4.b.i. – Promote Tobacco Use Cessation, Especially Among Low SES Populations and Those with Poor Mental Health

Summary	Resources in Place	Challenges	Resource Needs
• Establish smoke-free indoor and outdoor environments at all of our facilities. • Advocate for change in Medicaid reimbursement policies. • Advocate for coverage of smoking cessation meds. • Track referrals/utilization of the NYS smokers Quitline. • Peer-to-Peer Counseling. • Process and outcomes measures tracking.	• NYS Smokers' Quitline • Ten"Stop Smoking Programs" located throughout Nassau and Queens. • NYC DOHMH's Tobacco – Free Hospitals Campaign. • Public policy assets including NYS's Clean Indoor Air Act, the Adolescence Tobacco Use and Prevention Act. • Existing Community-Based Organizations.	• Staff in FQHCs and OMH/OASAS funded programs may be averse to tobacco training. • Medicaid benefits that limit clinician reimbursement . • Health literacy issues related to education materials. • Engaging low SES people.	• All PPS members will need to have EHRs that prompt and track the 5 A's. • Presentation equipment. • Expanded Medicaid Coverage for smoking cessation initiatives.

4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)

Project Objective: This project will promote tobacco use cessation, especially among low SES populations and those with poor mental health.

Project Description: Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State (NYS). Cigarette use alone results in an estimated 25,000 deaths in NYS. There are estimated to be 570,000 New Yorkers afflicted with serious disease directly attributable to their smoking. The list of illnesses caused by tobacco use is long and contains many of the most common causes of death. These include many forms of cancer (including lung and oral); heart disease; stroke; chronic obstructive pulmonary disease and other lung diseases.

The economic costs of tobacco use in NYS are staggering. Smoking-attributable healthcare costs are $8.2 billion annually, including $3.3 billion in annual Medicaid expenditures. In addition, smoking-related illnesses result in $6 billion in lost productivity. Reducing tobacco use has the potential to save NYS taxpayers billions of dollars every year.

Although there have been substantial reductions in adult smoking in NYS, some tobacco use disparities have become more pronounced over the past decade. Smoking rates did not decline among low-socioeconomic status adults and adults with poor mental health. This project is targets decreasing the prevalence of cigarette smoking by adults 18 and older by increasing the use of tobacco cessation services, including NYS Smokers' Quitline and nicotine replacement products.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements. The implementation must address a specific need identified in the community assessment and address the full service area population.

1. Adopt tobacco-free outdoor policies.
2. Implement the US Public Health Services Guidelines for Treating Tobacco Use.
3. Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).
4. Facilitate referrals to the NYS Smokers' Quitline.
5. Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications.
6. Promote smoking cessation benefits among Medicaid providers.
7. Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications.
8. Promote cessation counseling among all smokers, including people with disabilities.

Partnering with Entities Outside of the PPS for this Project
Please provide the name of any partners included for this project outside of the PPS providers. This may include an entity or organization with a proven track record in addressing the goals of this project.

Entity Name
NYS Department of Health Bureau of Tobacco Control
NYC Department of Health and Mental Hygiene
American Lung Association
American Cancer Society
American Heart Association
Tobacco Action Coalition of Long Island

Project Response & Evaluation (Total Possible Points – 100):

Project Response & Evaluation (Total Possible Points – 100):

1. **<u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 100)**

   a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

Smoking and other tobacco use are significant risk factors for many chronic conditions identified as priorities, such as COPD, heart disease, diabetes, cancer and pediatric asthma. The prevalence of adult smoking in Nassau County was 10.1% and in Queens 15.5%, while the state rate was 17.0% (2009). While smoking rates in New York have declined, they remain high among certain subgroups. The smoking rate among the general population has declined to 16% but individuals with low SES continue to smoke at a rate of 28%. In fact, between 2003 and 2011, people with incomes below $25,000 were the only group in NYS to see their smoking rate increase. Nassau County Community Health Assessment indicates that smoking continues to be highly prevalent among the mentally ill population. People with mental health disorders have a 33% smoking rate, although studies indicate that people with mental illness who receive comprehensive tobacco dependence treatment (TDT) are able to quit at a rate similar to people without mental illness. Additionally, 63% of people with substance use disorders smoke even though data demonstrate that people who stop using tobacco and other substances simultaneously are more likely to abstain from both in the long term. Finally, rates of asthma in children are substantially higher in homes with an adult smoker.

There is reason to believe smoking rates among the Medicaid population are under-reported. Focus groups with Medicaid patients conducted by the Bureau of Tobacco Control found that they did not know about the Medicaid cessation medication benefit, didn't think the medications were effective, and didn't feel comfortable telling doctors about their tobacco use (they indicated that they felt that doctors "looked down" on them for smoking).

All indoor spaces of health care facilities are smoke-free. We will establish smoke-free outdoor environments at all our hospital facilities. We will advocate for changes in current Medicaid

policies that limit the number of times practitioners can be reimbursed for TDT counseling sessions and limit the coverage for cessation medications. We will advocate for health insurance coverage for all prescription and over-the-counter cessation medications and tobacco dependence treatment.

