Louisiana Medicaid

Provider Update

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Message from the Medicaid Director

Jerry Phillips

In this 2009 legislative session, we face many budgetary challenges within the Medicaid office. As the state of Louisiana faces a significant decline in state revenue next year, and with the same or possibly worse forecast for the following year, our budget must reflect those changes as well. We will be looking closely at all our programs to see how we can continue to provide these vital services to our recipients and to work more efficiently with a reduction in funding. Many programs have already been affected by a 3.5% reimbursement reduction for the remainder of this fiscal year, and it appears these as well as other reductions may be necessary for the next fiscal year.

We understand the challenges providers experience as they await the outcome of how these budgetary shortfalls may affect their businesses. In an effort to keep providers abreast of these changes, we will be placing information regarding all programs that will be affected by either rate reductions or service limitations on the www.lamedicaid.com website. We encourage providers to check this website often and follow the link provided to review these changes in their entirety, as published in the *Louisiana Register*, on the Office of the State Register's website.

As a Medicaid provider, we appreciate your commitment as we work together through these difficult financial times to meet the medical needs of the citizens of Louisiana.

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EMERGENCY RULES
REIMBURSEMENT RATE REDUCTIONS

The Department of Health and Hospitals has determined that reimbursement rate reductions are necessary in order to avoid a budget deficit in the Louisiana Medicaid Program. Emergency rules to implement these reimbursement reductions were published in the **February 20, 2009** and **March 20, 2009** editions of the *Louisiana Register*, the state's official journal.

For details regarding which services are affected by these reductions, please go to the *Emergency Rule* section of the above-referenced editions of the *Louisiana Register* at the Office of the State Register's website (http://doa.louisiana.gov/osr/).

FEBRUARY 20, 2009 *LOUISIANA REGISTER*

The following rules are effective for dates of service on or after **February 1, 2009**.

Home and Community Based Services Waivers-Elderly and Disabled Adults Waiver-Reimbursement Rate Reduction: amends the provisions governing the reimbursement methodology for the Elderly and Disabled Adult Waiver to reduce the reimbursement rates paid for certain services.

Home and Community-Based Services Waivers-New Opportunities Waiver-Reimbursement Rate Reduction: amends the provisions governing the reimbursement methodology for the New Opportunities Waiver to reduce the reimbursement rate paid for certain services.

Home Health Program-Durable Medical Equipment-Reimbursement Reduction: reduces the reimbursement rates paid for certain durable medical equipment.

Hospice-Payment for Long Term Care Residents-Reimbursement Rate Reduction: amends the provisions governing the reimbursement for hospice services provided to long term care residents to reduce the reimbursement rates.

Mental Health Rehabilitation Program-Reimbursement Rate Reduction: amends the provisions governing the reimbursement methodology for mental health rehabilitation services to reduce the reimbursement rates.

Personal Care Services-Long Term Care-Reimbursement Rate Reduction: amends the provisions governing the reimbursement methodology for long-term personal care services to reduce the reimbursement rate.

Targeted Case Management-Reimbursement Rate Reduction: amends the provisions governing the reimbursement methodology for targeted case management to reduce the reimbursement rate paid for services provided to participants in the Nurse Family Partnership Program, participants in the New Opportunities Waiver, and individuals with disabilities resulting from HIV.

The following rules are effective for dates of service on after **February 20, 2009**.

Hospital Services-Inpatient Hospitals-Reimbursement Rate Reduction: amends the provisions governing the reimbursement methodology for inpatient hospital services to reduce the current reimbursement rates.

Intermediate Care Facilities for the Developmentally Disabled-Reimbursement Rate Reduction: amends the provisions governing the reimbursement methodology for intermediate care facilities for persons with developmental disabilities (ICF/DDs) to reduce the reimbursement rates paid to non-state ICF/DDs.

Nursing Facilities-Leave of Absence Days-Reimbursement Reduction: amends the provisions governing the reimbursement methodology for nursing facilities to reduce the reimbursement paid to nursing facilities for leave of absence days.

Outpatient Hospital Services-Private Hospitals-Reimbursement Reduction: amends the provisions governing the reimbursement methodology for certain outpatient hospital services to reduce the reimbursement rates.

MARCH 20, 2009 *LOUISIANA REGISTER*

The following rules are effective for dates of service on or after **February 26, 2009**.

