health Goals (2018)

Publisher: Centers for Disease Control and Prevention

Summary: Steps to create public-private partnerships

http://bit.ly/cdc_partnerships

Cessation Treatment and E-cigarettes: A Report on Current Literature and Quitline Practices (2014)

Publisher: North American Quitline Consortium

Summary: Information on how quitlines respond to questions about e-cigarettes

http://bit.ly/naqc_ecigarettes

Conducting Quitline Evaluations: A Workbook for Tobacco Control Professionals (2015)

Publisher: Centers for Disease Control and Prevention

Summary: Guidance on evaluating quitlines

http://bit.ly/cdc_quitlineevals

Five Reasons Why Calling a Quitline Can Be Key to Your Success (2018)

Publisher: Centers for Disease Control and Prevention

Summary: Guidance for people who smoke on the benefits of quitlines

http://bit.ly/cdc_fivereasons

Increasing Reach of Tobacco Cessation Quitlines: A Review of the Literature and Promising Practices (2009)

Publisher: North American Quitline Consortium

Authors: Bronar C, Saul J

Summary: Strategies to increase quitline reach

http://bit.ly/naqc_increasingreach

Minimal Data Set (2012)

Publisher: North American Quitline Consortium

Summary: Measures for evaluating caller satisfaction and effectiveness of quitline services

http://bit.ly/naqc_minimaldataset

National Quitline Data Warehouse (2018)

Publisher: Centers for Disease Control and Prevention

Summary: Data on quitline services and caller demographics from all 50 states

http://bit.ly/cdc_datawarehouse

Public-Private Partnership Initiative

Publisher: North American Quitline Consortium

Summary: Initiative to help states form cost-saving partnerships with private and public insurers

http://bit.ly/naqc_partnership

Quality Improvement Initiative Issue Paper: Quitline Referral Systems (2013)

Publisher: North American Quitline Consortium

Summary: Types of referral systems and how they work

http://bit.ly/naqc_qii

Quit Your Way (2018)

Publisher: Tobacco Free Florida

Summary: Online portal for Tobacco Free Florida's quitline with links to telephone, group, and web-based services

http://tobaccofreeflorida.com/quityourway

Quitline Services: Current Practice and Evidence Base (2016)

Publisher: North American Quitline Consortium

Summary: Strategies to implement and evaluate quitlines, including telephone and web-based services

http://bit.ly/naqc_evidence

Smokefree Apps

Publisher: Smokefree.gov

Summary: Online portal for QuitGuide and QuitSTART cessation smartphone apps

https://smokefree.gov/tools-tips/apps

Smokefree TXT

Publisher: Smokefree.gov

Summary: Online portal for the national text messaging cessation program, SmokefreeTXT

https://smokefree.gov/smokefreeTXT

Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions (2012)

Publisher: Community Guide

Summary: Effectiveness of quitlines on increasing cessation

http://bit.ly/communityguide_quitlines

Web-Based Services (2018)

Publisher: North American Quitline Consortium

Summary: List of web-based cessation services each state quitline provides

http://bit.ly/naqc_webbased

Reducing Disparities

Best Practices User Guide: Health Equity in Tobacco Prevention and Control (2015)

Publisher: Centers for Disease Control and Prevention

Summary: Steps that state tobacco control staff and partners can take to promote health equity and reduce tobacco-related disparities

http://bit.ly/cdc_healthequity

Guide to Providing Effective Communication and Language Assistance Services(2018)

Publisher: U.S. Department of Health & Human Services

Summary: Guidance for healthcare providers and administrators on effectively communicating with patients from diverse cultures

https://hclsig.thinkculturalhealth.hhs.gov

Implementing Tobacco Cessation Programs in Substance Use Disorder Treatment Settings (2018)

Publisher: Substance Abuse and Mental Health Services Administration

Summary: A guide for program directors and providers on how to incorporate tobacco cessation into substance use treatment programs

http://bit.ly/samhsa_cessation

Networking2Save: CDC's National Network Approach to Preventing and Controlling Tobacco-related Cancers in Special Populations

Publisher: Centers for Disease Control and Prevention

Summary: Consortium of national networks focused on tobacco-related disparities in priority populations

http://bit.ly/cdc_networking2save

Quitlines and Priority Populations: An Update on Our Progress to Reach and Serve Those Most Impacted by Tobacco's Harm (2016)

Publisher: North American Quitline Consortium

Summary: Promising practices to reach priority populations with quitline services

http://bit.ly/naqc_prioritypopulations

Smokefree Policies in Multi-Unit Housing (2019)

Publisher: American Lung Association

Summary: Tools and resources to help housing properties go smokefree

http://bit.ly/ala_smokefreehousing

Case Studies

OKLAHOMA

Advancing Tobacco Treatment: Oklahoma Hospital Tobacco Cessation Systems Program (2018)

Publisher: Oklahoma Hospital Association

Summary: Overview and resources for the Hospitals Helping Patients Quit Initiative

http://bit.ly/OHA_cessationprogram

Cessation Systems Coordination (2019)

Publisher: Oklahoma State Department of Health

Summary: Home page for the Oklahoma tobacco control program's cessation systems initiatives

http://bit.ly/OK_cessationsystems

Health Systems Initiative (2019)

Publisher: Oklahoma Tobacco Settlement Endowment Trust (TSET)

Summary: Overview of the projects funded by the TSET Health Systems Initiative

http://bit.ly/tset_healthsystems

Partnering to Create a Tobacco-Free Culture

Publisher: Oklahoma Hospital Association

Summary: Step-by-step manual on promoting health systems change in hospitals

http://bit.ly/OHA_tobaccofree

RHODE ISLAND

RI Health Plan 2018 Annual Report Form on Tobacco Cessation Benefits (2018)

Publisher: Rhode Island Department of Health

Summary: Form for health plans to report cessation coverage data

http://bit.ly/RI_2018reportform

Tobacco Control Program (2019)

Publisher: Rhode Island Department of Health

Summary: Home page of the Rhode Island tobacco control program

http://bit.ly/RI_TCP

Tobacco Information for Providers (2019)

Publisher: Rhode Island Department of Health

Summary: Guidance for Rhode Island healthcare providers with links to tables describing coverage provided under Medicaid and private health plans

http://health.ri.gov/healthrisks/tobacco/for/providers

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