6.13.2017 | PREPARED FOR VERMONT TOBACCO CONTROL PROGRAM

PROVIDER RESEARCH

FINDINGS & IMPLICATIONS

HMC

802 QUITS

VERMONT DEPARTMENT OF HEALTH

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EXECUTIVE SUMMARY

Primary care providers are uniquely positioned to serve as tobacco cessation hubs to which other providers act as spokes and refer patients in need of personalized tobacco cessation counseling.

These findings strive to complete the picture of Vermont providers' knowledge, attitudes, and behaviors surrounding tobacco treatment best practices. Although most providers consistently ask about tobacco use and advise patients to quit, variances exist in how patients are advised and counseled, how and where patients are referred for additional support, and who is counseled about medication. Additionally, most providers have significant knowledge gaps specific to available quit resources.

Despite these inconsistencies, all providers, regardless of specialty, demonstrated inclinations to treat their patients holistically and with compassion, often striving to address the emotional, social, and cultural contributors. For many providers, the most significant counseling barriers related to the severity of nicotine addiction and knowledge and skill gaps on effectively engaging and motivating patients.

Knowing this, primary care providers are uniquely positioned to serve as tobacco cessation hubs to which other providers act as spokes and refer patients in need of personalized tobacco cessation support. Given the familiarity, exposure, and trust patients tend to have with their primary care providers, these providers are best suited to pursue tobacco cessation counseling, discuss appropriate quit resources and tools, and follow up on their patients' progress.

These findings also shed new light on the complex field of medical coding and billing in relation to tobacco treatment and counseling. While accurate coding and maximized reimbursement are key priorities for both providers and coding and billing professionals, both groups were not familiar with and did not use tobacco counseling CPT codes.

Considering these insights, the Vermont Tobacco Control Program (TCP) should tailor and fortify its cessation information, channels, and resources to fill specific knowledge and self-efficacy gaps for primary care providers. Outreach should take into consideration providers' barriers to cessation counseling, their preferences and desired resources for tobacco treatment, and incorporate preferred and trusted information sources and continuing education methods.

INTRODUCTION

THE PROGRAM SITUATION

TCP has made significant strides to encourage and equip health care providers with information and resources for incorporating tobacco cessation counseling into the clinical setting. Leading in to this research, anecdotal research, 802Quits web metrics, and CPT code utilization data suggest that there's more work to be done to support providers in tobacco cessation counseling.

THE PROGRAM DECISIONS

The research will supply information to help the Tobacco Control Program answer:

- What information would this key audience of providers (a) desire the most, and (b) be most likely to put into action?
- How is this pertinent information best packaged?
- What messaging and communications channels most successfully reach the provider audience?

RESEARCH OBJECTIVES

1) Uncover barriers for Vermont providers in successfully:
    a. Counseling patients around tobacco cessation,
    b. Coding and billing for counselling reimbursement; and
    c. Accessing and utilizing available cessation resources.
2) Describe the types of tobacco cessation information and resources that promote and support Vermont providers in the delivery of cessation counseling, treatment, referral, and reimbursement.
3) Identify channels that effectively reach most Vermont providers in order to deliver information and resources.
4) Evaluate differentiating factors among providers that may define unique sub-groups for outreach and targeting.

(1) Provider In-Depth Interviews (IDIs)

Qualitative, in-depth-interviews (IDIs) using open-ended questions were conducted with Vermont medical and dental providers (collectively referred to as providers throughout the document).

Sample

Specialty	Total	By Roles
Primary Care (Family Medicine, Internal Medicine, Pediatrics)	14	4 Nurse Practitioners (NP) 5 Physicians (MD) 5 Physician Assistants (PA)
Specialists (Dentistry, Orthopedics, Outpatient Surgery, Anesthesiology, Cardiology, Nephrology)	8	2 MDs 1 Dental Hygienist 1 NP 1 Registered Nurse (RN 1 Dentist (DMD) 1 PA 1 Addiction Counselor (MA)
Urgent Care, Emergency Medicine	3	2 NPs 1 PA
Total IDIs	**25**	

Sample Source

HMC employed both convenience snowball sampling and paid outreach to recruit participants. First, a preliminary set of potential participants was directly recruited and then asked to refer other interested participants.

The Tobacco Control Program shared the opportunity with its partners and programs of the Vermont Department of Health (VDH). Likewise, participants were recruited via paid ads and listings in targeted social media.

Data Collection

HMC researchers spoke with participants via phone for 30 to 45 minutes. Calls were audio recorded for transcription purposes only, and written notes were captured during each call.

Participants received a $100 gift card to compensate them for their time and feedback.

Analysis Approach

Each IDI transcription was coded for key topic areas and trends. Codes for all interviews were then analyzed for patterns.

(2) Billing & Coding Specialist In-Depth Interviews (IDIs)

Qualitative in-depth-interviews (IDIs) using open-ended questions were deployed among Vermont-based billing and coding specialists.

Sample

Clinical Setting	Total
Third-party coding and billing company	2
Hospital-based coding and billing department	3
Private practice	1
Total	**6**

Sample Source

HMC likewise employed convenience snowball sampling to recruit participants for billing and coding interviews by asking participating providers to refer relevant contacts.

Data Collection

HMC spoke with specialists via phone for 30 to 45 minutes. The calls were audio recorded for transcription purposes only, and written notes were captured by the interviewer during each conversation.

Participants received a $50 gift card to compensate them for their time and feedback.

Analysis Approach

Each IDI transcription was coded for key topic areas and trends. Codes for all interviews were then analyzed for patterns.

(3) Provider Online Survey

To expand the reach of the qualitative data garnered in the previous phase's IDIs, a qualitative online provider survey was deployed among Vermont medical and dental providers to capture their

preferences surrounding continued learning on tobacco cessation research, strategies, and methods. This survey also gauged provider trust of various informational resources as well as awareness and perceptions of 802Quits and cessation-reimbursement opportunities in Vermont.

Note, the survey did not employ a sample approach or size to project results to the population. Rather, the data collected aims to broaden the reach of the qualitative study.

Sample

Specialty	Total
Primary Care, Family Medicine, OB/GYN, Internal Medicine, Pediatrics	27
Dentistry	24
Specialists (Pulmonology, Respiratory Therapy, Anesthesiology, Nephrology, Research, Podiatry, Sleep Medicine, Lifestyle Medicine, Dietetics)	13
Non-medical/dental	3
Did not answer/did not complete/did not qualify	20
Total	**84**
Total completes	**64**

Sample source(s)

Like other methodologies, a convenience snowball sampling technique was employed for the survey, beginning with sharing the link with associated Health Department program staff and key partners and stakeholders to reach Vermont-based health care and dental providers. Paid digital advertising was also used to achieve broader reach among providers.

Data Collection

HMC programmed the survey in SurveyMonkey. Surveys were anonymous, so responses by email address were not tracked. IP restrictions did prevent duplication in taking the survey. Because of the anonymity, it is possible there are duplications between the survey respondents and the provider IDI participants.

Analysis Approach

Frequency of response was calculated for each question either within SurveyMonkey or Excel. Results were also analyzed by medical/dental specialty.

KEY FINDINGS

CONCLUSIONS & IMPLICATIONS

Tobacco cessation is a natural fit and top priority for all providers

Significant conceptual overlap exists in providers' perceptions of their overarching care philosophy as well as their roles specific to treating tobacco use.

Themes such as efficacy in practice (e.g. using evidence-based strategies), collaboration and shared decision making with patients, and the importance of prevention prominently emerged when providers described their general approach to practicing medicine/dentistry and the key aspects of their role in treating tobacco use.

"I approach tobacco cessation with all patients who are currently smoking, but I'm more involved when they're here for an exacerbation of emphysema or an upper respiratory infection."

-NP, Urgent Care

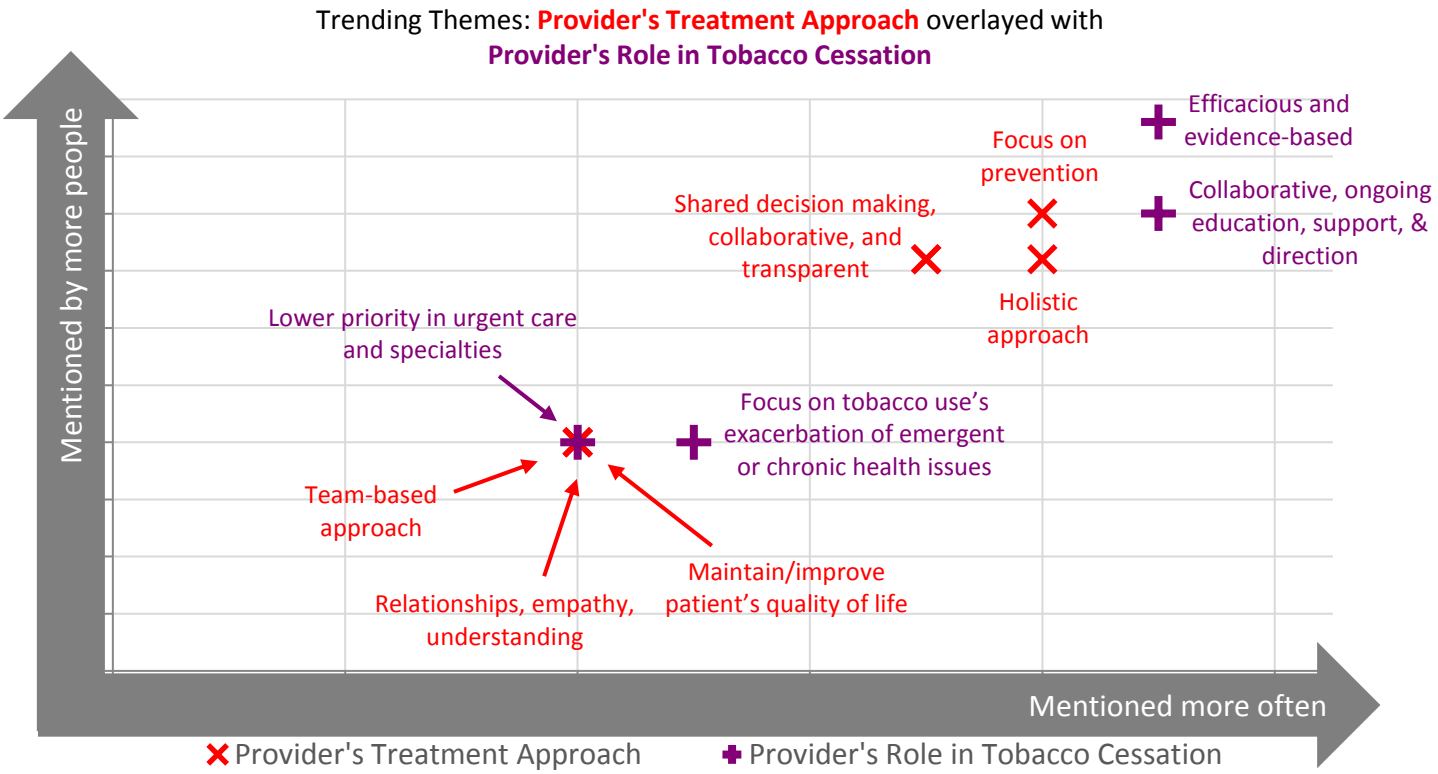
In addition to these parallels, most providers reported being intrinsically motivated by tobacco's impact and exacerbation of their patients' health conditions and risks. Many providers reported relating their tobacco cessation discussions to a patient's current health condition and, thus, feeling more relevant and effective in the delivery of these messages, in the course of the patient's overall care. Specialists, including dental providers, were more likely to report having a minor role in treating tobacco use among patients, leaving that responsibility to primary care providers.

Figure 1: Top Provider Keywords Related to Treatment Approach and Tobacco Cessation Counseling (Provider IDIs)

Approach to Treatment Generally

Approach to Tobacco Cessation Counseling

Figure 2: Key Aspects of Provider Treatment Approach and Role in Cessation (Provider IDIs)



Implication #1

When communicating to providers about tobacco treatment best practices, frame messages and asks in terms of the key characteristics of providers' care philosophy, particularly efficacy in practice, collaboration and trust with patients, and benefits of prevention, among others. This focus leverages the primary benefits of helping patients quit tobacco, but also draws on secondary, implicit benefits to both providers and patients. Moreover, emphasizing elements of the cessation process that naturally align with a provider's priorities allows for more seamless integration into practice, allows for more customized feedback and support for patients, and ultimately strengthens the patient-provider bond needed to help a patient make positive changes that extend beyond tobacco use.

Providers do not see tobacco cessation counseling and support as distinct from or in addition to how they would normally approach interactions with patients. Rather, providers integrate tobacco conversations into their overarching, holistic approach to their patient's health and wellbeing. Asking providers to take a formulaic, start-stop approach to cessation counseling (i.e. an abrupt transition from one topic to the next, or introducing the tobacco conversation as a standalone topic) may feel foreign or disjointed in the context of a patient visit.

This is especially true considering cases of disinterested patients or patients who push back, and in the context of provider time and resources constraints. Weaving the cessation conversation in a bigger context that links to other health priorities eases the burden on the provider and fits more naturally into the patient visit flow—all of which may make the provider more likely to counsel and provide ongoing support.

Likewise, providers recognize that a formulaic or start-stop approach is inherently one-sided to the provider, and does not constitute all the required inputs. From their perspective, successful counseling is a combination of fact-based evidence plus the patient's reality. Based on training, and consequences of how the medical system works today, the provider enters an exam room best positioned to bring an evidence-based perspective to the conversation. However, they value and prioritize collaboration to better understand a patient's reality, and this is not an insignificant bridge to build. There are many dots providers work to connect—usually quickly and on the fly—in order to link factual knowledge to the life experience of the patient in a way that resonates. Focusing provider-targeted messaging and support, whether explicitly or implicitly, primarily on the provider as *knowledge giver* risks overlooking two key roles they see themselves playing: listener and problem solver.