Ambulatory Surgical Centers-Reimbursement Rate Reduction: amends the provisions governing the reimbursement methodology for ambulatory surgical centers to reduce the reimbursement rates paid for ambulatory surgical services.

Professional Services Program-Anesthesia Services-Reimbursement Rate Reduction: amends the provisions governing the reimbursement methodology for anesthesia services to reduce the reimbursement rates for services performed by certified registered nurse anesthetists (CRNAs).

End Stage Renal Disease Facilities (ESRD) Reimbursement Rate Reduction: amends the provisions governing the reimbursement methodology for end stage renal disease facilities to reduce the reimbursement rates.

Laboratory and Radiology-Reimbursement Rate Reduction: amends the reimbursement methodology for laboratory and radiology services to reduce the reimbursement rates paid for laboratory and radiology services.

The following rule is effective for dates of service on or after **March 7, 2009**.

Prosthetics and Orthotics-Reimbursement Rate Reduction: amends the provisions governing the reimbursement methodology for prosthetic and orthotic devices to reduce the reimbursement rate.

NOTE: Claims paid at the inappropriate rate due to delays in system implementation will be systematically adjusted. No other action is required by providers. Providers should monitor the Louisiana Medicaid website and remittance advice (RA) messages for updates regarding these rate reductions.

KIDMED Providers

Claims Recycled for Immunization Administration Reimbursement Changes

Immunization administration procedure codes impacted by the reimbursement rate changes effective for dates of service August 6, 2008 and after have been systematically adjusted. See the RA message dated December 16, 2008 for details. Claims where the billed charges were less than or equal to the previous fee on file were not included in this systematic adjustment. For this situation, if it is determined that adjustments are needed, providers should review the claim adjustment policy and procedures in the *2007 Louisiana Medicaid KIDMED Provider Training*, pages 38 and 64 or the *2007 Louisiana Medicaid Professional Services Provider Training*, pages 121 and 128. Contact Unisys Provider Relations at (800) 473-2783 with any questions.

Adult Immunizations

Adult Immunizations - Denied Claims Recycled

Beginning with date of service October 1, 2007, Louisiana Medicaid made select vaccine Current Procedure Terminology (CPT) codes payable to professional service providers for adult recipients ages 21 and older. Information regarding the details of these procedure codes can be found in the Remittance Advice (RA) messages dated November 13, 2007 and October 28, 2008. Affected claims that denied for services provided on or after October 1, 2007 were systematically recycled on the RA of February 24, 2009. If providers determine the need to resubmit any claims, voids or adjustments to rectify any outstanding issues, providers should review the policy and procedures for claim voids/adjustments in the *2007 Louisiana Medicaid Professional Services Provider Training*, pages 121 and 128. Contact Unisys Provider Relations at (800) 473-2783 with any questions.

Professional Service Providers

QW Modifier Update

System changes have been made for the following CPT codes that require a QW modifier:

Effective Date of Service	Codes Affected
10/4/06	82042, 82150, 82247, 82977, 84075, 84157, 84520, 87808
10/22/07	86703
10/30/07	80051
1/1/08	80047
1/16/08	80048, 80053

Claims that previously denied due to error 386 (Not Payable with CLIA Cert Type) for the aforementioned procedure codes were systematically adjusted with the RA of February 17, 2009.

Professional Service Providers

Lupron Depot Therapy for Prostate Cancer

Updates have been made to the claims processing system to allow reimbursement for multiple units of Lupron Depot 7.5 mg IM (J9217) to be administered on the same date of service to a recipient when medically indicated for the treatment of prostate cancer. It continues to be the Department's intent that provision of this medication, other than for the treatment of prostate cancer, is not reimbursable in Medicaid's Professional Services program. A systematic adjustment of inappropriately denied or "cutback" claims will be made. No action is required by providers. Notification will be made via remittance advice messages when the adjustments occur.

EarlySteps Providers

Early Steps Claims Recycled

EarlySteps claims for select procedures provided in the Natural Environment, and impacted by the reimbursement rate change effective for dates of service September 1, 2008 and after, are being systematically adjusted to reflect the updated reimbursement rates if the billed charges were greater than the previous fee on file. These adjustments appeared on the remittance advice of March 31, 2009. No action was required by providers. See the remittance advice message dated January 20, 2009 for details.

