

Smoking Cessation: An Addition to Plan 1st Protocol

**Satellite Conference and Live Webcast
Wednesday, October 24, 2012
10:00 – 11:00 a.m. Central Time**

Produced by the Alabama Department of Public Health
Video Communications and Distance Learning Division

Faculty

**Meredith Adams, LCSW, PIP
Director of Case Management /
Care Coordination
Bureau of Family Health Services
Alabama Department of Public Health**

Process

- Nurse and patient
- Prescription and referral form
- The Care Coordinator's Role
- Changes to Protocol

Medicaid Pharmacy Form

Alabama Medicaid Pharmacy
SMOKING CESSATION FOR PRESUMED BENEVOLENT MEDICAID FIRST RECIPIENTS
PRICE AUTHORIZATION REQUEST FORM

P.A.N. 0800-7462114 Fax or Mail to P.O. Box 2710
Phone: (205) 746-2114 Health Services Division Auburn, AL 36833-0210

PATIENT INFORMATION

Patient Name: _____ Patient Medicaid #: _____
Patient DOB: _____ Patient Home # with area code: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ License #: _____
Prescriber with area code: _____ Fax # with area code: _____
Address (optional): _____

DRUG/CLINICAL INFORMATION

Drug requested: _____ Strength: _____
Drug trade name: _____ (for generic) _____ (for brand)
Indication of usage: _____ (if limited supply) _____ (if unusual supply)
Is the recipient currently pregnant or within 90 days postpartum? Yes No
Is the recipient currently enrolled in the Quitline program through the Department of Public Health and has the recipient
to the Quitline program? Yes No
If the recipient is not currently enrolled in the Quitline program, please provide a written request to the Alabama Tobacco Quitline (ATQ) at 1-800-QUIT-NOW.
If the requested drug is a brand name drug with an active generic equivalent, the P.A.N. Medicaid Form 3300 may be submitted to
ATQ in addition to this P.A.N. Medicaid Form.

DISPENSING PHARMACY INFORMATION

Dispensing Pharmacy: _____
Phone # with area code: _____ Fax # with area code: _____

Quitline Referral form

ADPH **Plan first** **QUITLINE**
PLAN FIRST SMOKING CESSATION PROGRAM
PATIENT REFERRAL/CONSENT FORM

Patient's Name: _____ Medicaid #: _____ Date: _____
Residence #: _____ Best Contact Time: _____ Daytime _____ Evening _____

I hereby authorize my healthcare provider to release my contact information and authorization regarding my tobacco use to the Alabama Tobacco Quitline. This authorization is continuing. I understand that the Alabama Tobacco Quitline will contact me to provide information, offer support in quitting tobacco and will provide progress reports to my healthcare provider. I agree to take part in this program and I understand that my participation is voluntary. I understand that any information I provide will be kept confidential.

Patient/Client Signature for Consent: _____

Comments: _____

I request that the Alabama Tobacco Quitline, operated by IQH, contact my patient for the provision of tobacco cessation services.

Care Coordinator/Referral Provider: _____
Facility Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Facility/County Health Department Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Would you like the Quitline to send you a brief monthly activity report on your patient? Yes No

Alabama Tobacco Quitline
1-800-QUIT-NOW
Fax: _____
IQH, Alabama Tobacco Quitline
1-800-QUIT-NOW

For assistance forms PLEASE COPY or visit www.adph.org

Public Health Service - 507 Designated Non-Smoking Signage OCTOBER 2012

Patient Information Section

Patient's Name: _____ Medicaid #: _____ Date: _____

Telephone #: _____ *Best Contact Time: _____ *Daytime _____ *Evening _____

I hereby authorize my healthcare provider to release my contact information and information regarding my tobacco use to the Alabama Tobacco Quitline. This authorization is continuing. I understand that the Alabama Tobacco Quitline will contact me to provide information, offer support in quitting tobacco and will provide progress reports to my healthcare provider. I agree to take part in this program and I understand that my participation is voluntary. I understand that any information I provide will be kept confidential.

Patient/Client Signature for Consent: _____

Comments: _____

Risk Assessment Form

FAMILY PLANNING RISK ASSESSMENT TOOL

Patient Name: SCULL, AMANDA MARIE **SSN:** 987-67-3210
County: Colliour **Area:** PHA05
Employee:
Program: Family Planning
Date: 10/12/2012 15
Medical Provider: ADPH

If you are in a private provider's office, you will need to change the selection, via the drop down box, to private provider. If you are in the health department, you will not need to change anything, it will auto-fill.