Because providers intrinsically value cessation, particularly in the context of the whole-body impact, and because providers feel it is essential to fill in blanks with the patient's collaboration, messages should deprioritize reminders for providers to counsel, and focus on how providers can leverage these existing values with their patients who use tobacco to jointly reach a solution. It's likely this strategy is more relevant and impactful than education about why tobacco cessation is a benefit to patients. While ongoing education on tobacco treatment best practices and new clinical information are important and should continue, more nuanced opportunities exist to support providers in having effective patient encounters that engage, motivate, and ultimately spur patient action.

Primary care providers, as the hub of tobacco cessation, need unique support

Using the "5 A's" model for treating tobacco use and dependence (Agency for Healthcare Research and Quality, 2012) as a best-practices template, providers were mixed in the consistent and effective execution of these evidence-based strategies (Ask, Advise, Assess, Assist or Refer, Arrange or Follow-up). Despite diverse knowledge, attitudes, and behaviors among providers, data suggest primary care providers are best suited and have the most influence to positively prompt and support a patient's tobacco cessation journey.

Ask

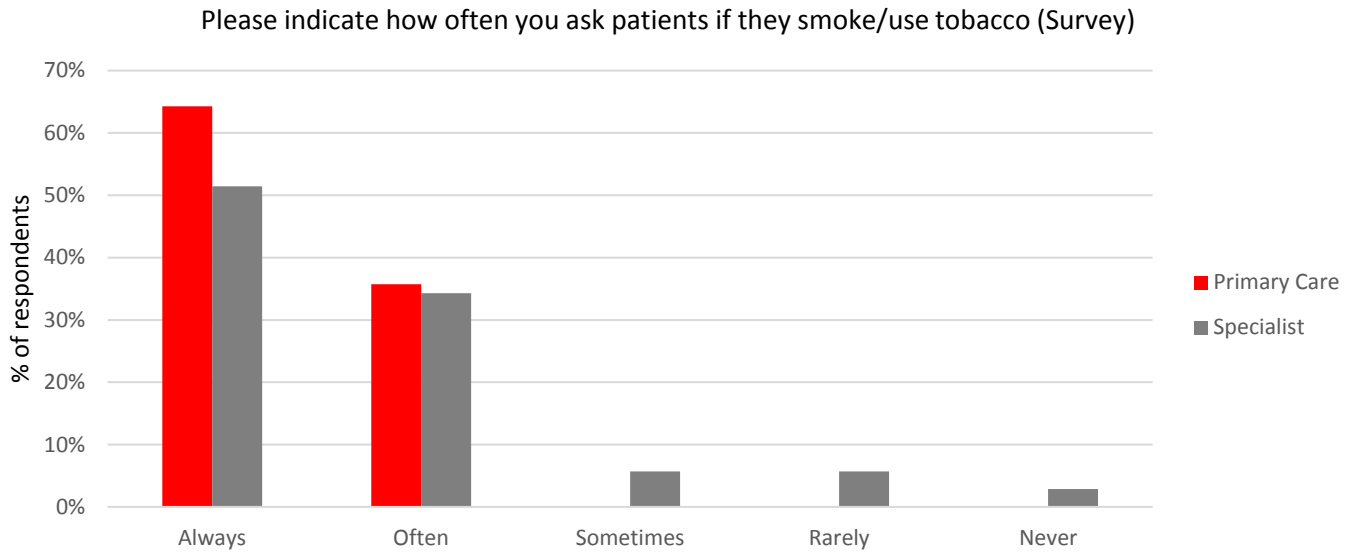
All providers indicated that their electronic health record (EHR) system documents tobacco use and, as a result of the initial EHR screening process, all patients are "asked" about tobacco use—often by the nurse or medical assistant. In addition to electronic documentation of tobacco use, most medical providers still ask their patients if they use tobacco, especially those who present with tobacco-related or exacerbated conditions (e.g. cold/respiratory infection, asthma, etc.).

"If they're in for a cold and coughing, I ask them right away, or if I'm trying to use it to make a point about their health."

-MD, Primary Care

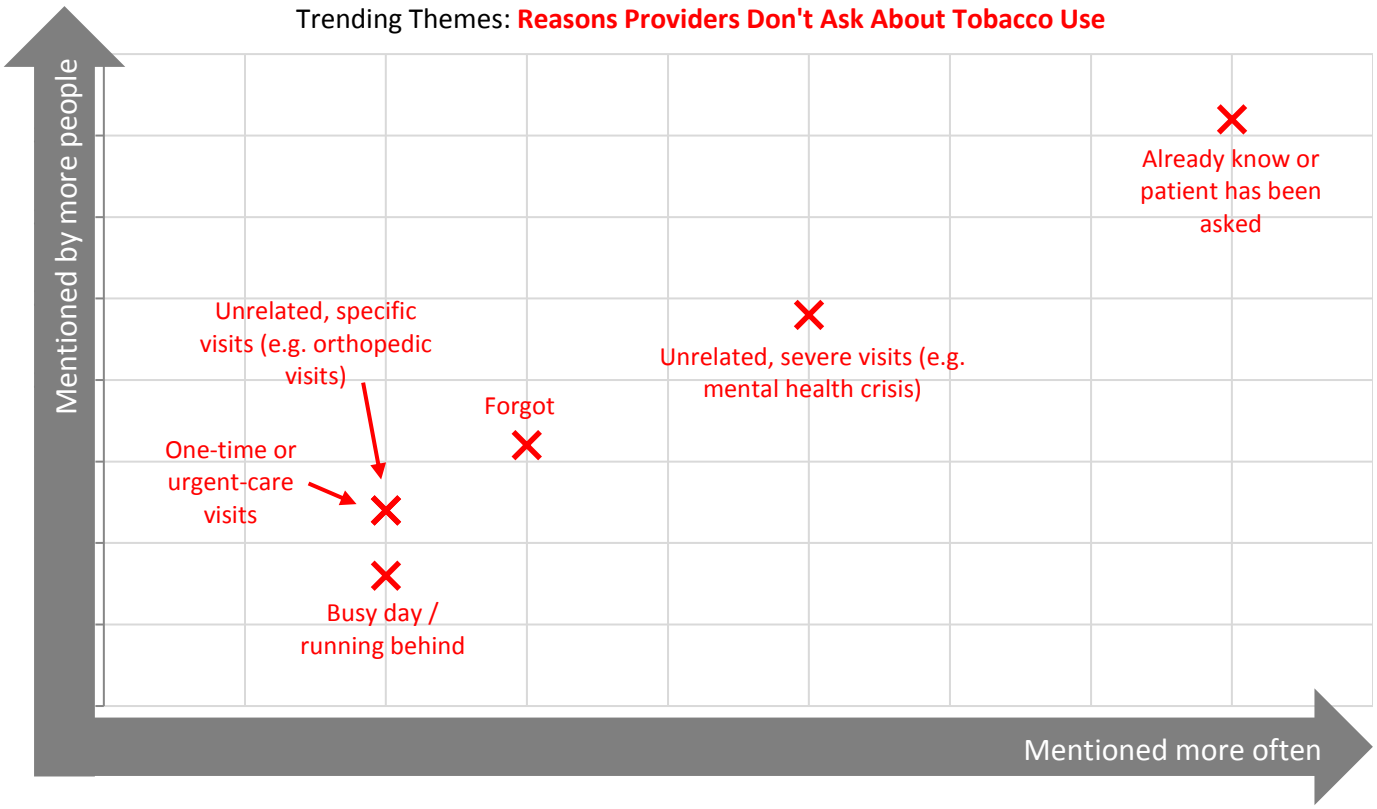
This focus on asking patients about tobacco use was also reflected in the survey, for both primary care providers and specialists.

Figure 3: Frequency of Asking About Tobacco Use (Survey)



Common reasons providers may not ask include: the patient was already asked by a nurse or medical assistant, time constraints, the provider forgot, and the patient had a serious, urgent, and/or non-tobacco-related condition/injury.

Figure 4: Reasons Providers Don't Ask About Tobacco Use (Provider IDIs)



Advise/Assess

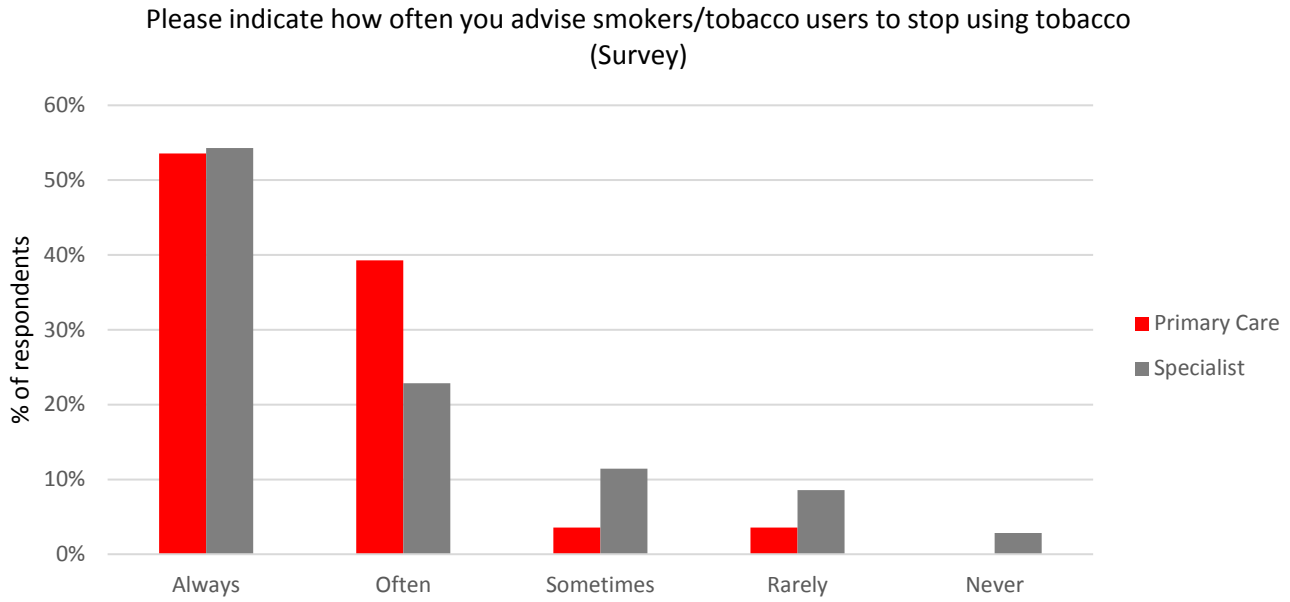
Per IDIs, two thirds of providers reported advising all patients who use tobacco to quit. As seen in the previous "ask" step, providers were more motivated to advise and assess when a patient presented with a health condition complicated or exacerbated by tobacco use.

Survey feedback likewise indicated that most providers – whether primary care or specialist – always or often advise a tobacco user to quit.

"I always advise them to quit. The question is how hard am I going to push? I push less hard if people are not motivated in any way."

-NP, Primary Care

Figure 5: Frequency of Advising Cessation (Survey)



In addition to a patient's health status, providers' methods for advising and assessing are greatly influenced by a patient's readiness to quit, which providers gauge by asking patients directly or reading their body language and verbal cues. For most providers, this "readiness" conversation incorporates principles of stages of change theory and motivational interviewing.

According to several providers from primary care, urgent care, and other specialties, patients tend to be more open and motivated to quitting when they are experiencing direct, negative health effects and discomfort due to an illness or injury.

"It's easier for me because [my patients] have an active problem. They are sometimes more receptive to quitting because they're in so much pain."

- PA, Orthopedics

Patients with other addictions or mental health concerns and those under chronic stress or in a crisis/grieving situation were the most common reasons cited for not advising/assessing about tobacco cessation. Primary care providers were the only specialty to not advise/assess (or were less likely to advise/assess) because of a patient's competing health care, emotional or mental health, and lifestyle concerns.