Claims where the billed charges were less than or equal to the previous fee on file were not included in this systematic adjustment. If providers determine adjustments are needed in this situation, they should review the claim adjustment policy and procedures in the *2007 Louisiana Medicaid EarlySteps Provider Training* manual, pages 31-36. Contact Unisys Provider Relations at (800) 473-2783 or (225) 924-5040 with any questions.

Physician and Hemodialysis Center Providers

Delay in National Drug Code (NDC) Implementation

Providers should be aware of the change in the implementation date of claims requiring National Drug Code (NDC) data. In order to prevent claims requiring this information from processing differently during the same weekly cycle, the implementation of NDC denial edits was moved from Wednesday, April 1, 2009 to Monday, April 6, 2009. This affects claims with dates of service of March 1, 2008 forward.

Refusal of Services to Recipients of Long-Term Personal Care Services and Elderly and Disabled Adult Waiver Services

Providers of Long Term - Personal Care Services (LT-PCS) and Elderly and Disabled Adult (EDA) Waiver services cannot refuse to provide service to any recipient when their agency has been selected to provide these services. This requirement can only be waived by the Office of Aging and Adult Services (OAAS) or its designee. Providers should notify OAAS immediately if there is documentation to support their inability to meet the individual's health, safety and welfare needs, or all previous efforts to provide service and supports to the recipient have failed.

Mandatory Training Held

In the month of April, mandatory training sessions were held at various locations across the state for providers of the Long Term - Personal Care Services (LT-PCS) and Elderly and Disabled Adult (EDA) Waiver programs. Training conducted by the Office of Aging and Adult Services (OAAS) staff included an overview of the new Service Hour Allocation of Resources (SHARe) methodology and how service hours are assigned to recipients. In addition, the training also covered information and instructions about the new Service Log that is to be used when documenting these services. For additional information about SHARe or the requirements of the new Service Log, please call your OAAS Regional Office Manager.

This is an Official
CDC HEALTH ADVISORY

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Wednesday, March 18, 2009, 15:00 EST (3:00 PM EST)
CDCHAN-00281-2009-03-18-ADV-N

Invasive *Haemophilus influenzae* Type B Disease in Young Children and Importance for All Young Children to Receive 3 Dose Primary Series with Available Hib-containing Vaccine

Background of the Hib Vaccine Shortage

Health care providers must be vigilant about ensuring that all young children are appropriately vaccinated with the 3 dose primary series of Hib (*Haemophilus influenzae* type b) vaccine. A nationwide shortage of Hib vaccine began in December 2007 and is ongoing. The recall of certain lots of the two Hib-containing vaccines produced by Merck & Co., Inc. and cessation of production of both vaccines has left only one manufacturer of Hib vaccine in the United States (sanofi pasteur). The shortage resulted in a recommendation by CDC to defer the Hib booster (routinely recommended at 12 through 15 months) for children who are NOT at high risk of Hib infection temporarily, until supplies are restored. This recommendation is still in effect.

Temporary deferral of the booster dose at 12 through 15 months of age for non-high risk children may have resulted in increased Hib carriage and transmission in non-symptomatic children. There is potential to see increases in cases of Hib disease at the local level. During 2008 in Minnesota, five children aged 5 months through 3 years were reported with invasive Hib disease; one died. Three patients had received no vaccinations because of parent or guardian deferral or refusal. One child was aged 5 months and had received 2 doses of Hib PRP-TT vaccine in accordance with the primary series schedule. Another child had received 2 doses of Hib PRP-OMP vaccine, but no booster dose, per CDC recommendations during the shortage. Subsequent to Hib infection, this child was diagnosed with hypogammaglobulinemia. The five cases in 2008 were the most reported for 1 year from Minnesota since 1992, when 10 cases were reported.

There is enough Hib-containing vaccine for all U.S. children to receive the primary series. All children should complete the primary series by 7 months of age; high risk children should continue to receive the full primary series and the booster dose. Completion of the primary series with currently available vaccine products (manufactured by sanofi pasteur) requires a total of 3 doses of Hib-containing vaccine (2, 4, and 6 months). Although there is enough Hib-containing vaccine nationally to support these recommendations, there may be times when practitioners do not have an adequate supply of vaccine to meet local demand. If Hib vaccine is not available in the office at the time of a visit, children who are unable to receive one of the primary series doses should be tracked and recalled to schedule an appointment to receive their dose as soon as vaccine becomes available in the office.

