State Stories on Tobacco Cessation: Michigan:
Improving Tobacco Cessation among Adults with Serious Mental Illness

[Voiceover] State stories on Tobacco Cessation
Michigan: Improving Tobacco Cessation among Adults with Serious Mental Illness

This video is part of a series highlighting successful tobacco cessation strategies for populations at an elevated risk for tobacco use.

Medicaid and CHIP agencies may consider implementing these strategies into their programs.

Michigan's Region 10 Prepaid Inpatient Health Plan provides services for residents of Genesee, Lapeer, Sanilac, and St. Clair counties.

[Tom Seilheimer] Hi, I'm Tom Seilheimer. I'm the Chief Clinical Officer at Region 10 Prepaid Inpatient Health Plan, in Michigan. Today I want to talk to you about a Performance Improvement Project, or PIP, that our prepaid inpatient health plan has been working on for the past couple of years. The PIP focused on increasing the use medical assistance for tobacco cessation to help people quit using tobacco products. The PIP was designed for people with serious mental illness, or SMI, served within our Medicaid region.

Tobacco use comes with serious health risks, and the consequences are especially impactful for people with SMI. Life-expectancy for people with SMI is on average at least 15 years less than the general population, and this outcome is due to chronic medical conditions, many of which are associated with tobacco use.

And so, for the people we serve, tobacco use is another serious challenge to their Psychiatric Recovery.

In Michigan, approximately 70% of people with SMI who use tobacco report *wanting* to quit, which is similar to what is reported by our state's general population. Yet despite this desire, people with SMI have low rates of receiving medical assistance for tobacco use cessation. Only 6.9% of Region 10 SMI adults received medical assistance with tobacco use cessation.

On the next slide, you will see that medical assistance for tobacco use cessation has three components:
(1) advising people who use tobacco to quit
(2) recommending or discussing tobacco use cessation medications, such as nicotine gum and patches, nicotine nasal spray, bupropion, and varenicline, and
(3) Discussing non-medication cessation strategies, such as group therapy, telephone helplines, and individual counseling.

For quite some time then, Region 10 has been aware that tobacco use is a serious problem for people with SMI, that tobacco use cessation treatments were available and that behavioral health care (or BH) providers seemed to be in the position to help. But we were still faced with some challenging questions. If we were to do something about this problem, what needs to be done and how can we all work together?

At about the same time, the Michigan Department of Health and Human Services sent a broad list of PIP ideas to all prepaid inpatient health plans to consider for the coming calendar year, and medication

assisted treatment for tobacco use cessation was on that list. In Region 10 there was broad based interest in medication assisted treatment for tobacco use cessation. And so, our Quality Management Committee (or QMC) took lead with this task, bringing together the prepaid inpatient health plan as well as Community Mental Health Services Program Quality and Data Management leaders.

We quickly noticed that, even though the four Community Mental Health Services Programs were already doing something to address tobacco use cessation, much more needed to be done.

To prepare for the PIP, each Community Mental Health Services Program carried out a barrier and root cause analysis. Using this analysis, we identified key organizational factors and beneficiary factors that needed to be addressed.

For organizational factors, the low rate of medical assistance for tobacco use cessation was linked to a variety of factors. Two factors were misconceptions held by BH providers - one was that tobacco cessation services were not significant aspects of psychiatric recovery, and the other was that cessation services did not work or did not work well for adults with SMI. BH providers also believed that discussing tobacco cessation was either not within a BH provider's scope of practice or was a low priority within the BH provider's scope of practice. As a result, assessments for tobacco use were not being completed and psychiatry staff were not writing scripts for tobacco cessation medication. Further, it was found that some staff even encouraged residents to smoke when presenting with anxiety or agitation. We also found that there was no clear programming or messaging in support of tobacco cessation to address these misconceptions.