Figure 6: Reasons Providers Don't Advise to Quit and Deterrents to Cessation Counseling (Provider IDIs)

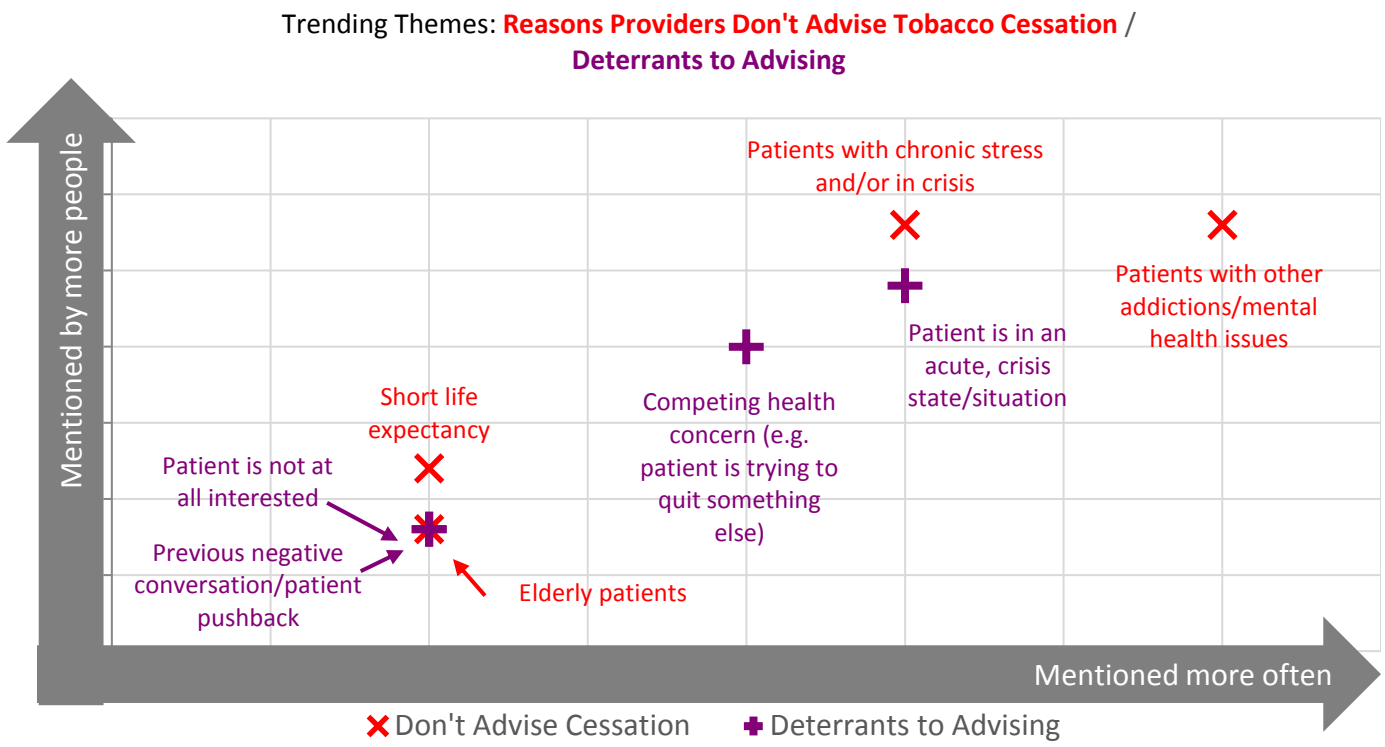
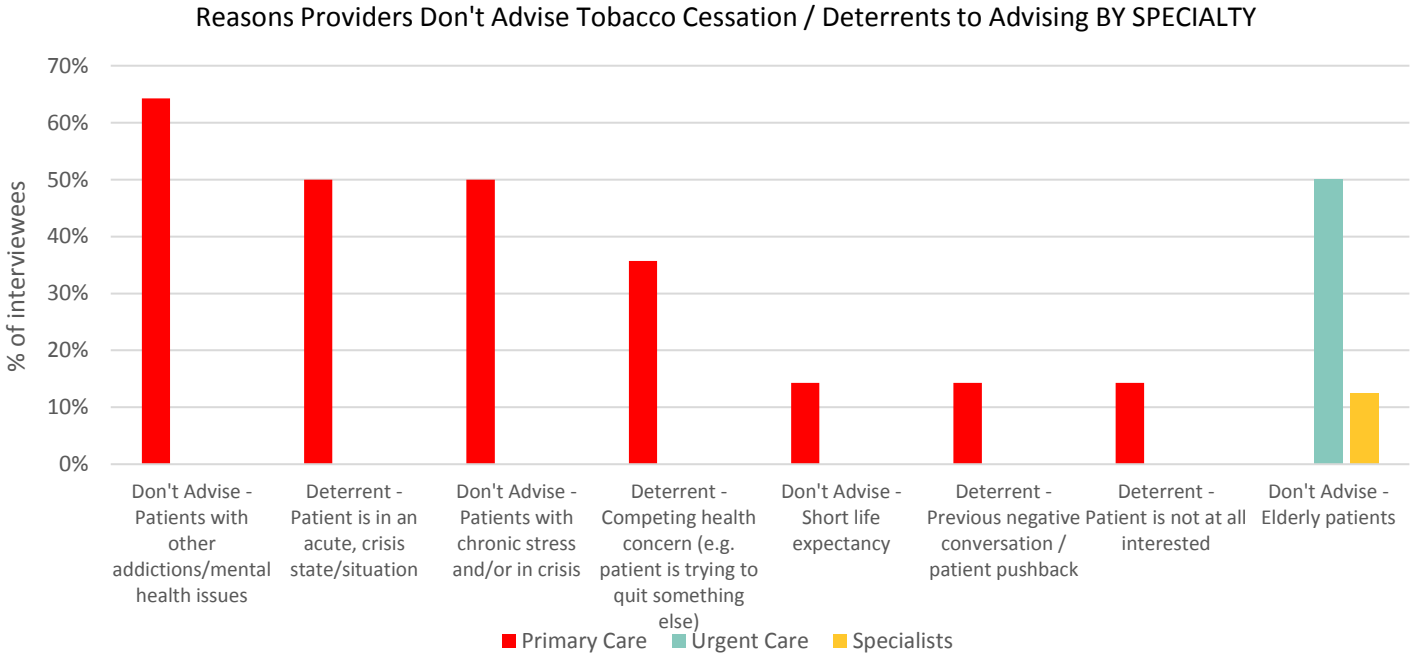


Figure 7: Reasons Providers Don't Advise to Quit and Deterrents to Cessation Counseling by Specialty (Provider IDIs)



Refer (Assist)

Across roles and specialties, providers weigh heavily a patient's interest in quitting and their readiness and motivation to quit when deciding to refer patients to additional support. Nearly all providers only refer patients who are open to and engaged in the quitting process.

Providers' knowledge (or limited knowledge) of referral information, sources, and materials is a key factor in how and where a patient is referred to for follow-up cessation support. This is true for many providers—across all specialties—who only know of one or two quit-help types (e.g. Quitline, 802Quits, hospital classes, etc.) to which they refer most of their patients.

"I only know about the Quitline and that's where I refer people."

-RN, Urgent Care

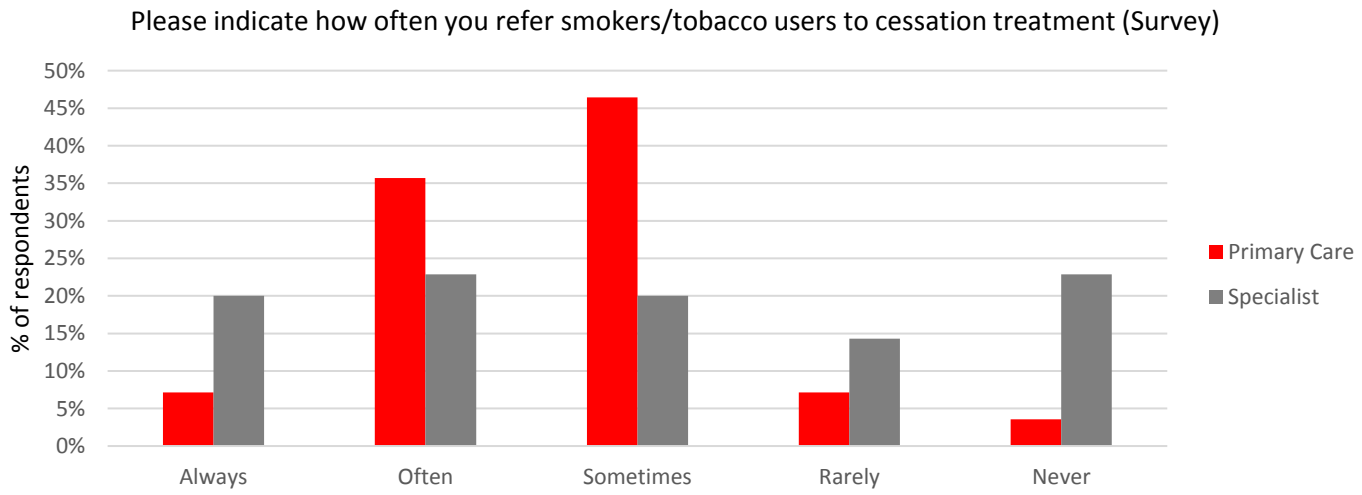
Primary care providers are more likely to consider and discuss referral options with their patients and make an informed and collaborative decision. These providers are more likely to consider a patient's experience with quitting as well as their lifestyle and access to resources (e.g. transportation, free time, SES, etc.), while specialists and urgent care providers are more likely to hand off printed referral information and/or encourage the patient to follow-up with their primary care provider for additional support.

Survey feedback likewise showed that while providers typically ask about tobacco use and advise patients to quit, they are not as likely to refer a patient to cessation treatment. This is particularly true of specialists.

"Because I'm a specialist, I tell them about educational materials in the clinic and to continue this discussion with your PCP who has more resources to help with this."

-MD, Nephrology

Figure 8: Frequency of Referring to Cessation Treatment (Survey)



Referral Preferences

Among primary and urgent care providers, smoking cessation groups / classes, the Quitline, and one-on-one support from a dedicated tobacco-cessation counselor were the most commonly mentioned form of quit help. Specialists largely referred patients to their primary care provider or a tobacco- or addiction-focused provider.

Figure 9: Provider Referrals to Quit Help (Provider IDIs)

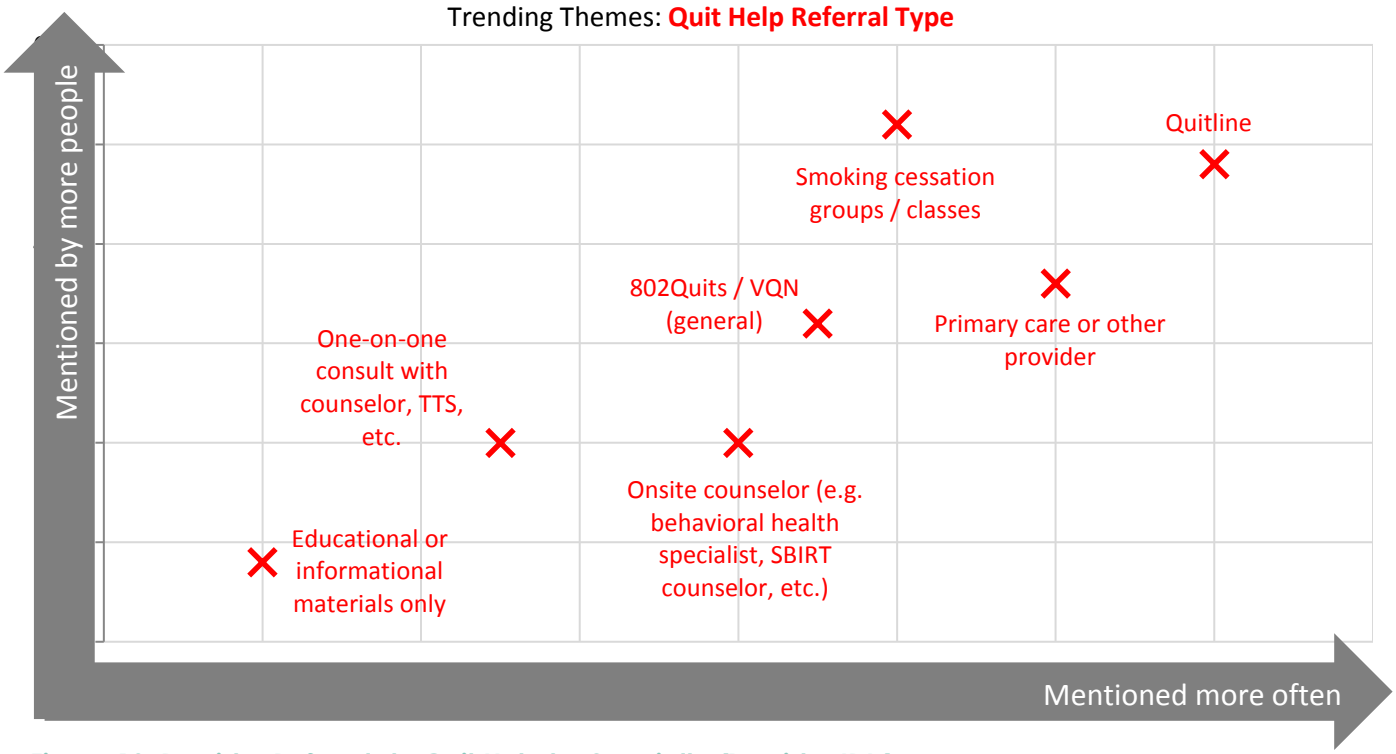
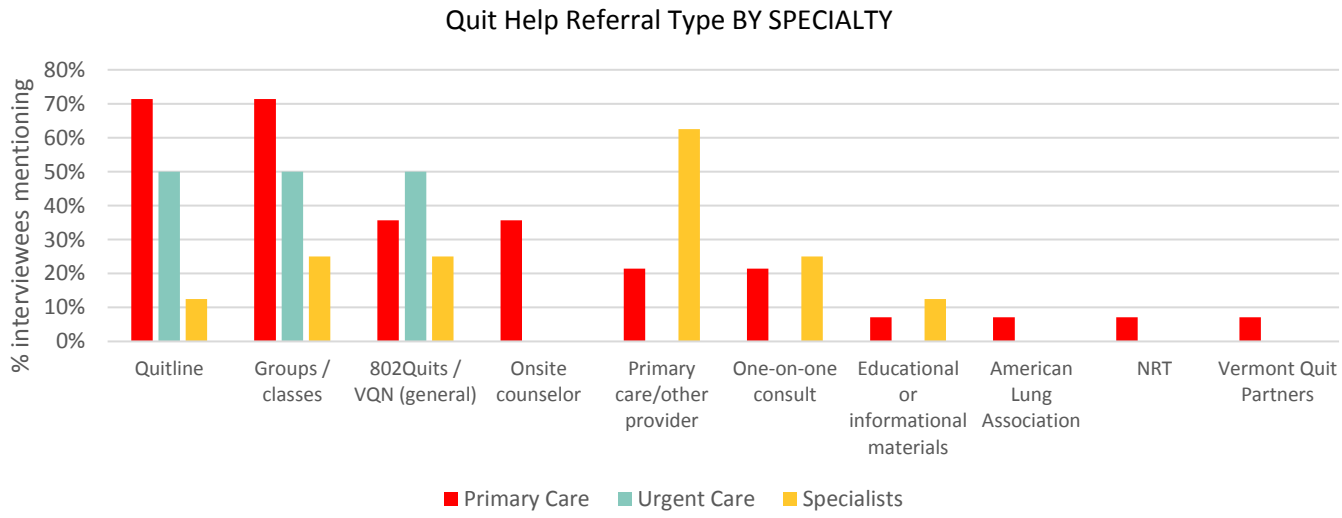
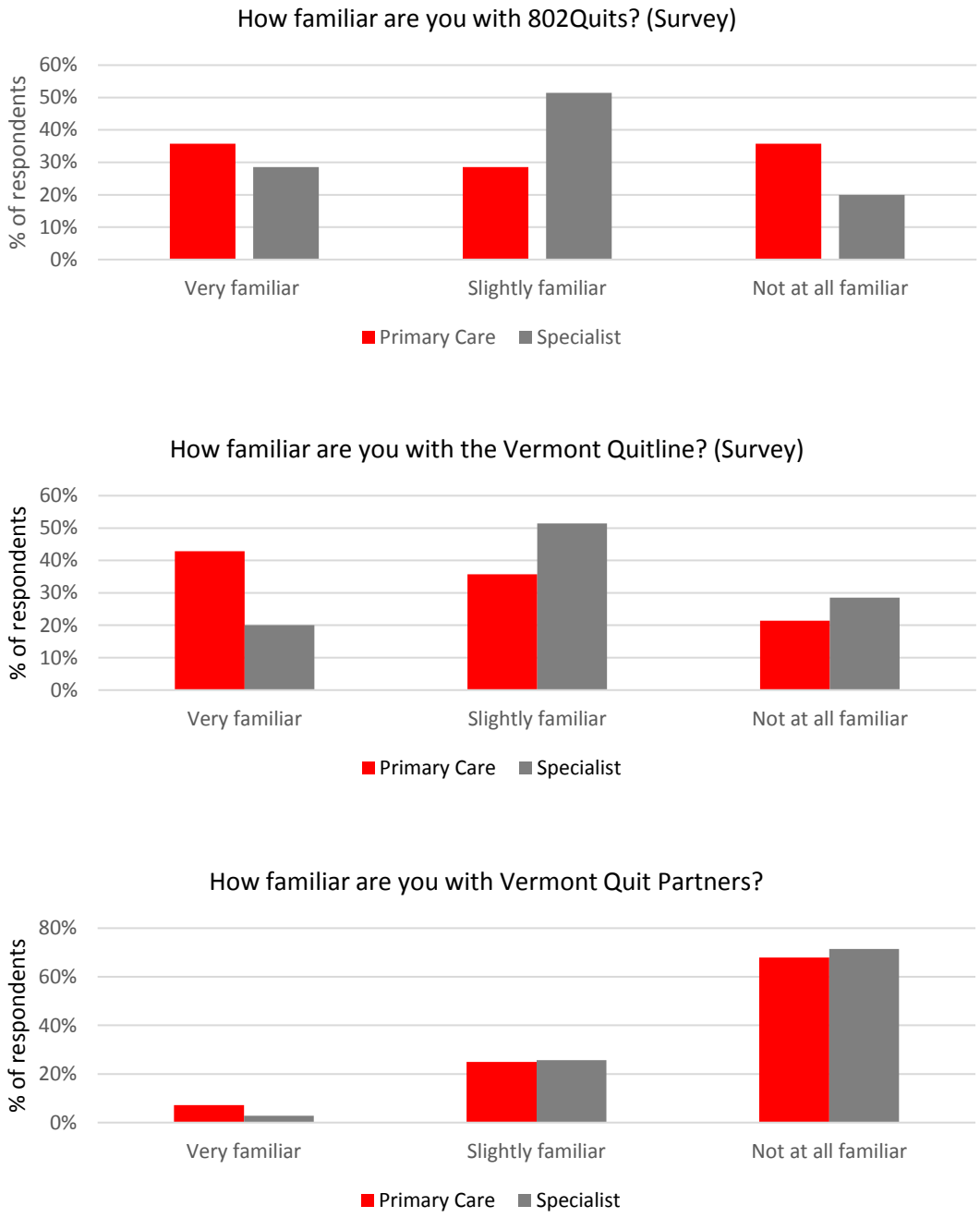