In addition, using available Hib-containing vaccines has presented challenges associated with switching from the Merck to sanofi products for some providers.

There are indications that these challenges have led to lower completion of the primary series. Preliminary information comes from sentinel immunization information systems (registries) in select states, which have indicated up to 10% lower coverage with the third Hib dose in the primary series compared to other vaccines (DTaP, PCV7) commonly administered at the same visit. In the scenario of booster dose deferral, it is even more important that all infants receive the complete primary series.

Specifically, some of the challenges in using the currently available Hib-containing vaccines have included provider reluctance to switch inventory and schedules, misunderstanding regarding what constitutes primary versus booster doses, determining a catch-up schedule in the setting of the deferred booster, and provider and parent concerns about over vaccination resulting from switching to the sanofi pasteur Hib-containing vaccine. Despite these challenges, health care providers need to ensure that all children are appropriately vaccinated with the primary series. For example, if Pentacel (DTaP-IPV/Hib) is the only Hib-containing vaccine available, this combination product should be used to complete the primary series, even if doing so results in receipt of additional doses of other antigens (e.g., DTaP, IPV). The Hib-containing vaccine products that are available may not be what providers used previously in their practice; however, the potential for increased transmission of Hib makes it more important than ever that every child is adequately protected.

Recommendations

The following non-high risk children should be scheduled to receive the primary series of Hib vaccine as outlined below:

- If the child is at least 6 weeks but less than 12 months of age and has received zero, one, or two doses of Hib vaccine, schedule him/her for the first or next dose(s) immediately with a minimum of four weeks between the doses. These children will need one booster dose when the Hib vaccine shortage is over.
- If the child is between 12 and 14 months of age and has not had any doses of Hib vaccine, schedule appointments for two doses, eight weeks apart.
- If the child is between 12 and 14 months of age and has received Hib vaccine but did not complete the primary series before they turned 1 year old (i.e., had 1 dose of the Merck product OR 1-2 doses of the sanofi product), schedule an appointment for 1 additional dose, a minimum of eight weeks from the last dose.
- If the child is at least 15 months of age but less than 5 years of age and has not received any doses of Hib vaccine OR has not completed the primary series (i.e., had 1 dose of the Merck product OR 1-2 doses of the sanofi product), schedule an appointment for one dose.
- If the child is 5 years old or older and hasn't received any Hib vaccine, Hib vaccine is not necessary.

Certain children are at increased risk for Hib disease, including children with asplenia, sickle cell disease, human immunodeficiency virus infection and certain other immunodeficiency syndromes, and malignant neoplasms. CDC recommends that providers continue to vaccinate these children with available Hib conjugate vaccines according to the routinely recommended schedules, including the 12 through 15 month booster dose. Providers who serve predominantly American Indian/Alaska Native (AI/AN) children living in AI/AN communities should continue to stock and use PRP-OMP- containing Hib vaccines (Merck product) and vaccinate according to the routinely recommended schedule, which includes the 2-dose primary series (ages 2 and 4 months) and a 12 through 15 month booster dose. This product is available from the VFC Pediatric Vaccine Stockpile, through their state immunization programs.

For more information about Hib disease and vaccination contact your state or local public health official or CDC at 1-800-232-4636/1-800-CDC-INFO or by email at www.cdc.gov/vaccines/about/contact/nipinfo_contact_form.htm. Information about current vaccine shortages and delays can be found at http://www.cdc.gov/vaccines/vac-gen/shortages/default.htm.

Additional Sources of Information

CDC. Invasive *Haemophilus influenzae* Type B Disease in Five Young Children - Minnesota, 2008. MMWR 2009;58:1-3.

CDC. Continued shortage of *Haemophilus influenzae* Type B (Hib) Conjugate Vaccines and Potential Implications for Hib Surveillance - United States, 2008. MMWR 2008;57(46):1252-1255.

CDC. Interim recommendations for the Use of *Haemophilus influenzae* Type B (Hib) Conjugate Vaccines Related to the Recall of Certain Lots of Hib-containing Vaccines (PedvaxHIB and Comvax). MMWR 2007; 56(50):1318-1320.

