TEAM KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

OFFICE OF DATA ANALYTICS
DIVISION OF ANALYTICS

TOBACCO USE DOCUMENTATION: A QUALITY IMPROVEMENT PLAN

Summary Prepared by the Office of Data Analytics Division of Analytics

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What is Known on This Topic?
Providers and MCOs implement strategies to identify, prevent, and treat tobacco use. Statewide, the rate of tobacco use remains high, especially among Medicaid beneficiaries. While provider-level efforts have been previously studies, the processes in which MCO structure and implement tobacco use strategies is less studies.

What Did this Project Do?
Working with MCO collaborators and Medicaid claims data, this project evaluated current systematic approaches for proactive identification, treatment, prevention, and rates/claims of tobacco use among members and proposes refinements/additions to Best Practice recommendations.

What Could Medicaid Do with These Conclusions?
Continue collaborative efforts with MCOs and University partnerships to support continuous refinement Best Practices to combat tobacco use in Kentucky.

Introduction

In 2017, statutes and guidelines for tobacco cessation efforts among Medicaid beneficiaries (KRS 304.17A-168) were implemented to overcome barriers to treatment.[1]These policies included provisions for both prescription and over-the-counter cessation drugs and enhanced treatment services at no cost to beneficiaries. While practitioner-level treatment and training efforts have been previously evaluated, the promotional efforts for methods of tobacco cessation training and/or advanced treatment methods by managed care organizations (MCOs) have been less studied. MCOs have statutory directives to ensure beneficiary health, including measures such as intermittent health surveys and documentation of overall patient health (i.e., diagnoses, procedures, treatments, and prescriptions). This study examined how enhanced tobacco treatment programs are administered by MCOs, as well as providing analyses of historical Medicaid claims data to quantify tobacco treatment efforts among tobacco users. Overall, the goal of this study was to develop and define best practice recommendations for tobacco treatment processes and to assess the extent to which tobacco users receive treatment.

Project Methods & Results

MCO Tobacco Treatment Workflow

Between March 2021 and June 2022, MCO collaborators from Aetna Better Health of KY (ABHKY) and Passport/Molina Health (PMH) were paneled to examine procedures for documenting tobacco use and promotion and delivery of tobacco treatment programs for their members. Collaborators discussed and developed generalized ”swim lane” diagrams for each MCO to denote the organization’s interdepartmental workflow, categorizing engagement with external persons (or “touchpoints”) as either member-facing or provider/MCO-facing. Workflow information gathered from both MCOs was further coalesced into a single, summarized workflow of MCO tobacco treatment.

Several opportunities for potential improvement of tobacco treatment processes were identified. These include (a) enhancement of existing strategies to identify tobacco users through annual health risk assessments (HRAs), which could improve the triaging and provision of cessation treatment; (b) refinement of best practice approaches to tailor tobacco treatment based on risk through proactive outreach, shared care planning, and regular reassessments, and; (c) enhance the use of claims data in combination with pharmacy data to evaluate treatment effectiveness and shared reporting of findings internally and with providers.

Survey of High-Risk Tobacco Users

A collaboration with MCOs resulted in the development of a Tobacco User Survey (TUS) which was distributed to high-risk tobacco users. The survey included questions about tobacco use, quantity, frequency, duration of use, exposure to other users, quit attempts and methods, quitting motivation, tobacco-

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related medical conditions, and demographic information, and was mailed to targeted high-risk participants. Out of the 971 mailed surveys, 17 were completed and returned. Survey response rates were relatively low; however, findings were consistent with other studies that utilized similar methods[2]. Participant's age ranged from 32-64 (average of 49), most did not live with minors, identified female, white, and non-Hispanic. Slightly over half had high school diplomas or equivalents and the majority had a steady place to live. The majority used cigarette tobacco products (88.2%). The rate of participants expressing interest in quitting was relatively high but reported self-confidence in ability to quit was lower. Most participants indicated regular discussions about tobacco treatment options with providers. On average, participants had attempted to quit tobacco use 0.5 times in the past month and 1.9 in the past year, with the "cold-turkey" method being the most prevalent. An additional 60% indicating they planned to quit within the next six months.

Tobacco Use and Treatment Among Medicaid Beneficiaries

Diagnosis and procedure codes related to tobacco use treatment and tobacco cessation-prescription claims were utilized to identify tobacco related claims pre- and post-KRS 304.17A. Tobacco use prevalence showed a significant but minor decline from the pre- to post-KRS period overall. Claims with documented procedures for cessation counseling varied across ADD region. Baseline utilization for counseling increased significantly statewide by 64% between the two time periods. Table 1 describes this result.