Targeted interventions
The evidence-based guideline recommends screening all patients for tobacco use; and all patients who use tobacco are at risk for developing tobacco-related illness. NQP will promulgate a protocol that requires tobacco screening upon admission. All patients will be asked about their tobacco use, advised to quit, assessed for readiness, assisted to quit with counseling and cessation medications, and provided planning for discharge, including cessation resources (information about local programs, NYS Smokers' Quitline information, prescriptions for cessation medications). The US Public Health Services Clinical Practice Guideline (USPHS) for Treating Tobacco Use and Dependence will be used by PPS partners. Many NQP practices have electronic medical records, and the lead entities have embedded prompts to ensure the provision of tobacco cessation interventions such as the 5 A's (Ask, Assess, Advise, Assist, and Arrange). NQP will ensure all its members' EHRs prompt and track the five A's. We will ensure that our educational efforts are evidence-based by relying on the USPHS Clinical Practice Guideline.

This project will work with providers in FQHCs and OMH/OASAS funded facilities. Staff at the Center for Tobacco Control will train them in the evidence-based practice of tobacco dependence treatment. In addition, they will help develop and support peer-to-peer counseling models in the behavioral health setting.

By coordinating with the public relations departments of NQP' members, we will use earned media to support NYS DOH and CDC anti-tobacco media campaigns that target the low SES and behavioral health populations.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population *must be specific and could be based on geography, disease type, demographics, social need or other criteria.*

While NQP proposes to address tobacco use and dependence among the entire population of Nassau and Eastern Queens, we will also concentrate efforts on the subpopulations that are suffering from negative health consequences of cigarettes at a much higher rate. NYS data indicate that those with low Socio-Economic Status (SES) and Serious Mental illness (SMI) have the highest rates of smoking and consequently the highest rates of chronic illness. NQP will particularly target the Rockaways, which has one of the highest smoking rates in Queens coupled with a low SES population.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Assets related to assisting the population to quit smoking include tobacco-free policies, evidence-based guidelines and prompts for screening and intervention for the patient population, resources to assist in quitting and educating providers, and Medicaid and other health plan

coverage that ensures cost is not a barrier to quitting. Easily accessible providers in the community that are available at all hours, such as pharmacists who are available evenings, and sometimes around the clock, helps to increase the success rate for smoking cessation. Educating the providers who will be recommending and writing prescriptions for both OTC and prescription cessation medications (Medicaid requires a prescription for both types) is essential. Training pharmacists to continue the discussion and counseling would reinforce the message.

Cost can be a barrier to quitting. Although cigarettes are heavily taxed in NYS, many individuals are able to circumvent the tax laws by buying cheaper cigarettes from Native American reservations or online vendors. Although Medicaid Managed Care plans cover cessation medications at low or no cost, patients sometimes perceive cessation medications as too costly. We plan to advocate for better coverage of cessation medications to remove cost as a barrier to treatment.

Public policy assets include NYS's Clean Indoor Air Act, the Adolescent Tobacco Use Prevention Act, prohibitions against smoking on hospital grounds and various taxes imposed by the State; in NYC, amendments to the Smoke Free Air Act of 2002 expanded smoking prohibitions in parks, beaches, and pedestrian plazas. Nassau County has also adopted policies related to the outdoor environment.

There exist two NYSDOH-funded tobacco control multi-sector coalitions: the Long Island Tobacco Action Coalition and the Queens Smoke Free Partnership. In addition the Long Island and Queens Asthma Coalitions provide additional resources.

The USPHS Guideline for Treating Tobacco Use and Dependence will be used by PPS partners. Many NQP practices have electronic medical records, and the lead entities have embedded prompts to ensure the provision of tobacco cessation interventions such as the 5 A's.

The NYS Smokers' Quitline is a multi-lingual resource designed to assist residents with quitting. Services include telephonic quitting assistance, free/discounted cessation medications, an on-line peer support community, linkages to local support programs, and relevant guides and other written materials. Comprehensive "Stop Smoking" programs are located throughout the NQP's region with six in Nassau County and four in Queens.

NYC DOHMH's Tobacco-Free Hospitals Campaign is designed to help every hospital in the city achieve excellence related to comprehensive tobacco-free environments and programs. By joining the campaign, hospitals in Queens can access tools and resources to assess and improve their campus environment, employee cessation programs and patient care systems.

NQP has a robust health care delivery system including 12 hospitals, FQHCs, and OMH facilities. Many have preexisting smoking cessation programs that are resources for this project including NSUH's Center for Tobacco Control, an LIJ affiliate, which has over a decade of experience helping Long Island and Queens individuals quit smoking.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

We anticipate a number of significant challenges with these initiatives, and have proposed methods for overcoming them:

- Engaging staff in TDT training - Concerns that TDT is inappropriate for their clinical role, is time-consuming, and/or ineffective for individuals with behavioral health disorders may result in a reluctance to engage in TDT with patients. By working with our community partners, we intend to provide data to health care providers about: the overwhelmingly negative health impact tobacco use has on patients, particularly those with behavioral health disorders and other chronic conditions; the benefits of quitting tobacco; the desire and ability of individuals to quit; and the significance of treating tobacco dependence, simultaneously with substance use disorders.