This Message was distributed to State and Local Health Officers, Public Information Officers, Epidemiologists, State Laboratory Directors, PHEP/BT Coordinators and HAN Coordinators, as well as Public Health Associations and Clinician organizations

A Primer on Smoking Cessation for the Older Patient

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Of the leading causes of morbidity and mortality in America, tobacco-related diseases account for the number one cause-approximately 440,000 deaths annually.[1] Although the nation's rate of adult smokers has fallen below 20% for the first time in almost fifty years, this news regarding cessation progress is much grimmer for older Americans.[2] Those 45 years and older account for 41% of all adult smokers. Also, 4.5 million over the age of 65 still smoke and disproportionately experience mortality.[3] Of the total number of annual deaths, approximately 300,000 of the smokers who die are aged 65 and older. While the largest cause of smoking-related mortality for those over 60 years is lung cancer, the death rates from chronic obstructive lung disease and cardiovascular disease are equal.[4] Additionally, smoking can attribute to stroke, hypertension, diabetes, osteoporosis, macular degeneration, abdominal aortic aneurysm, erectile dysfunction, and cataracts.[3]

Although smoking cessation interventions should always focus on the individual, older smokers may have similar characteristics, attitudes, and behaviors.[5] Many started during their teens, with an average starting age of 17. At that time in America's history, smoking was more glamorized, so older smokers started to enhance their self-image, due to peer pressure, or because it was "the in thing." Through the years, older smokers have varied the amount of nicotine use, but most are aware of the daily number of cigarettes they smoke and monitor this carefully for fear of running out unexpectedly. Older smokers are more likely to have higher scores on the Fagerstrom Test for Nicotine Dependence, consume one to two packs daily, and seek cessation assistance due to comorbidities or a previous myocardial infarction or stroke.

At the same time, healthcare providers are less likely to offer interventions to older smokers when compared to their younger counterparts, including cessation medications.[1] However, they are at least comparable to younger smokers in their quit rate success and respond favorably to strong advice from healthcare providers. Age does not decrease their desire to quit and, as will be explained, does not absolve the benefits from quitting.[1]

An Initial Assessment

All clinicians should be proactive in assisting smokers to quit. Smokers who receive assistance from a health-care provider are 1.7 to 2.2 times more likely to quit for five or more months.[6] Once the patient is identified as a smoker and interested in cessation counseling, an initial assessment should be performed. The clinician collects general medical information, including any concomitant disease states, all medications used (to avoid cessation medication interactions), and a general smoking history.[7] Patients should reveal when they started and how long they have smoked, the largest and least amount of nicotine used per day, and current use. They should be asked how many packs per day they use, which brands, and possible triggers for smoking.

Next, smokers should discuss their quit history. How many quit attempts have they made, and for how long was each successful? What, if any, cessation medications did they try? Many times patients have used a cessation medication inappropriately or did not give it a sufficient trial. Thus, the same medication might be beneficial if properly implemented. Even a twenty-four hour smoke-free period deserves praise since the quit attempt is a fragile thing and small successes need nurturing. Also, smokers should discuss why they relapsed because they will likely experience the same problems during the current attempt and should plan a different strategy. Finally, smokers should state how confident they feel for their upcoming quit attempt.

Questionnaires can determine the stage of readiness the patient is in for a quit attempt (i.e., Transtheoretical Model of Behavioral Change) and their level of nicotine dependence (i.e., Fagerstrom Test for Nicotine Dependence).[8] The former questionnaire can ascertain whether the patient is in the *preparation* or later stage and, thus, be most likely to benefit from extensive-and often expensive-cessation services. Finally, patients should discuss their willingness to set a quit date and comply with extensive counseling, with the goals of treatment individualized for each patient.

How Does Cessation Benefit Older Smokers?

Older patients may not "buy into" the harmful effects of smoking if they are not currently experiencing problems; thus, the clinician should emphasize specific problems and comorbidities. The types of cancers resulting from smoking are numerous, including lung, lip, oral cavity, pharynx, esophageal, larynx, pancreatic, kidney, and bladder. Smoking also yields a ten times increased risk of death from COPD, and triples the risk of death from coronary artery disease.