Table 1. *Count of Tobacco Cessation Counseling Claims*

Procedure – **Tobacco cessation counseling**	Pre (N_1 = 2,370,272 encounters)	Post (N_2 = 3,001,477 encounters)	*IRR* (95% CI); p
ADD	n_1	n_2	
Barren River	37,590	61,265	1.17 (1.16 - 1.18); <.001
Big Sandy	48,595	85,295	1.44 (1.43 - 1.46); <.001
Bluegrass	62,313	126,267	1.62 (1.60 - 1.63); <.001
Buffalo Trace	11,958	15,433	1.06 (1.04 - 1.08); <.001
Cumberland Valley	42,656	56,790	1.05 (1.03 - 1.06); <.001
FIVCO	21,081	47,383	1.79 (1.77 - 1.82); <.001
Gateway	16,921	28,895	1.40 (1.38 - 1.43); <.001
Green River	27,709	48,283	1.40 (1.38 - 1.41); <.001
KIPDA	78,674	138,362	1.32 (1.31 - 1.33); <.001
Kentucky River	50,031	32,480	0.63 (0.63 - 0.64); <.001
Lake Cumberland	16,752	25,981	1.11 (1.09 - 1.12); <.001
Lincoln Trail	39,826	59,139	1.14 (1.13 - 1.15); <.001
Northern Kentucky	40,074	61,914	1.49 (1.47 - 1.51); <.001
Pennyrile	16,863	38,022	1.39 (1.37 - 1.41); <.001
Purchase	23,324	53,654	1.45 (1.43 - 1.47); <.001
Statewide	**534,367**	**879,163**	**1.30 (1.30 - 1.30); <.001**

Note: Table 1 here appears at Table 7 in the SUP report.
IRR = Incidence Rate Ratio

The number of medications also varied tremendously by type. The number of patients with a Wellbutrin® prescription increased from 638 to 752. Most ADDs also demonstrated an increase in the baseline number of prescriptions for Chantix®, with a statewide increase of 85%. Table 2 describes this growth in the state. Nicotine replacement therapy (NRT) prescriptions also showed a significant, modest increase of 32% between the pre- to post-KRS 304.17A-168 eras statewide.

Table 2. *Count of Claims for a Chantix® Prescription*

NDC Code – **Chantix**	Pre (N_1 = 2,370,272 encounters)	Post (N_2 = 3,001,477 encounters)	*IRR* (95% CI); p
ADD	n_1	n_2	
Barren River	583	1,674	2.06 (1.88 - 2.27); <.001
Big Sandy	318	638	2.65 (1.44 - 1.89); <.001
Bluegrass	1,334	3,337	2.00 (1.87 - 2.13); <.001
Buffalo Trace	134	313	1.92 (1.57 - 2.35); <.001
Cumberland Valley	445	1,500	2.65 (2.38 - 2.94); <.001
FIVCO	807	1,839	1.81 (1.66 - 1.96); <.001
Gateway	165	404	2.01 (1.68 - 2.41); <.001
Green River	631	1,648	2.09 (1.91 - 2.29); <.001
KIPDA	3,114	1,973	0.47 (0.45 - 0.50); <.001
Kentucky River	383	837	2.13 (1.89 - 2.41); <.001
Lake Cumberland	78	804	7.34 (5.82 - 9.26); <.001
Lincoln Trail	1,105	649	0.45 (0.41 - 0.50); <.001
Northern Kentucky	957	1,970	1.99 (1.84 - 2.15); <.001
Pennyrile	156	655	2.58 (2.17 - 3.08); <.001
Purchase	211	997	3.15 (2.71 - 3.65); <.001
Statewide	**10,421**	**19,238**	**1.46 (1.42 - 1.49); <.001**

Note: Table 2 here appears at Table 8 in the SUP report.
IRR = Incidence Rate Ratio

Conclusion

The high prevalence of tobacco use, especially among Medicaid beneficiaries, necessitates the refinement and consideration of new strategies to identify, track, and treat tobacco use. By improving best practice recommendations and supporting the refinement of strategies deployed by MCOs, including proactive measures such as surveys, claims, or pharmacy analyses, statewide rates of tobacco use cessation and prevention services could continue to rise.

Overall, the following best practice recommendations, derived from insights from this study, were devised into four categories:

1. **Identify tobacco users:** Annual assessments (HRA) should be incentivized to increase completion rates. Assessment should also assess all types of tobacco/nicotine product use (including electronic cigarettes/vaping), denote users as current (used in past 30 days), former (not used in past 30 days), or never users and include fields for social determinants of health screening.
2. **Reach tobacco users:** Improving outreach to tobacco users should include increases in promotion of support and services for cessation services and medications, engagement in community outreach for tobacco use prevention and treatment, continue focus on the beneficiary's cessation during "touchpoint" periods, and the exploration of pharmacy data to reach tobacco users.
3. **Connect tobacco users to treatment:** Efforts should be made to stratify risk to match users with the appropriate level of services and connect them to appropriate treatment resources
4. **Evaluate tobacco treatment:** Treatment engagement and effectiveness definitions should be standardized, claims/HRA/pharmacy data should be collected and evaluated for use and treatment to share in public reports, and promotion of collaboration across MCOs and state agencies is encouraged.

References

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2. Brasky TM, Hinton A, Doogan NJ, et al. Characteristics of the Tobacco User Adult Cohort in Urban and Rural Ohio. *Tob Regul Sci*. 2018;4(1):614-630. doi:10.18001/TRS.4.1.8