Comments Tab

Medicaid Number: **Medical Provider:** ADPH
Risk Factors: **Comments:** **10 Day Follow-Up:** **Quarterly Follow-Up:**
Comments:
 Pt is high risk, interested in expanding, conditions with smoking cessation
Type of Birth Control:
 PT (3 Counseling Methods) Informed
 High risk Low risk Minimal Intensive
Quitline Referral Date: 10/15/2012 15
 Patient accepted minimum assistance care coordination
 Patient accepted intensive care coordination
 Patient refused name management

New Tabs to Risk Assessment

Medicaid Number: **Medical Provider:** ADPH
Comments: **10 Day Follow-Up:** **Quarterly Follow-Up:** **Final Disposition:**
Risk Factors:
 Listed below are risk factors that may indicate the need for Family Planning Care Coordination services. Each patient should be assessed individually in a face-to-face encounter.

10 Day Follow-up Tab

Patient Name: SPANIC, AMANDA MARIE **SSN:** 013-29-4653
County: Madison **Area:** PHA02
Employee: Adams, Meredith
Program: Family Planning
Date of Service: 10/15/2012 16
Medicaid Number: **Medical Provider:** ADPH
Comments: **10 Day Follow-Up:** **Quarterly Follow-Up:** **Final Disposition:**
10 Day Follow-Up Date: 15

10 Day Follow-up Tab

Medicaid Number: **Medical Provider:** ADPH
Comments: **10 Day Follow-Up:** **Quarterly Follow-Up:** **Final Disposition:**
10 Day Follow-Up Date: 10/25/2012 15
 Y N N/A Have you filled NRT/cessation medication prescription?
 Y N N/A Are you using NRT/cessation medication?
 Y N N/A Have you spoken with the ADPH Quitline?
 Y N Have you stopped using tobacco products?
 Y N Patient has decided to continue using tobacco products.
AUTHORS: Meredith Adams/FHS/ADPH

10 Day Follow-up with Additional Questions

Medicaid Number: **Medical Provider:** ADPH
Comments: **10 Day Follow-Up:** **Quarterly Follow-Up:** **Final Disposition:**
10 Day Follow-Up Date: 10/25/2012 15
 Y N N/A Have you filled NRT/cessation medication prescription?
 Y N Are you planning to fill the prescription?
 Y N N/A Are you using NRT/cessation medication?
 Y N Are you planning to begin using NRT/cessation medication?
 Y N N/A Have you spoken with the ADPH Quitline?
 Y N Do you plan to speak with the ADPH Quitline?
 Y N Have you stopped using tobacco products?
 Y N Patient has decided to continue using tobacco products.
What is your Quit Date? 05/23/2013 15
AUTHORS: Meredith Adams/FHS/ADPH

Quarterly Follow-up Tab

Medicaid Number: Medical Provider:

Comments: 10 Day Follow-Up **Quarterly Follow-Up** Final Disposition

Quarterly Follow-Up Date:

<input type="radio"/> Y <input type="radio"/> N	Have you stopped using tobacco products?
<input type="text" value="05/23/2013"/>	What is your Quit Date?
<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> N/A	Have you filled NRT/cessation medication prescription?
<input type="radio"/> Y <input type="radio"/> N	Are you planning to fill the prescription?
<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> N/A	Are you using NRT/cessation medication?
<input type="radio"/> Y <input type="radio"/> N	Are you planning to begin using NRT/cessation medication?
<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> N/A	I have you spoken with the ADPH Quitline?
<input type="radio"/> Y <input type="radio"/> N	Are you planning to continue counseling with ADPH Quitline?
<input type="radio"/> Y <input type="radio"/> N	Patient has decided to continue using tobacco products.

Final Smoking Cessation Disposition Tab

Medicaid Number: Medical Provider:

Comments: 10 Day Follow-Up Quarterly Follow-Up **Final Disposition**

Final Smoking Cessation Disposition Date:

<input type="radio"/> Y <input type="radio"/> N	Have you stopped using tobacco products?
<input type="radio"/> Y <input type="radio"/> N	Did you use NRT/cessation medication?
<input type="radio"/> Y <input type="radio"/> N	Did you receive counseling with the ADPH Quitline?

- ### Reminders
- 10 day follow-up reminder will be e-mailed 5 days prior to the required date of completion
 - Quarterly follow-up reminder will be e-mailed 60 days from the date in the Quitline referral date box
 - Final smoking cessation reminder

- ### Tips
- When talking to the patient about the Quitline be sure to let them know the Quitline # is a 601 area code
 - Send Quitline referrals daily
 - Patient's phone number
 - Monthly activity reports

- ### Possible Questions
- Do we have to continue to follow as high risk intensive if the patient states they will continue to use tobacco products?
 - How long before the patient can get the prescription filled?
 - How long will the patient be on the phone with the Quitline?

- ### Possible Questions
- Why does the additional question on the risk assessment not appear for a Patient 1st patient?

Summary

- **Fax Quitline referral form and Medicaid Pharmacy form to Medicaid**
- **Fax Quitline referral form to Quitline**
- **Patients interested in smoking cessation medications will be high risk intensive and require 10 day follow-up and personal quarterly contact**