Figure 10: Provider Referrals to Quit Help by Specialty (Provider IDIs)



It's noteworthy that, according to IDIs, nearly one quarter of providers were not familiar with 802Quits, and Vermont Quit Partners was only mentioned by one provider as a common referral type. This ratio reflects familiarity levels observed in the survey feedback as well.

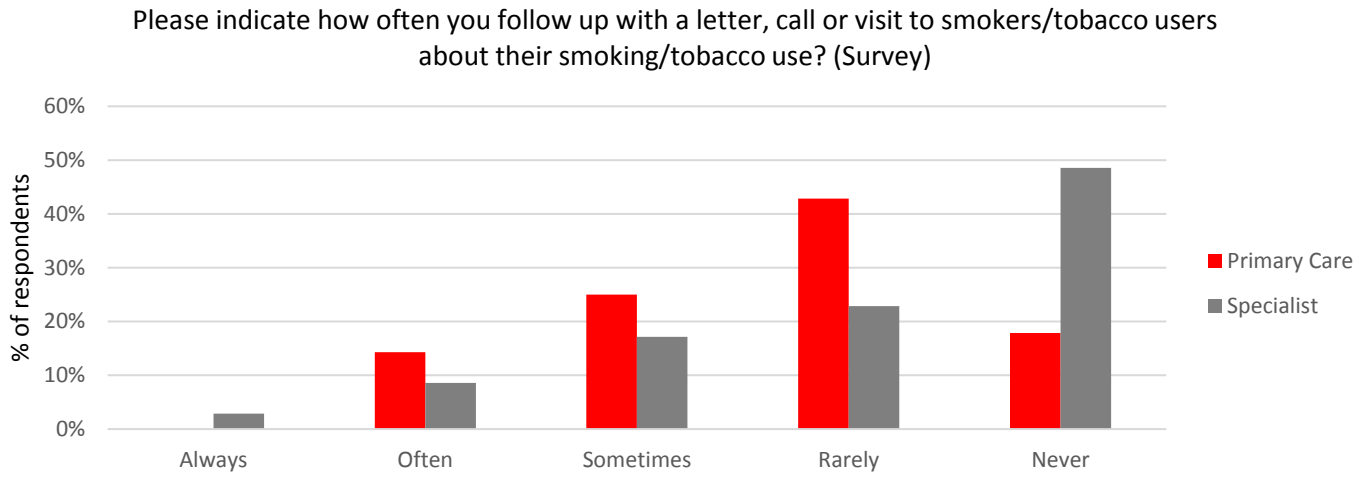
Figure 11: Familiarity with Ways to Quit (Survey)



Arrange/Follow-up

Responses in the survey illustrate that providers do not commonly follow up with a patient after cessation counseling, particularly for specialists. Even among primary care providers, only a minority report often or sometimes following up.

Figure 12: Frequency of Follow-Up Post-Counseling (Survey)



NRT & Medication

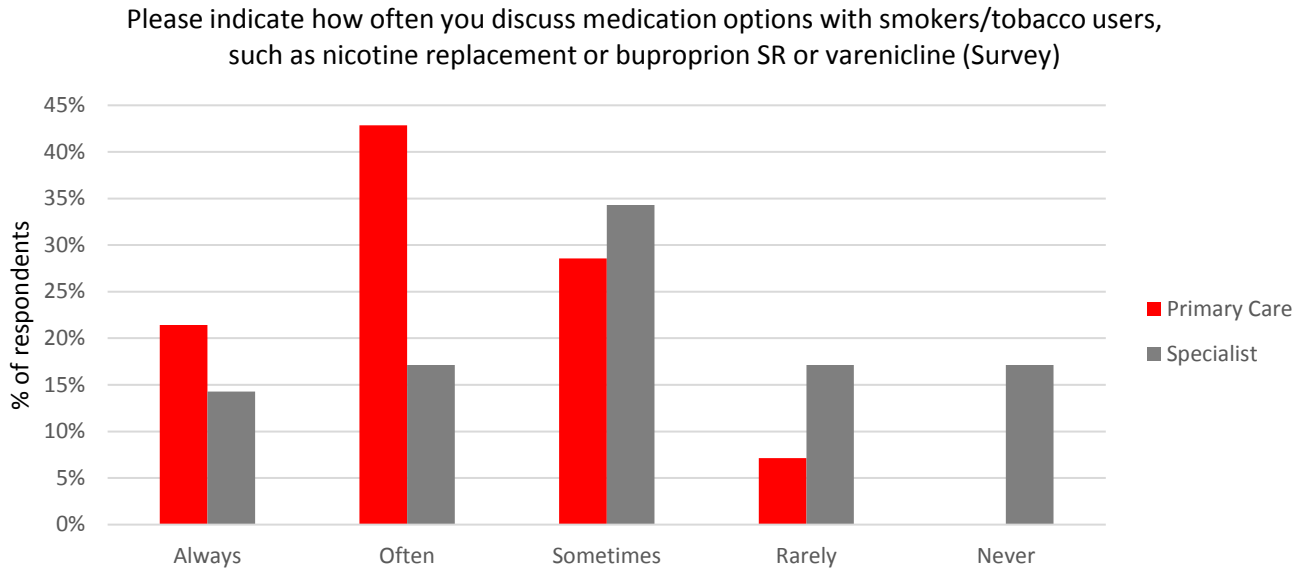
In general, most providers are open to discussing the benefits of pharmacotherapy, such as NRT and cessation medications, with any patient who is ready and motivated to quit. Several providers cited the fact that medication increases the likelihood of a successful quit. While primary care providers most often prescribe pharmacotherapy, they are also more likely to have reservations and/or avoid discussing medication if a patient has a mental health condition or concern or is in a crisis situation. Urgent care providers and specialists tend to be less familiar with NRT and medication strategies, and are less comfortable prescribing medication in general. As with the referral habits, most urgent care and specialists refer interested patients to their primary care provider.

"As an urgent care provider, I don't RX the psycho-drugs (I don't have the follow-up access). I often discuss NRT as part of 802Quits benefits."

-PA, Emergency Medicine

This finding is also reflected in feedback obtained through the survey, showing that primary care providers are more likely to discuss medication options with patients.

Figure 13: Frequency of Discussing Medication (Survey)



Implication #2

Providers are aware of and consistently execute the first two steps in the 5As methodology: Ask and Advise/Assess. Although primary care providers cite a broader set of reasons for not advising, most note reasons that reflect a personalized and holistic understanding of a patient's health and life situation (e.g. in a crisis, has a competing addiction, etc.) This is also true for primary care providers' habits surrounding referrals and medication.

The research illuminated a potential disconnect for providers between advise/assess and assist/refer. The drop-off from assessing to assisting could be due, in part, to the provider listening and appropriately assessing the tobacco user's readiness, and subsequently deciding that the patient is not ready to make a quit attempt. However, when combined with previously executed research with tobacco users, we see a chicken-and-egg effect. Often, provider encouragement and support are an impetus for cessation attempts, so providers play a key role in motivating their patients. TCP has an opportunity to help providers strike a balance between (a) referring patients who are open to and engaged in the quitting process and (b) being a catalyst for that openness and engagement.

Likewise, this discontinuity between advise/assess and assist/refer could also be due in part to knowledge gaps. Although primary care providers are more likely to have a collaborative and in-depth tobacco cessation conversation with patients, refer them to quit help, and discuss NRT and medication, they have similar gaps in knowledge about available quit help resources as specialists and urgent care providers. All providers exhibit limited knowledge about the universe of cessation resources and support for patients. Awareness building should continue to be a priority for 802Quits.

Knowledge gaps suggest that not only are providers unfamiliar with all available quit help options, they also lack associated knowledge about appropriateness and efficacy of various quit help types. What's more, very few providers report systematically following up with patients after a referral.

First and foremost, communication and outreach to providers on tobacco treatment best practices should prioritize and bolster primary care providers over urgent care providers and specialists. Primary care providers have the requisite patient familiarity and face time, trust and influence, and proximity to resources to adequately prompt, guide, and support a patient in their tobacco cessation journey. In addition, these providers tend to have better access to care coordinators, tobacco treatment specialists, and community health teams to further support tobacco users.

Outreach to primary care providers should reinforce three provider capabilities: 1) having a collaborative and personalized discussion about quit help options, including patient concerns, preferences, and feedback channels, 2) knowledge and literacy about the universe of quit help options and how to send the patient on an appropriate path, and 3) familiarity with and quick access to an in-person, tobacco resource(s) to whom providers can reach out to for clinical cessation support and education (e.g. TTS, SBIRT counselor, peer expert, etc.).

While specialists can often leverage the urgency and seriousness of a patient's illness or injury to encourage and motivate them to quit, they are often not equipped or able to adequately support a patient in tobacco cessation counseling. Outreach and messages to this group should focus on consistently and efficiently referring patients to their primary care providers or an easy-to-access, information hub for quit help options (e.g. 802Quits, in-person tobacco resource, etc.). Communication to this group should continue to promote tobacco cessation best practices in a way that is tailored and mindful of the impactful but limited role urgent care providers and specialists play.

