Behavioral Health Tobacco Dependence Treatment for Kentucky Medicaid Recipients

ABSTRACT

ISSUE: Despite a decline in tobacco use rates among the U.S. general population, people with mental illnesses (MI) have continued to experience disparate rates of tobacco use and related burden. Based on CDC estimates, adults with MI consume about 41% of all tobacco products. Tobacco use is even higher (~ 74%) among individuals with serious MI, such as schizophrenia. Smoking costs Kentucky Medicaid an estimated $589.8 million annually.

PURPOSE: To assess the capacity for delivering evidence-based tobacco treatment interventions in Kentucky Community Mental Health Centers (CMHCs).

SUMMARY: 1) Though there are existing tobacco treatment clinical guidelines, few providers in behavioral health settings fully adhere to them; and 2) In behavioral health settings, there is need for implementing tobacco-free policies, providing specialized tobacco treatment trainings, and connecting providers with community tobacco cessation referral resources.

RECOMMENDATIONS: To enhance the tobacco treatment capacity of Kentucky Medicaid providers in behavioral health settings,

1) Provide focused tobacco treatment training;
2) Increase the number of certified Tobacco Treatment Specialists;
3) Increase the number of community behavioral health partners supporting tobacco-free environments, and
4) Assure that behavioral health providers can bill separately for tobacco treatment services.

KEY TAKEAWAYS

- **In 2019, of 1,155,299 million Kentucky Medicaid beneficiaries, 862,740 (74.7%) were adults with MI.**
- **People with MI continue to experience higher rates of tobacco use and related burden compared to the US general population.**
- **Though there are existing clinical tobacco treatment guidelines, few behavioral health providers engage tobacco users with MI in tobacco treatment.**
- **Enhancing tailored tobacco treatment interventions for this vulnerable population is critical in addressing the disparate rates of tobacco use and related burden.**
- **Opportunities for increasing the capacity of Kentucky behavioral health programs to provide evidence-based tobacco control initiatives should be supported and billable.**

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BACKGROUND

Based on Medicaid 2019 data, of 1,155,299 million Kentucky Medicaid beneficiaries, 862,740 (74.7%) were adults with MI. Smoking costs Kentucky Medicaid an estimated $589.8 million annually. Despite a reduction in tobacco use rates in the US population over the past five decades, rates of tobacco use remain high among persons with MI,[1,2] resulting in high morbidity and mortality from tobacco-related burden.[3] Due to heart and lung disease and cancer, tobacco users with MI die approximately 25 years earlier than adults in the U.S. general population.[4] Thus, it is crucial to promote initiatives to reduce the disparate tobacco-related disease and mortality in this vulnerable population.

With adequate provider support, tobacco users with MI are capable of successfully achieving tobacco cessation.[5] However, although clinical practice guidelines recommend routine screening and provision of tobacco dependence treatment for tobacco users with MI, few providers in behavioral health settings adhere to these guidelines.[6] If tobacco treatment is not supported and billable in behavioral health settings, people with MI will continue to be disproportionately affected by tobacco-related morbidity and mortality.

The behavioral health tobacco dependence treatment program for Medicaid recipients' expanded a novel training program for behavioral health providers and clients with MI through a collaborative model with the UK College of Nursing, Community Mental Health Centers (CMHCs) in Kentucky, and key behavioral health partners. We examined the needs of the Kentucky CMHCs in terms of their capacity for tobacco control initiatives and conducted both in-person and web-based generalist trainings on evidence-based tobacco treatment interventions for those with MI. We also provided specialist tobacco treatment training for providers within the Kentucky CMHCs with a focus on behavioral health populations who are Medicaid recipients. We engaged all 14 CMHCs that serve the 120 counties of Kentucky. The Kentucky CMHCs provide services through a combined total of 374 addiction and mental health centers.

SUMMARY

1. **Despite current tobacco treatment clinical guidelines, few providers in behavioral health settings fully adhere to them.** We found that providers in CMHCs screen for tobacco use, but are less likely to provide evidence-based treatments. For systematic treatment provision, these services need to be allowed as separate billable services in behavioral health settings as in other settings.
2. **Enhancing provider delivery of tobacco treatment interventions in behavioral health settings is critical in addressing the tobacco use disparity and related burden among people with MI.** Surveyed behavioral health providers highlighted the need for tobacco free policies, specialized tobacco treatment trainings, and connecting to community referral resources (see table 1).

Table 1. Key findings from the CMHC's provider policy survey (N = 159)

	n	%
Provider Role		
Manager/ Supervisor	82	51.6
Staff Member	49	30.8
Healthcare Provider	28	17.6
Facility has "No Smoking" signs displayed	92	57.9
Facility has a written policy restricting tobacco product use	131	82.4
• **Policy highlights impact of tobacco use on physical health**	29	18.2
• **Policy highlights impact of tobacco use on mental health**	14	8.8
Facility provides tobacco treatment services	45	28.3
Facility interested in training on tobacco free policy	81	50.9
Facility interested in tobacco treatment specialist training	88	55.3
Facility interested in community tobacco treatment referral resources	106	66.7

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KEY RECOMMENDATIONS:

1. **Provide focused tobacco treatment trainings for KY Medicaid providers in behavioral health settings to enhance their tobacco treatment capacity.**

   Few providers in behavioral health settings engage clients with MI in evidence-based tobacco treatment (i.e., brief interventions).[7] A majority ask clients about their tobacco use, but few advise on, assess willingness to, assist in, or refer to quitting resources. We recommend integrating brief interventions for tobacco treatment into routine behavioral health care and to disseminate information on available community tobacco treatment resources for people with MI to enhance treatment and referral by providers.

2. **Increase the number of certified tobacco treatment specialists (TTS) in behavioral health settings:**

   Only 1 CMHC in KY had trained tobacco treatment specialists. There is a need for on-going tobacco treatment certification training in behavioral health settings. Increasing opportunities to enhance behavioral health providers' competence in delivering evidence-based tobacco treatment can reduce the rates of tobacco use and related burden in this vulnerable population.

3. **Increase the number of community behavioral health partners supporting tobacco treatment engagement and tobacco-free environments for clients.**

   Though a majority of the Kentucky CMHCs have policies restricting tobacco use, these policies seldom highlight the effect of tobacco use on physical and mental health. We recommend providing technical assistance to Kentucky CMHCs to support their design, adoption and implementation of comprehensive tobacco-free policies that highlight the impact of tobacco use on both physical and mental health. Such technical assistance would target reduction of tobacco exposure, disparity and disease burden in this population.

4. **Assure separate billing for tobacco treatment services according to existing clinical guidelines.**

   The ability of behavioral health providers to bill separately for tobacco treatment services needs to be assured. We recommend that Medicaid require the covering of tobacco treatment services separate from any bundled mental health services, just as CMS requires that such services be covered for hospitalized patients. Coverage for tobacco treatment has demonstrated decreased hospitalizations and health care costs for those with heart disease,[8] but is yet to be studied among those with MI.

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