- Medicaid benefits that limit clinician reimbursement to six counseling sessions per year and two 3-month courses of cessation medications annually for Medicaid recipients - We will advocate to expand Medicaid coverage and reduce treatment limits. We will also encourage MCOs to expand this covered benefit. NQP may also investigate provider incentive programs which reward high rates of counseling and smoking cessation.

- Health literacy deficits - We will work to ensure our public education materials are simple and easy to understand, and translated into the appropriate languages to ensure residents of the entire area can understand them.

- Enforcement of outdoor smoking bans - NQP intends to provide positive reinforcement for people who choose not to smoke, and work with people wherever they are in their quitting process. Tobacco dependence needs to be treated as an addiction with counseling, medications, empathy, and understanding (recognizing that addiction may include relapses).

- Engaging low SES people in health promotion efforts - We intend to work with CBOs and faith-based organizations in low-SES communities that are already known and trusted. These groups can engage community members in screenings, educational activities and support groups. We will also leverage existing support groups around other issues in order to access people who are open to health messages.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

NQP has no overlap in Nassau or Suffolk. Overlap exists in Queens: Advocate Community Partners (ACP) has included eastern Queens in its service area, but not Rockaway Peninsula. The New York Hospital of Queens and Health & Hospitals Corporation are located in Queens. It appears that we are the only one undertaking this project.

LIJ is a member of NSLIJ, which is a member of ACP and in the first year has 25% of the Board of Directors votes, and in the remaining years of the DSRIP program will have 50% of the Board of Directors votes. Leveraging the LIJ role in NQP and in ACP, LIJ will be able to communicate/share information/best practices or problems with the other PPS as they surface. ACP plans to pursue project 4.b.i Promote tobacco use cessation.

NQP has experienced hub members who have developed population health management models collaborating with PCMH, primary and specialist physicians, behavioral health and substance abuse providers and the health home. North Shore University Hospital, a NQP partner, is a state designated Tobacco Cessation Center. Linking all partners to the RHIO and thereby sharing patient information appropriately for the benefit of the patient is one of the features of reducing tobacco use. Similarly, ACP and other PPSs will be utilizing the RHIO. This common health information technology platform will enable the PPSs to communicate about their patients clinical needs. The RHIO will become a vehicle for the PPSs to effectively and efficiently share patients and understand the patients' clinical history and care plans.

The NYC Department of Health has made this project its top priority within the DSRIP program. It is quite possible that PPSs will choose this project. Currently this PPS has a relationship with the NYC DOH that is also working with the overlapping PPS in NYC. We plan to meet monthly in NYC to discuss strategy and how best to adequately coordinate efforts. The Bureau of Tobacco Control funds contractors who have already been working collaboratively on tobacco control in the 5 boroughs and Nassau County and plan to continue that collaboration over the next 5 years. A population-based project like this one calls for cooperation among overlapping PPSs. It provides the opportunity for efforts to build upon each other.

f. Please identify and describe the important project milestones relative to the implementation of this project. In describing each of the project milestones relative to implementation, please also provide the anticipated timeline for achieving the milestone.

Establish monthly meetings with NYC DOHMH and quarterly project team meetings: end of DY1

Evaluate all EHRs evaluations to determine if TDT prompts are guideline-concordant: 100% by end of DY1

Number of practices that have developed/implemented TDT policies: 100% by end of DY2

Number of staff members trained about TDT at community health centers and at behavioral health centers: 100% by end of DY2

Number of health care providers offering TDT and receiving reimbursement for counseling: 75% gradually from DY1-5

Number of established smoke-free outdoor policies: 75% gradually over DY 1-5

Number of health care providers offering TDT and receiving reimbursement for counseling: 75% gradually over DY 1-5

2. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

This project requires that all PPS members have EHRs (and the technology infrastructure to support them), that prompt and track the 5 A's.

In addition, this project's success will be supported by capital investments in presentation equipment such as laptops and portable LCD projectors to bring various provider sites, which will enable us to more effectively get our tobacco cessation message to the community.

b. Are any of the providers within the PPS and included in the Project Plan PPS currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Descript ion of Initiatives
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollee s with Chronic Conditions	9/1 /12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital.

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

Project 4.b.i will build on and expand the work of this initiative, including a population intervention that targets change in public policy affecting smoking. The project will develop PPS-wide protocols on tobacco screening and counseling. It will also train staff at FQHCs and OMH/OASAS funded facilities in the evidence-based practice of TDT and help develop and support peer-to-peer counseling models in the behavioral health setting.

3. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due by March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.