Many older patients will respond to the realization that since smoking will increase blood pressure, smoking a pack daily means that their blood pressures are elevated twenty times a day. Patients can easily see how this increases the cardiovascular risk over time. Additionally, smoking can increase triglycerides, lower high density lipoprotein levels, and can reduce the effectiveness of insulin for those with diabetes. [1]

"It's Not Too Late to Quit"

Older smokers, not unlike all smokers, will place barriers in the way of their quit attempt. Many may feel that the "damage has already been done" and thus, would like to be reassured that cessation still benefits them. Although a paucity of studies show benefit specifically in the older population, one study in particular is helpful.[9] A longitudinal study observed mortality for over 34,000 British male physicians for fifty years. Smokers died on average about ten years sooner than lifelong non-smokers. However, interesting findings occurred regarding when the smokers quit. Cessation prior to age 30 yielded a death rate not significantly different than nonsmokers. When cessation occurred during the smokers' 30s, 40s, and 50s, they gained 10, 9, and 6 years of life expectancy, respectively, in comparison to those who did not quit. Even smokers who quit during their 60s gained, on average, 3 more years of life expectancy. Thus, mortality is reduced even for older smokers upon cessation. When considering the combined effect of cessation on comorbidity and overall mortality, these findings are indeed encouraging.

Clinicians should also emphasize benefits that manifest fairly quickly. For example, walking becomes easier as circulation improves within two weeks to three months post-cessation.[6] Within nine months, the ex-smoker has an increased ability to clear mucus out of the lungs. Also, coughing, fatigue, and shortness of breath begin to decrease.

The first couple of weeks after the quit date will be the roughest as they "kick" their physical addiction to nicotine. In fact, relapse is most likely within the first three days of the quit date.[6] During the first couple of weeks, they will likely experience cravings and other symptoms of withdrawal, including cough, insomnia, restlessness, anxiety, increased appetite, weight gain, and depression. The rate of recidivism is proportional to the strength of withdrawal symptoms, so caution patients prior to the quit date that these are only temporary.

Cessation Medication for the Elderly

Current clinical guidelines assert that interventions advocated for all smokers include the older population as well because cessation studies have diverse populations. All smokers should try cessation medications except for the following: adolescents, pregnant or lactating women, or others with medical contraindications.[1] Cessation medications are all twice as effective as placebo in helping any smoker quit. Nicotine replacement therapy given OTC could be a viable starting place, due to its availability, few adverse effects, and ease of administration. While nicotine patches are a relatively safe form of administration, nicotine gum and lozenges cannot be used by denture wearers. Patients are most likely to experience skin irritation with the patches, while the gum and lozenge may cause gastric irritation if not used correctly. A basic outline for the pros and cons of all smoking cessation products is offered in TABLE 1.

While there exists no specific contraindications to cessation medications used by older smokers, some comorbid conditions may prevent the use of certain agents. Prescription nicotine replacement therapy, such as nasal sprays and inhalers, cannot be used by patients with bronchospastic disease because of the particulate matter delivered with these products. Bupropion SR, one of the two oral prescription cessation products, can increase the risk of seizures with a supratherapeutic dose. Thus, bupropion SR users should avoid medications that lower the seizure threshold. Finally, varenicline is not recommended when kidney function is compromised, and a warning exists for suicidal ideation in patients with depression.

Specifically, providers are advised to stop a patient taking varenicline if agitation, depressed mood, or a change in typical behavior is observed for that patient. Likewise, because renal insufficiency is more common in older patients, those with the potential of kidney problems should be carefully monitored-such as patients with poorly controlled diabetes or hypertension.

Don't Forget to Counsel on Behavioral Change and Stress Management

Many of the older tobacco-using population can be characterized as having 20 to 30 pack-years of smoking, 1 to 2 packs per day current use, multiple past quit attempts, and a high level of dependence. Thus, this is not your typical smoker and efforts for cessation should be targeted appropriately. Barriers that may be prevalent include: a lack of current physical problems resulting from smoking, a lack of willpower, fear of failure, and a lack of information about specific smoking risks and cessation medications.[5] Further issues or concerns of this population that may need to be addressed include: other smokers in the household (spouses), comorbidities, need for multiple support systems, and fear of exposing live-in grandchildren to health consequences.