The analysis also found several beneficiary factors linked to the low rate of medical assistance for tobacco use cessation. For example, some people with SMI mistakenly believed they would not be able to quit. We also discovered an information gap. People with SMI lacked information about how quitting would improve their health, about tobacco use cessation services, and about tobacco medication assisted treatment. Many of these gaps in information were in part because people with SMI were not connected to, or did not engage with, a primary care team.

Based on these findings, we moved forward with a PIP that sought to minimize service system barriers and maximize service systems capacity so that adult Medicaid beneficiaries with SMI had a greater opportunity to effectively engage in and receive medical assistance for tobacco cessation. The PIP began in 2018 and, as of this presentation, it is expected to conclude during 2022.

Each Community Mental Health Services Program developed its own PIP Improvement Action Plan. As no surprise, many of the systems improvement tasks put into place were similar across the Community Mental Health Services Programs, because many of their root cause and barrier analysis findings were also similar.

The action plans addressed a wide range of service systems issues, by creating standardized tobacco use assessment and monitoring protocols, enhancing electronic health records, and expanding staff capacity by hiring tobacco cessation specialists and establishing peer-led focus groups and support groups.

Additional activities included establishing tobacco-free campuses, providing informational documents for beneficiaries, and partnered activities with Primary Care clinics and County Public Health clinics. They also offered staff orientation and refresher training in the 5As of tobacco cessation pertaining to Ask,

Advise, Assess, Assist, and Arrange and provided resources for beneficiary transportation to needed services.

Also essential to each plan was the need for clear, unwavering communications from executive and clinical leaders in support of the PIP.

PIP findings have been gathered across three years of systems improvement activity. We found that, compared to baseline, the PIP activities undertaken were linked to an increased rate of medical assistance for tobacco use cessation.

However, for 2020, which was remeasurement year 2, we found no statistically significant change to the rate, compared to the prior year. Evaluation of PIP activities undertaken identified negative impacts due to the COVID-19 pandemic and the significant implementation challenges across the region.

Evaluation of the findings for remeasurement Year 3 are underway, but our initial review indicates that, somewhat to our relief, the region's goal has been met in ensuring greater opportunity to effectively engage in and receive medical assistance for tobacco cessation. During 2021, the Community Mental Health Services Programs worked hard to reassess their plans and figure out workarounds for their improvement activities. But not to get ahead of ourselves, I'd like to focus on our lessons learned so far, as I think they are indeed worth sharing.

Due to the PIP, a variety of key organizational and service systems changes have occurred, such as tobacco-free campuses across the Community Mental Health Services Programs. Some of the largest changes relate to changes in BH provider beliefs and practices. For example, most staff now realize that tobacco use cessation services can be an important part of psychiatric recovery and that these services can be provided safely and effectively. Most BH providers now routinely use tobacco assessment protocols and discuss tobacco use and cessation options with the people they serve, and they actively address follow up services, as needed. Finally, all network prescribers now include such medical assistance in their scope of practice.

This PIP also led to a variety of key beneficiary service changes. More people with SMI now see tobacco use as a substance-related issue that they can address as part of their psychiatric recovery, and more people with SMI now report that they believe they can quit tobacco or that it's at least worth a try. Additionally, all people served with SMI have either been offered or received helpful information about the health benefits that come with quitting tobacco and about tobacco use cessation services.

I appreciate having had this opportunity to share our PIP with you, as this undertaking no doubt has offered immediate as well as ongoing benefits to the persons we serve. And so, if you have any questions or comments about this presentation, please feel free to contact me through my email address, posted on this last slide. And thanks again for your time.

[Voiceover] We hope that these videos have you considering how to start a tobacco cessation program in your state.

Here are a few tips from the Michigan program.

Find partners to work with. Your Managed Care Organizations can be good places to start. Remember that Managed Care, and Managed Care-like organizations, can bring unique resources to quality improvement work.

For more information and quality improvement support, contact CMS at MedicaidCHIPQI@cms.hhs.gov.