Providers struggle the most with patient engagement and activation

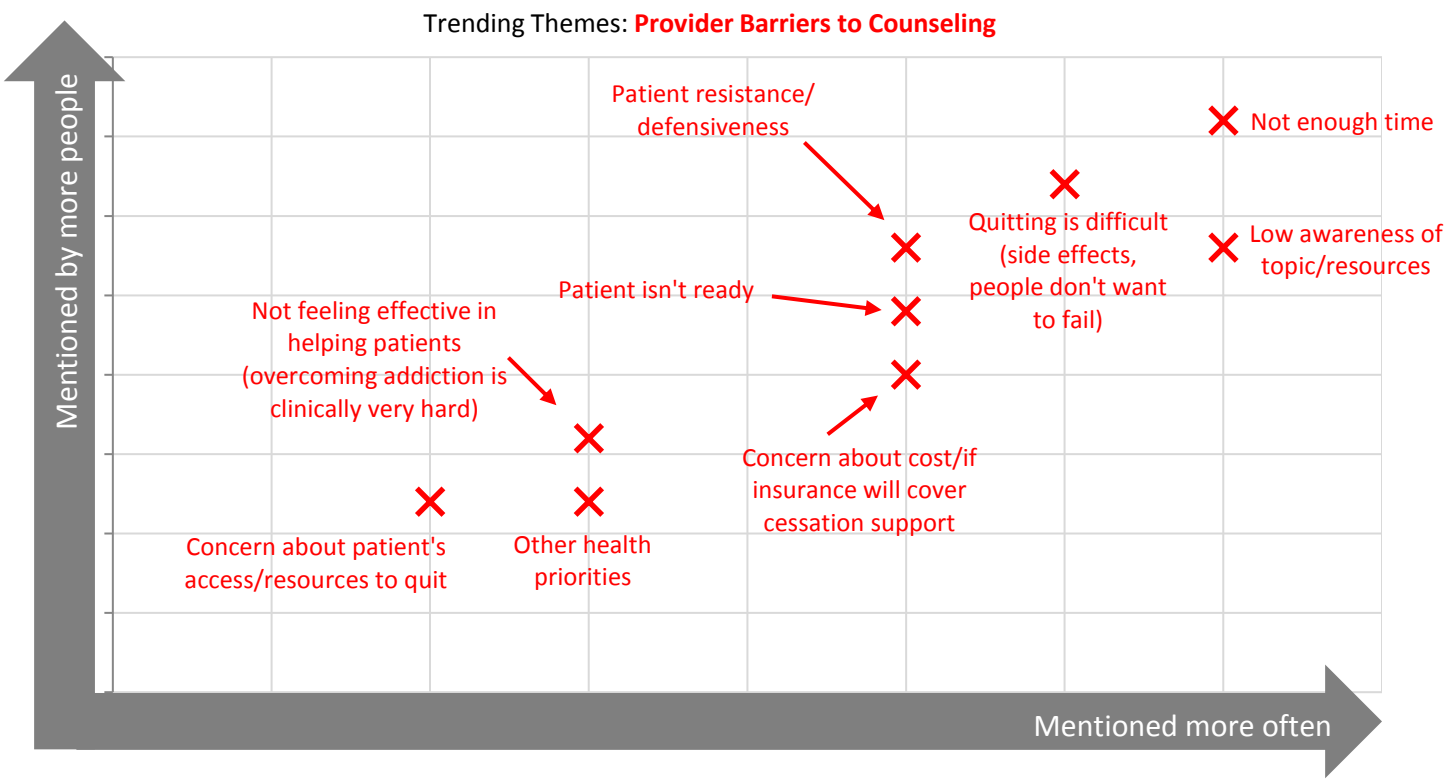
Barriers

When delivering tobacco cessation counseling and support, providers experience numerous barriers that revolve around the patient and their personal struggle with tobacco addiction. Outside of provider-specific barriers (time constraints and low awareness of cessation resources), patient challenges such as difficulty of quitting and previous failures, patient resistance to quitting, and concern about a patient's access to resources and insurance coverage remain top-of-mind for all providers, regardless of specialty and role.

"Past failures are a huge challenge. A lot of people talk about what they've done, and in their minds, none of those things have worked and there's no point in trying."

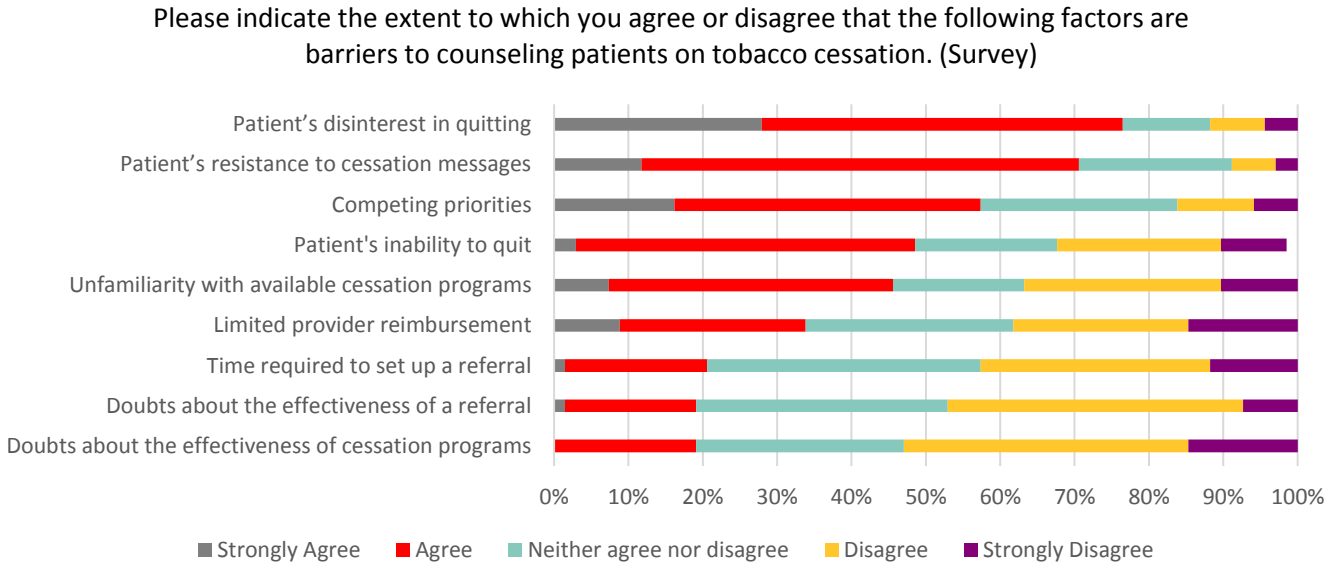
-PA, Primary Care

Figure 14: Provider Barriers to Counseling (Provider IDIs)



Patient challenges were also top-cited barriers in the survey, agreed upon more often than provider-specific barriers.

Figure 15: Barriers to Tobacco Cessation Counseling (Survey)

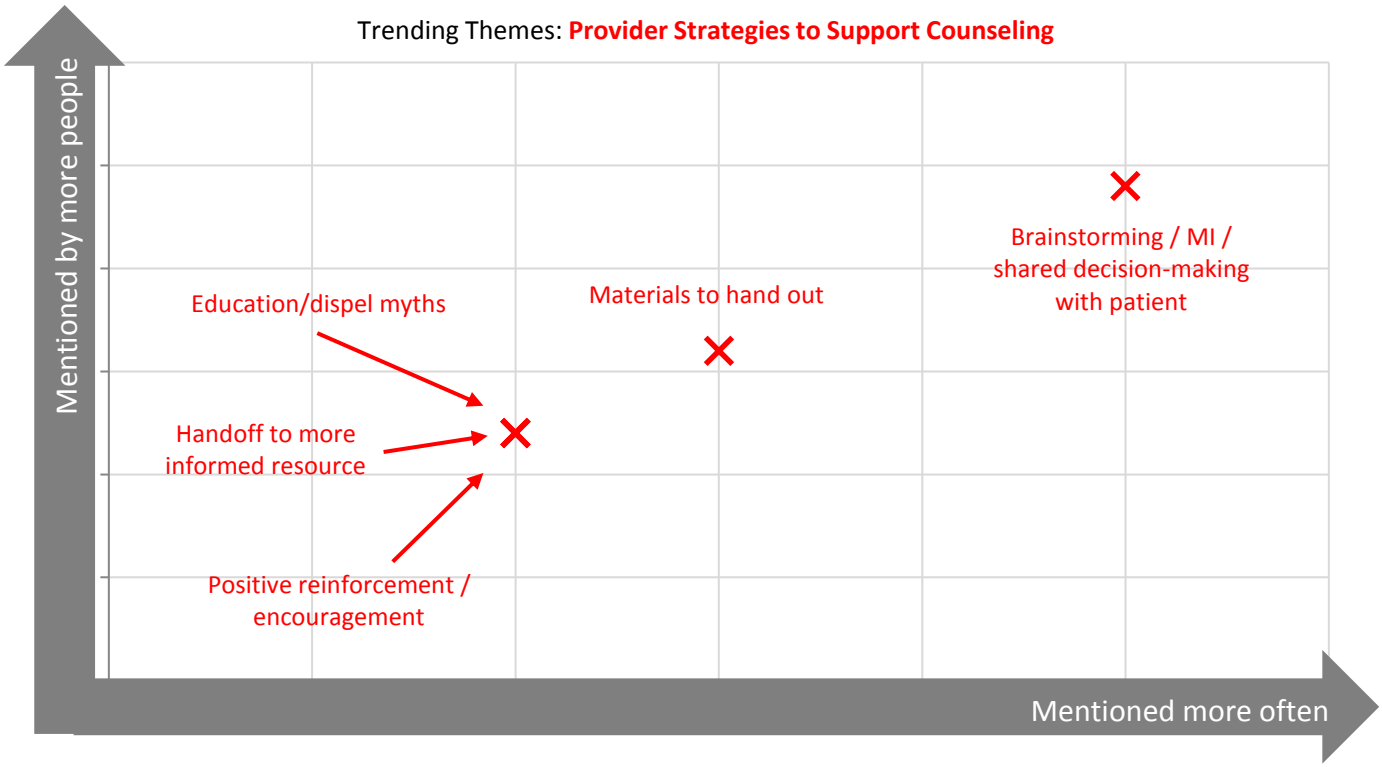


Strategies

Providers, across all specialties and roles, use positive communication and encouragement to help patients identify and overcome tobacco cessation challenges. Specifically, providers use brainstorming, problem solving, and motivational interviewing skills. Additionally, providers employ supplementary informational resources, including cessation support materials and one-on-one assistance to help patients with these barriers.

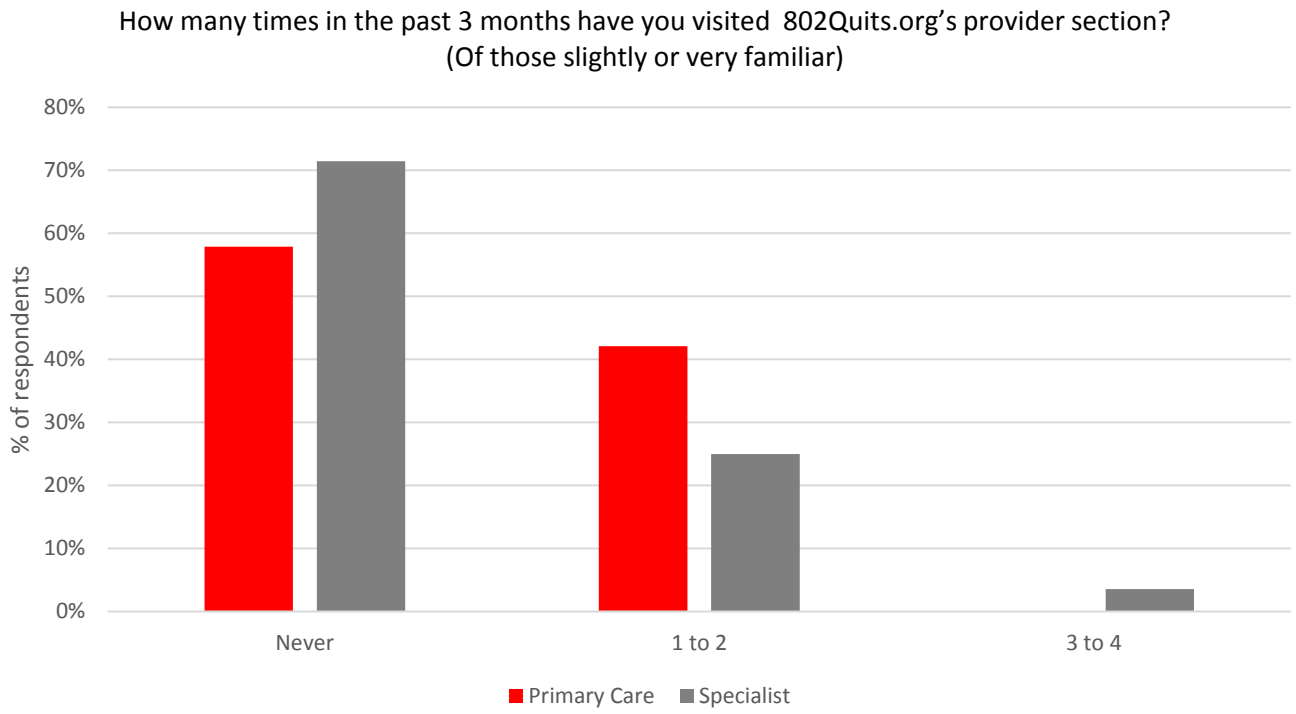
> **"I try to stay positive and I try to show them there can be positive things. These struggles are real, but one baby step in making your life better is to try to quit smoking. Think about how good you'll feel..."**
>
> - Dental Hygienist, General Dentistry

Figure 16: Provider Strategies to Support Counseling (Provider IDIs)



Few providers indicate regularly using the Provider Section of 802Quits.org as a tobacco treatment resource. Roughly 70% of survey respondents indicated they had never visited the provider section on 802Quits.org, skewing towards specialists. IDI data on use of 802Quits provider section matched these findings.