Successful cessation programs for the older smoker include: strong encouragement to set quit dates, use of sound behavioral and stress management techniques, treatment of withdrawal symptoms with medications, relapse prevention strategies, and provision of continual follow-up.[10] Smokers should set a quit date within a couple of weeks after committing to quit. In the author's clinic, patients are given a **START** strategy to prepare for the quit date: **S**et a quit date and stick to it; **T**ell everyone that they are preparing to quit; **A**nticipate problems that might be experienced; begin to **R**emove all tobacco products from the environment; and **T**ake action! Patients then progress toward their stated quit date with "baby-step" strategies.

They alter their environment in such a way to make smoking an unpleasurable, conscious effort, such as only smoking outside or facing the corner of an infrequently used room in the house (lack of pleasurable stimulus when they smoke). Some switch to a "bad tasting" (often cheap) brand and cut their usage in half for each week prior to the quit date-and some are only smoking two or three times daily prior to their actual quit date!

Upon their quit date, the patient should be using the proper pharmacotherapy for assistance to cut down-but not totally stop-the cravings. Since cessation medications are not a panacea, do not underestimate the effect of properly implemented behavioral and stress management strategies. Such information cannot be given extensively here, but a list of examples is given in TABLE 2.

A Call to Action

Just as "Take action" is part of the smoker's strategy to stop, clinicians have the responsibility to act when the opportunity arises. The clinician should tell the smoker in no uncertain terms that quitting is the best action that they can take for their health. The clinician should confidently recommend the proper pharmacotherapy for the quit attempt, counsel the smoker regarding benefits to stopping and behavioral changes that are needed, and-if he or she does not conduct such a class-refer the older smoker to a class for further support. Of all that clinicians do throughout the day, the small amount of time spent counseling the smoker at the definitive moment they have decided to quit can make all the difference.

REFERENCES

1. Clinical Practice Guideline: Treating Tobacco Use and Dependence: 2008 Update. US Department of Health and Human Services. May 2008 www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf. Accessed November 18th, 2008.

2. Fewer than 1 in 5 U.S. adults now smoke. News from National Public Radio. www.npr.org/templates/story/story.php?storyId=96950224. Accessed December 6th, 2008.

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5. Summary of focus group research on current and recent former older smokers. www.tcsg.org/tobacco/focusgroupsum.htm. Accessed November 29th, 2008.

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7. Stack NM, Zillich AJ. Implementation of inpatient and outpatient tobacco-cessation programs. *Am J Health-Syst Pharm*. 2007;64:2074-9.

8. Anczak JD, Nogler RA. Tobacco cessation in primary care: maximizing intervention strategies. *Clin Med & Res*. 2003;1(3):201-16.

9. Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. *BMJ* 2004:328(7455):1519-1527.

10. Appel DW, Aldrich TK. Smoking cessation in the elderly. *Clin Geriatr Med* 2003:19(1):77-100.

TABLE 1
FDA-Approved Smoking Cessation Medications[1]

Method	Advantages	Disadvantages
Nicotine Patch	- Easy for patients to use; fewer compliance issues - Can be obtained without a prescription - Patient receives more consistent nicotine levels throughout the day to alleviate continuous cravings - "Step down" therapy allows patients to receive decreasing levels of nicotine every few weeks	- Many patients experience pruritis as allergic reaction to adhesive used and may have to use another brand - Must avoid use in patients with dermatologic conditions (i.e., eczema, dermatitis, psoriasis)
Nicotine Gum/lozenge	- Adjustable use; should follow a specific schedule for use but can use for "breakthrough cravings" - Good for adjunct therapy with a longer-acting medication, such as patch or oral medication - Can be obtained without prescription - "Step down" therapy allows the patients to receive decreasing levels of nicotine every few weeks - Gum use may delay weight gain	- Proper chewing technique must be used to decrease adverse effects (lozenge is a little easier to use) - Cannot be used by denture wearers - Cannot drink acidic beverages (orange juice, colas) for 15 minutes before or while using gum/lozenge - Adverse effects are mainly gastrointestinal: nausea, hiccups, and heartburn
Nicotine Inhaler	- Adjustable use; should follow a specific schedule for use but can use for "breakthrough cravings" - Great choice for patients who cannot seem to get past the "hand-to-mouth" ritual of smoking - Provides "step-down" therapy although dosing is not as strict	- Obtained by prescription only - Patient could become dependent - Initial throat or mouth irritation - Cannot be used by patients with bronchospastic disease - Patients should avoid eating or drinking within 15 minutes of using the inhaler