Figure 17: Frequency of Visiting 802Quits.org Provider Section (Survey)



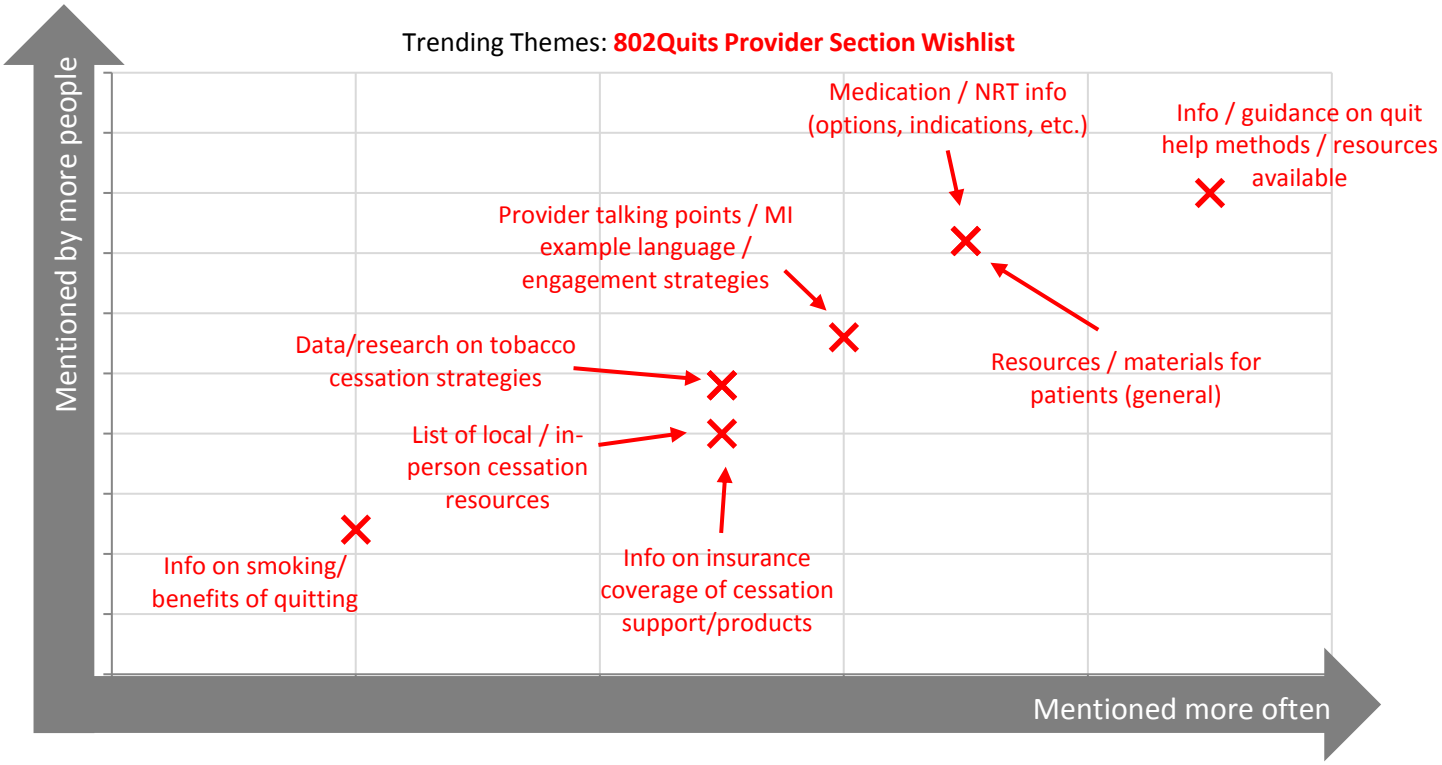
Per IDI data, of the providers who have visited this website, one-third thought the resource was helpful and two-thirds didn't recall their visit or did not find what they were looking for.

Providers who had not visited the website, in general, desired robust information and guidance on quit help methods and resources available for both patients and providers. Specifically, providers desired information and tools that helped them better relate to, motivate, and equip their patients to be successful.

"Talking points or tips to say to patients; things that might resonate better. One of the difficult things is patients finding conviction to quit, they don't believe they can. It might help me giving them guidance on this."

- NP, Cardiology

Figure 18: 802Quits Provider Section Wishlist (Provider IDIs)



Implication #3

In the context of tobacco treatment, providers' predominant concerns and challenges revolve around their patients' powerful addiction and its effects. This is evident in providers' cited barriers to tobacco cessation counseling: not having enough time with a patient, patient push back or disinterest in quitting, difficulty of quitting an addictive substance, and not feeling adequately knowledgeable to fully support patients.

These insights are amplified by previous findings suggesting that providers are intrinsically compassionate and approach patient health issues holistically and organically.

Communication and outreach for providers on tobacco treatment must acknowledge and address the fact that, across all specialties and roles, providers struggle with the universally challenging aspects of their patients' nicotine addiction, and the inherent personal and social challenges driving this habit. Provider outreach should reinforce easy-to-implement principles of effective patient engagement and activation, such as motivational interviewing, problem solving, and teach-back. More simply, providers expressed the need for sample scripts or talking points and cheat sheets on various tobacco counseling themes, especially advising/assessing and assisting/referring to additional support. It's imperative that these tools are easy to access, implement, and digest, given the time pressures all providers face.

Because so much of what providers need exists, either on 802Quits or other sources, communication efforts should aggregate, analyze and distill, reposition, and redistribute specific information and tools that fill these knowledge and skill gaps.

Coding and billing lives outside the provider sphere

Big picture

The field of medical coding and billing is complex, ever evolving, and varies depending on the clinical setting. In most clinics and practices, documenting, coding, and billing involves the coordination of front-desk staff, nurses and providers, coding and billing professionals, health record and billing software, and payers.

In smaller practices, the coding and billing process leverages EHR software that assigns codes to a templated, clinical questionnaire and provider notes in patient charts. This data is then confirmed by an in-house, coding/billing professional(s) or is outsourced to be reviewed, verified, and billed by a third-party company(s). In rare cases, it is billed automatically by a secondary billing system.

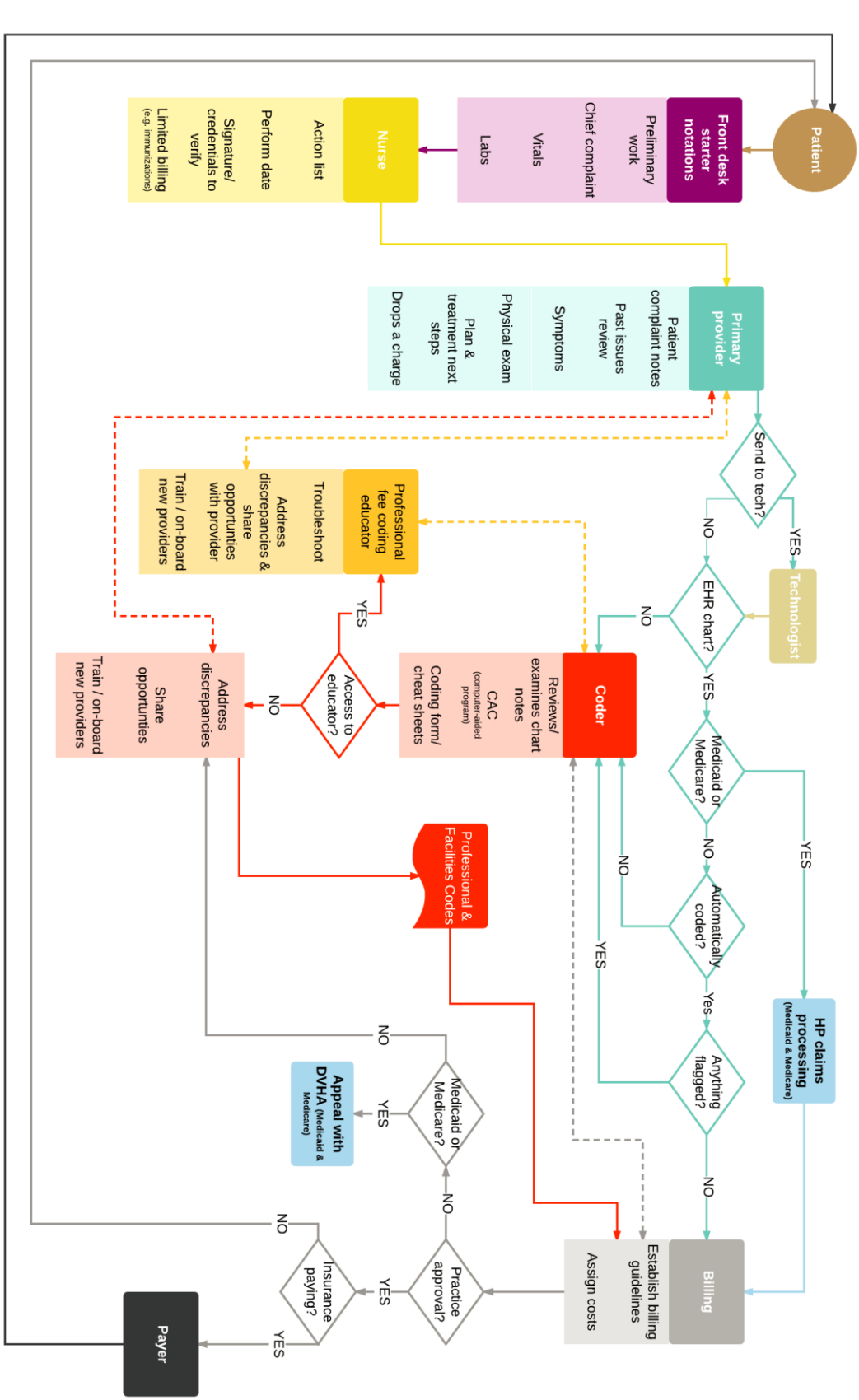
Larger clinics and hospitals tend to employ in-house coding and billing departments that manage, oversee, and audit provider coding activities. Coders and coding educators are responsible for reviewing and resolving coding discrepancies, informing providers about coding and billing opportunities, and educating new providers on systems and protocols.

The approach to coding and billing depends on the setting, but coders discussed three main ways visits are billed:

- Fee-for-services: billed for each service such as an office visit, test, procedure, or other health care service (U.S. Office of Personnel Management)
- Bundled fees: when a procedure or service is included as part of a more extensive procedure or service provided at the same time, all covered at one price (AAPC, 2012)
- Level of care: coding by history, examination, and medical decision-making, and various levels of complexity and sub-components within each of these (Medical Economics, 2014)

The appropriateness of CPT codes varies within each of these structures. Often, charges are separated by provider-based billing (or professional fees) and facilities (or technical) fees.

Figure 19: Billing & Coding Chart Journey (Coding & Billing IDIs)



Coder perspective

In most practices, coding and billing professionals are the authorities on medical documentation, coding, and reimbursement. These individuals can work in a variety of clinical settings—some work independently in small practices while others are employed as part of a department in a hospital or clinic. Other coders work remotely for third-party companies that receive a hospital, clinic, or practice's outsourced, electronic charts.

Although their titles, responsibilities, and job structure vary, coding and billing professionals are unified in their motivation to accurately and efficiently capture a patient's situation and associated issues, and acquire appropriate and timely reimbursement. Participating coders described striving for fair and balanced coding that neither undercodes or upcodes.

> **"If a practice supervisor sees they can get revenue from a certain coding set, they want this information."**
>
> - Coder, Hospital Coding Department

In most cases, these professionals receive electronic patient charts that have already been electronically coded, and either review the program's accuracy and/or resolve flagged discrepancies or issues. According to coding professionals, there is often much manual work involved in this process regardless, as automatic coding can often be inaccurate, chart information is incomplete (for example, time spent counseling on tobacco cessation is missing), or chart notes are unclear.

Coding and billing professionals are also alike in that they communicate regularly with medical providers, asking questions and following up on these unclear notes, resolving discrepancies, and providing feedback to providers on how to better document their activities to maximize reimbursement. In larger institutions, coding and billing professionals are specifically tasked with educating and onboarding new providers to the coding and billing system.

> **"I'm not familiar with [CPT codes for cessation counseling] … It's vague to me. I'm primarily ICD-10. I see the CPT codes but I don't use anything other than certain visit type codes.**
>
> - Coder, Third-Party Coding Company

Preliminary research suggests that coders are more familiar with using codes for documenting tobacco use but not as familiar with and/or do not use CPT codes for tobacco cessation counseling.

Provider perspective

Nearly all providers use an EHR that documents tobacco use as part of the patient's background and history, within their problem list, and/or as their current diagnosis. For many providers, the EHR automatically assigns appropriate diagnostic codes to tobacco use.

Beyond the initial screen, providers—across all specialties—do not consistently document, code, and bill specifically for tobacco cessation counseling. Most providers and practices code and subsequently bill patients based on general qualities of the patient visit: time spent counseling patients, level of complexity of patient's concerns/conditions, and/or the provider's decision making involved in a patient visit and follow-up. Rarely do they assign specific codes and bill for individual counseling.

"It's one of those things where there's probably a billing code for it and I don't use it and never remember it and wouldn't know where to find it. It gets wrapped up in the entire visit."

- MD, Family Medicine

Providers participating in this research typically reference or use CPT codes for tobacco-cessation counseling only in cases where the patient made a dedicated appointment for tobacco cessation and/or if tobacco cessation was the predominant topic discussed. What's more, providers are often dissuaded from using these codes because of the highly specific documentation and background research it often requires.

"I know there are codes, but finding them takes as long as the visit.

- MD, Family Medicine

Although many providers reported they are responsible for office- or practice-related coding and billing activities, an equal number of providers also noted that they do not personally assign codes or bill patients—these tasks are performed by coding and billing staff or automatically, by the EHR's algorithms.

Figure 20: Provider Role in Billing & Coding (Provider IDIs)

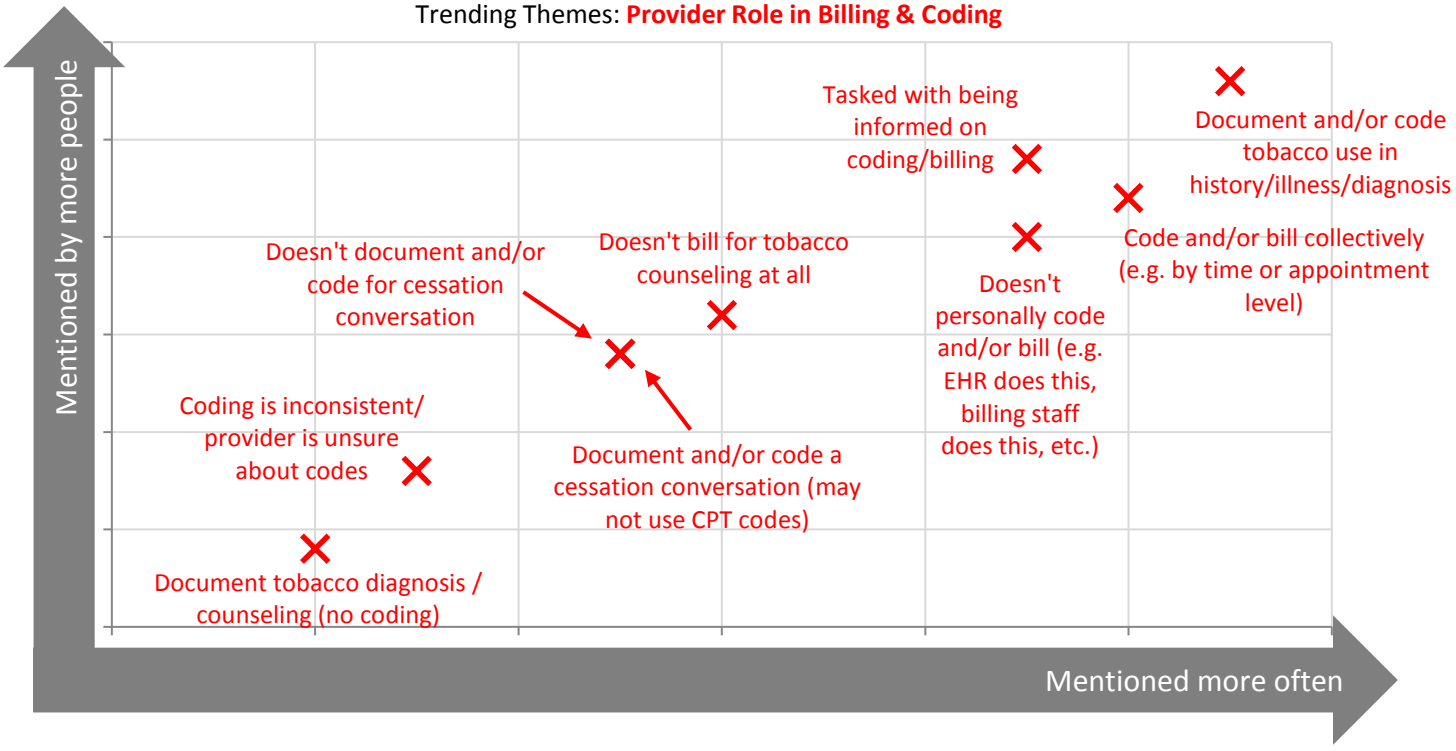
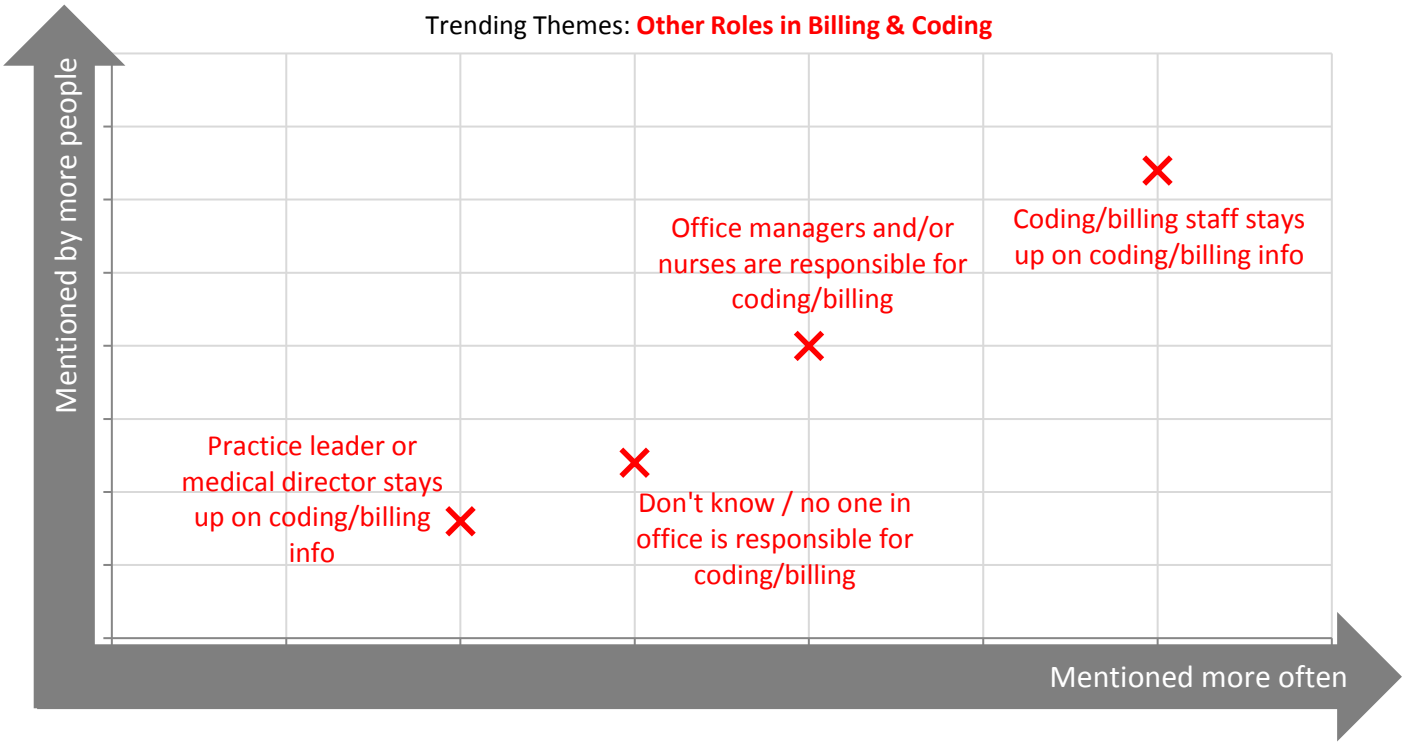


Figure 21: Other Roles in Billing & Coding (Provider IDIs)



Implication #4

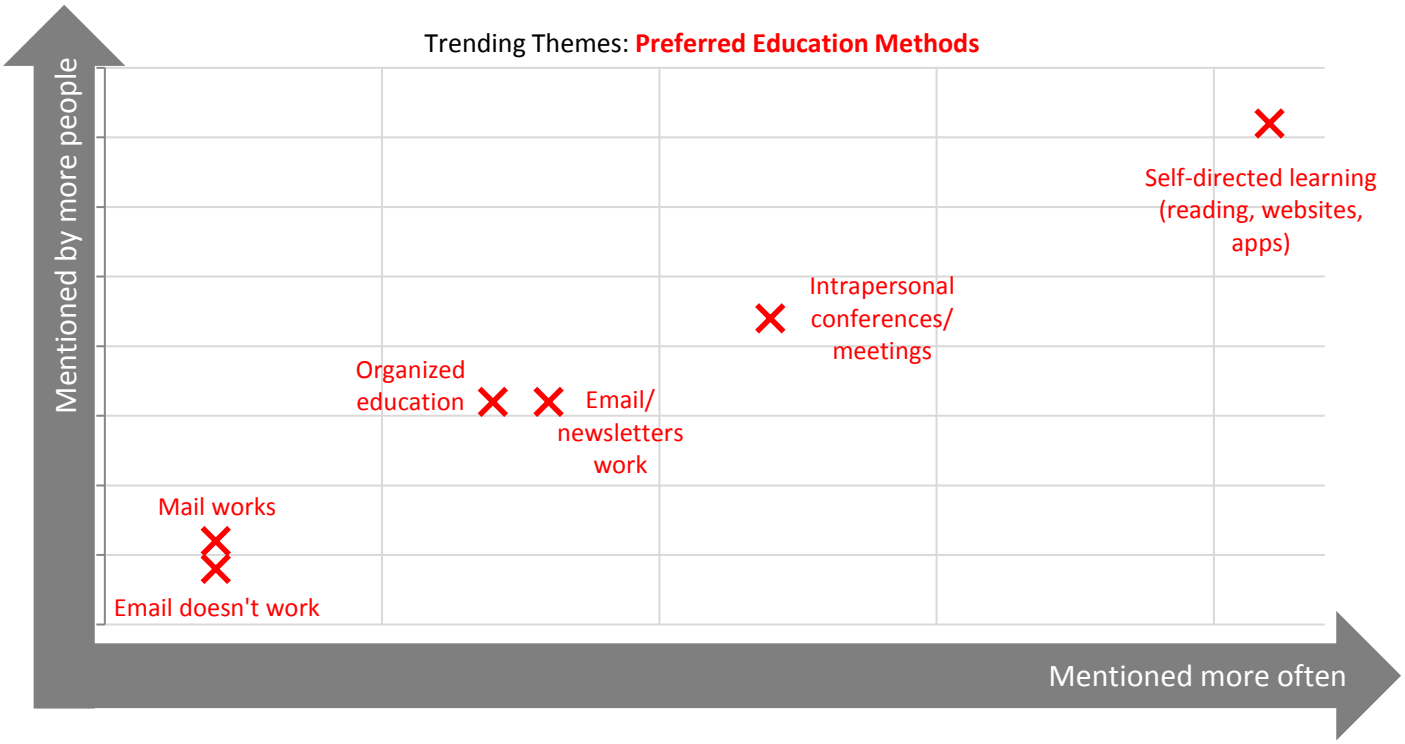
Provider-directed outreach that promotes reimbursement for tobacco cessation counseling (and the use of specific CPT codes) is likely not relevant to providers and will not significantly motivate them to change their approach to tobacco cessation treatment. Messages and updates about specific codes are relevant, however, to some providers, but more so coding and billing specialists, who oversee and manage the coding/billing activities in clinical settings. Simple reminders to providers—such as prompts to include the keywords 'smoking' and 'cessation' in charting, and to timestamp the conversation—could be an effective way to spur more reimbursement for tobacco cessation counseling.

Given that coding specialists often see themselves in the role of provider educator, working directly with coders on the details of codes and processes, and supporting them in the sometimes difficult conversations they have with practices, could prove to be a more efficient use of time and resources when it comes to reimbursement for tobacco cessation counseling.

Outreach to providers should fill specific knowledge and skill gaps

Providers use a variety of methods to continue to learn about tobacco cessation and treatment best practices. Most employ self-directed tactics such as medical apps or web browsing, reading medical articles and journals (print and online), and attending conferences, Grand Rounds, and meetings. Continuing education is also a common strategy for maintaining knowledge and skills surrounding tobacco treatment best practices.

Figure 22: Preferred Education Methods (Provider IDIs)



Peers, the Vermont Department of Health, peer-reviewed literature, and professional organizations were cited most often by both IDI participants and survey respondents as the most trusted sources of information and continued learning in the area of tobacco cessation.

Figure 23: Preferred Education Sources (Provider IDIs)