Nicotine Nasal Spray	- Adjustable use; should follow a specific schedule for use but can use for "breakthrough cravings" - Provides "step down" therapy, although dosing is not as strict	- Obtained by prescription only - Patients could become dependent - Potential for mouth/throat irritation is significant - Cannot be used by patients with bronchospastic disease
Bupropion SR	- One of two non-nicotine medications available - Easy to use; twice daily by mouth - Good choice in combination with nicotine-replacement therapy - May delay weight gain - Can also be used for depression	- Obtained by prescription only - Timing may be an issue: must begin using for at least 1 week before quit date - Should be avoided in patients with high seizure risk (seizure history, anorexia, some medications) - Patients should be monitored for suicidality or unusual changes in behavior[2]
Varenicline	- One of two non-nicotine medications available - Easy to use; twice daily by mouth - Mechanism of action as a partial nicotine agonist is beneficial - No significant drug interactions	- Obtained by prescription only - Timing may be an issue: must begin using for at least 1 week before quit date - Suggested to avoid use with NRT[3] due to its mechanism of action - Should be discontinued if patients develop neuropsychiatric symptoms[4]

[1] Table was adapted from the following article:
Sherman, J.J. (2005). The Impact of Smoking and Quitting Smoking on Patients With Diabetes, *Diabetes Spectrum*, 18(4), 202-208.

[2] Bupropion SR showed a reduction in risk of suicidality with antidepressants for patients ≥ age 65 in comparison to children, adolescents, and young adults; however, patients of all ages should be observed closely for suicidality or unusual changes in behavior when taking Bupropion SR.

[3] NRT = Nicotine Replacement Therapy

[4] Varenicline has been associated with the development of agitation, depressed mood, changes in behavior, suicidal ideation, and suicidal behavior. Patients exhibiting these symptoms should immediately discontinue varenicline.

TABLE 2
Sample Behavioral Strategies[1]

- Behavioral changes should focus on the individual and on preventing "triggers" for smoking.
- For many older smokers, morning coffee and the end of meals are strong triggers. Some example suggestions to eliminate smoking during morning rituals include:
    - Instruct the patient to change his or her morning patterns altogether with the "scrambling" technique. If the smoker perks coffee and smokes with the first cup, he or she should do something, *anything*, prior to perking coffee every morning for at least two consecutive weeks. He or she might take a walk in the fresh air or take a long shower. Or, without carrying along cigarettes, he or she might walk or drive to the nearest store and buy coffee there (without buying cigarettes!). Some smokers go the extra mile and go to sleep with their head at the foot of the bed. This way, upon awakening, their first thought is that "something" is different, and this is a reminder that they are quitting smoking.
    - Make sure they change their brand of coffee (along with their brand of cigarette) to a less favorable type so smoking with coffee is not so pleasurable. Some patients switch to decaf or half caffeine.

  Suggestions for ending meals without smoking include:
    - Encourage the patient to get up and go for another walk or busy themselves with a long, engrossing task, preferably outside if they tend to smoke inside after a meal.
    - Before the meal, they should commit to an exact time when they will stop eating. Thus, even if they have not yet finished their second slice of cherry pie, at the designated time they will push away from the table and leave the area. For either point, cigarettes are no longer used as a *signal* to end the meal-the smoker in the process of quitting dictates that!
- When smokers light up only in their car, any ride in the vehicle becomes the trigger (one of the author's patients said that her car was special-it only started when she was turning the keys with one hand and lighting up with the other!)
    - As the quit date arrives, encourage the patient to get their car professionally detailed. That way they are making a monetary investment, and the car will be so clean they won't want to spoil it with a cigarette.
    - Another smoker in the author's class had a good suggestion: he wrapped a carton of cigarettes in his car with thick tape. Then, when he made a *conscious decision* to have a smoke, he would have to unwrap the tape.
- The hand-to-mouth becomes a strong need for smokers, and this should not be underestimated. The author's patients have addressed this in various ways, such as carrying around licorice, carrots (a better choice, of course), and chewing toothpicks or straws. One patient that eventually stopped smoking stated during every class that he would "feel better" if only he could get his straw to light up!

[1]Behavioral strategies represent examples only and are taken from the author's smoking cessation clinic

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