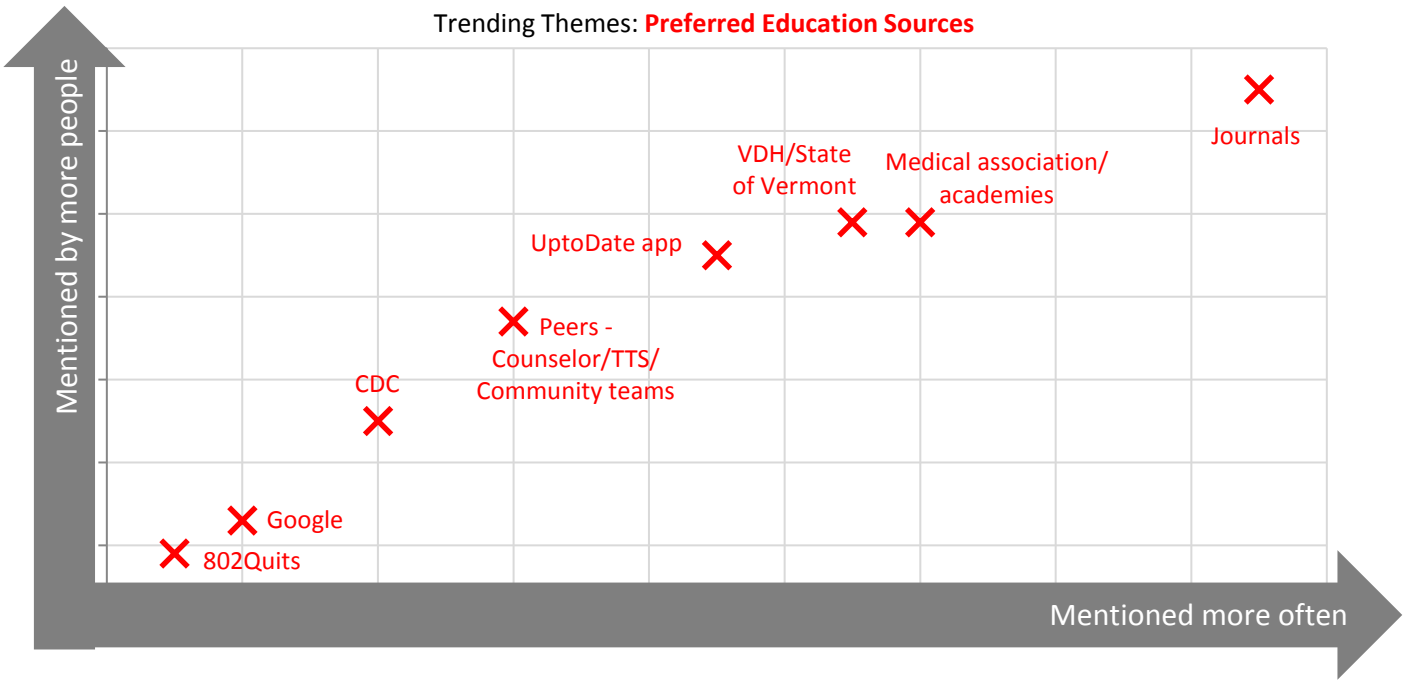
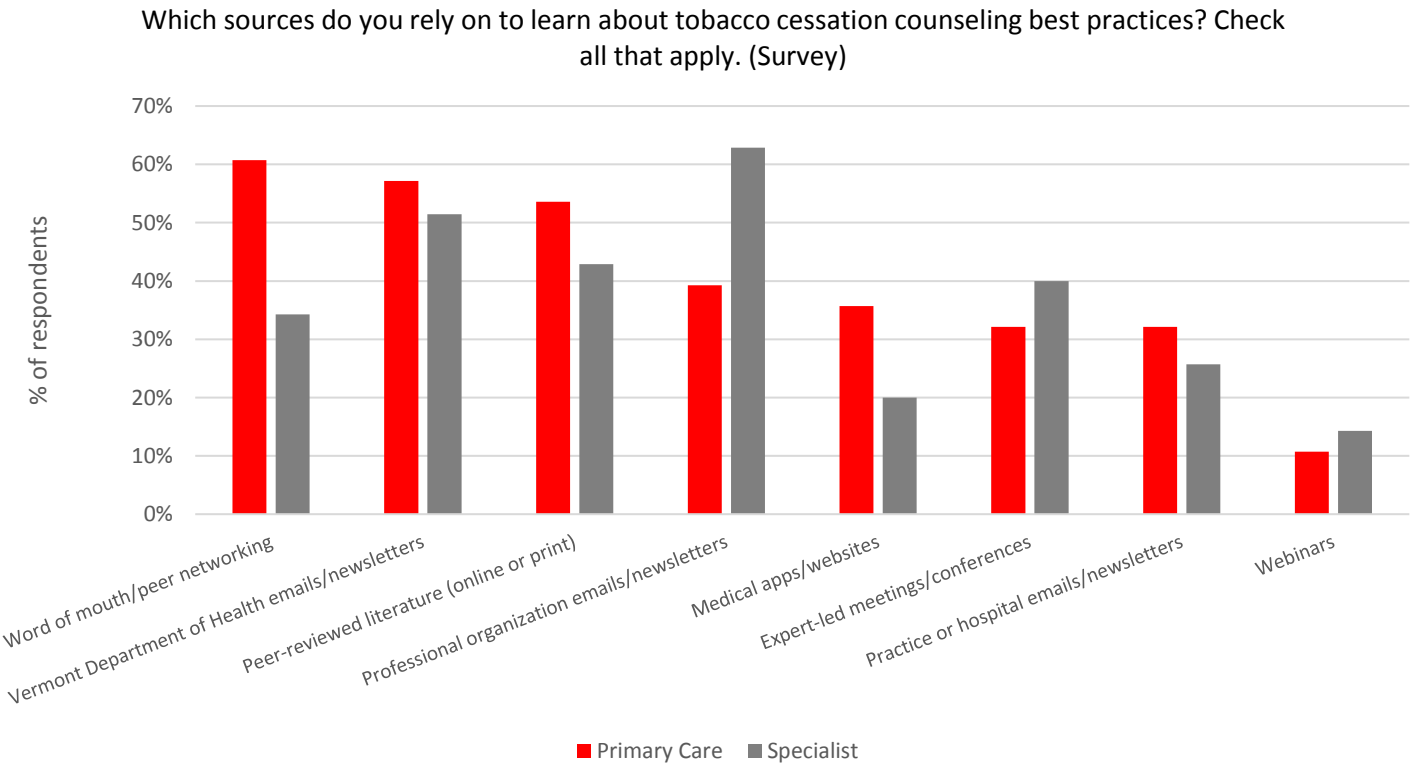
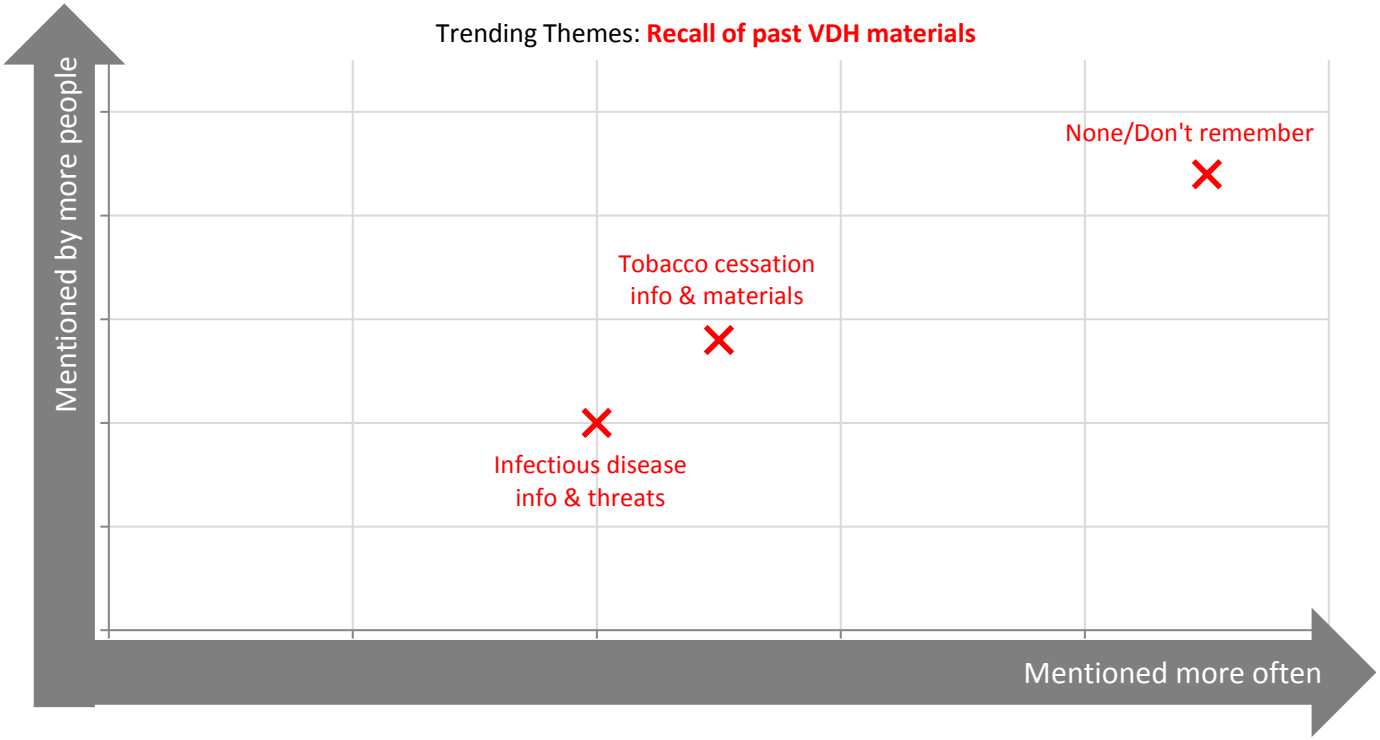


Figure 24: Preferred Education Sources (Survey)



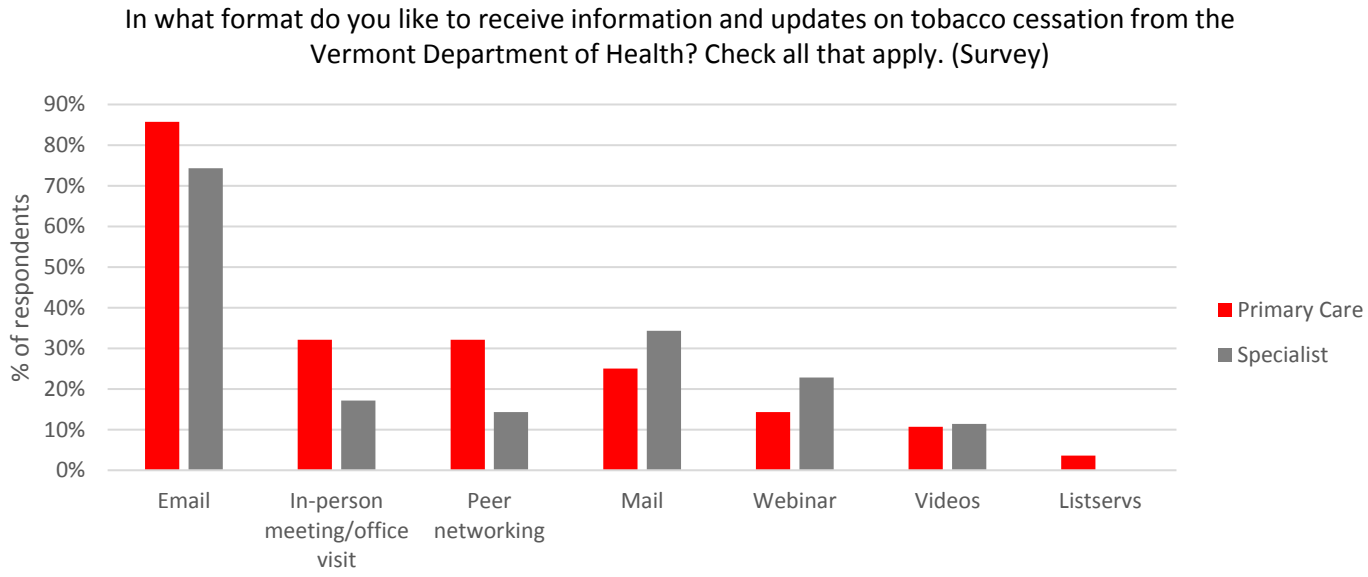
Although the Vermont Department of Health is considered a trusted and reliable source among providers, few recall previously emailed or mailed materials.

Figure 25: Provider Recall of Past VDH Materials (Provider IDIs)



Nonetheless, when it comes to materials from the Vermont Department of Health, providers who responded to the survey did overwhelmingly indicate that they prefer emails.

Figure 26: Communications Format from VDH (Survey)



Implication #5

Findings suggest that given the surplus of clinical and public health information available to providers, these individuals prioritize, pay attention to, and remember messages from multiple trusted sources in a variety of formats. During patient visits, they pull somewhat haphazardly—from recent and top-of-mind learnings, medical apps, and interpersonal and environmental cues.

This is exemplified in the following example: In the exam room, a provider mentally prepares for a cessation conversation with a patient by recalling a journal article on the efficacy of the 5As and the mailed reminder card from the Health Department (though he doesn't have it on hand). He's already used the EHR to document that this patient is in the "contemplation stage" and is open to quitting, but the EHR doesn't provide engagement or activation specifics on how to move the patient forward.

During the brief counseling session, the provider employs some motivational interviewing techniques he was taught in an online CME course and uses teach-back techniques he learned in medical school. The provider also recalls a recent Grand Rounds discussing latest data on the efficacy of and guidelines for combined NRT and cessation medication. After listing medication options, he uses the UpToDate app to check dosages and indications, and writes a prescription for Chantix. He also tells the patient to consider over-the-counter NRT and to check with their insurance to see if it's subsidized or covered.

In addition, the patient is open to outside cessation help and mentions the 802Quits ad on TV. The week prior, the provider had a phone call with the hospital's tobacco treatment specialist and has a flyer for in-person classes in the exam room. This serves as a reminder to the provider to recommend these classes. He also agrees that 802Quits is another good resource, but can't speak to the various quit help types and doesn't provide take-home materials. The provider completes the conversation by asking the patient to make a follow-up appointment in four weeks.

Although this example is hypothetical and does not represent all providers' behavior, it's meant to convey not only what methods and sources providers prefer, but how this information is recalled and used in the clinical setting.

In general, the Health Department and TCP should tailor and refine its information and resources for providers and, whenever possible, expand upon or integrate with other trusted sources, methods, and messages. To start, TCP should thoroughly catalog and audit the universe of information and messages providers receive on tobacco use and cessation. From here, TCP should identify where it provides the biggest information "value-adds,"—possibly an easy-to-access orientation to quit help types or conversation scripts for tobacco counseling—and avoid repeating topics from more common and accessible sources like UpToDate.

To maximize provider recall and use of these materials, the Health Department and TCP should establish direct and indirect communication channels with providers and continuously use these channels to

push out messages and reminders. Although direct outreach is still a viable tactic (in-person, conferences, mail, and email), indirect channels ensure subliminal and repeated exposure to tobacco themes and messages. To this end, TCP should build relationships and collaborate with other trusted sources like hospitals, UVM Medical School, DVHA/Medicaid, Blueprint for Health, and Vermont-based medical and dental associations and piggyback on their communication vehicles to extend the reach of its messages.

Lastly, knowing providers do not always have adequate time or knowledge to review quit help types with patients, current information hubs like 802Quits must be optimized to engage patients in a quit journey, with or without the provider's input. By doing so, a simple mention of 802Quits from the provider to 802Quits is not only effective for the tobacco user, but also removes some onus from the provider. The ask from TCP also becomes highly simplified, assuring providers that a referral can be as simple as encouraging a patient to start their journey on 802Quits.org.

In conclusion, in the same way that tobacco cessation itself is a journey rather than an event, TCP can likewise approach provider outreach as an on-going process that entails fostering, promotion, and a focus on key impactful elements, thereby streamlining its role with providers and closing gaps in the patient care journey.

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