Section D. Research Plan

On behalf of the MDQUIT Resource Center at UMBC and our collaborators at the Department of Health and Mental Hygiene (DHMH) and the Maryland Wellness and Smoking Cessation Steering Committee, we are submitting this full proposal for the RFP Smoking Cessation, Category 1 support for existing smoking cessation training initiatives. Our proposal expands and extends a number of prior and current research and evaluation projects. The first is our prior project, which ended several years ago, evaluating the feasibility and impact of training psychiatrists to implement the 5 A's with seriously mentally ill smokers (SMI) (Dixon et al., 2009). The second is our current SAMHSA funded project to create Screening Brief Intervention and Referral to Treatment (SBIRT) training and implementation protocols for medical residency programs for tobacco, alcohol, illegal drugs and nonprescription use of prescription medications. In both projects we have created screening and intervention training programs and materials and, more importantly, developed implementation protocols that produced successful implementation. In the evaluation of SMI clinic program, we demonstrated an impact on smoker motivation and cessation.

We are requesting funding to adapt our 5 A's/SBIRT trainings to focus specifically on the needs of low income Medicaid smokers and the providers who give them their healthcare in Maryland. To that end we will engage established Maryland Medicaid (MA) provider Managed Care Organization (MCOs) from the three organizations that provide State-wide coverage, namely Maryland Physicians Care, Priority Partners, and United Healthcare and offer comprehensive training aimed at enhancing providers' skills at reaching and intervening with current tobacco using patients. We will reach out to doctors, nurses, social workers, and pharmacists to implement brief interventions that can motivate and engage their patients in Maryland's comprehensive quitting plan. That plan includes several Maryland websites, one for consumers (Smokingstopshere.com) and one for providers (MDQUIT.org), access to Maryland Quitline services that consist of telephone counseling, Nicotine Replacement Therapy, fax to assist, web based, and text messaging capabilities, medication assistance and other cessation services at the local health department, and other support and intervention services provided by the MCOs.

Engaging MCO provider organizations as well as their individual providers will enhance efforts to disseminate and sustain primary care interventions and enable and extend the reach of tobacco control efforts to this neglected group of hard to reach smokers, especially those with mental health and substance abuse and other serious somatic health problems. We will use funding to adapt materials, offer incentives and training, and to evaluate this initiative. We will also start a medical records review process to determine when and how the providers are documenting tobacco use and interventions so we can create a sustainable system of record keeping facilitating the quality assurance monitoring needed as healthcare reform advances. Once we have trained personnel and have a system of monitoring in place, the probability of sustaining this intervention increases. Training multiple providers and engaging provider organizations will also enhance the probability of reaching patients with coordinated current messages and sources of support to increase the impact.

Overall Aims & Objectives

The primary goal of this project is to offer a more comprehensive, multi-method approach for healthcare providers to reach and intervene with Medicaid enrollees. Outlined below are the key objectives of this proposed project.

Key Objectives:

1.) Adapt training materials and strategies in collaboration with our organizational partners to meet the needs of Medicaid providers and patients;
2.) Provide training on identification and intervention processes (SBIRT & 5A's);
3.) Provide training for a multidisciplinary group of MA providers;
4.) Provide assistance with the implementation of smoking cessation patient services;
5.) Promote the system and medical records interventions that have the best chance for sustainability.

Impact of Proposed Project

Prevalence of cigarette smoking among adult Medicaid enrollees is significantly higher than the adult population: 33% compared to 19% (CDC, 2009), with some estimates as high as double the rate (Armour, Finklestein & Fiebelkorn, 2009). Estimates of smoking prevalence among Maryland Medicaid enrollees range from 24% (unpublished Maryland data) to 51% (Armour, Finklestein & Fiebelkorn, 2009). Figure 1 presents the number of Medicaid enrollees for Fiscal Year (FY) 2012 and Table 1 presents the potential pool of Medicaid tobacco users that our proposed training could reach, using the conservative smoking prevalence rate of 24%, the more liberal estimate of 51% and the average of the two estimates, 37.5%.

Figure 1. Number of Medicaid Enrollees in 3 Maryland Statewide MCOs for FY '12 (July, 2011 - June 2012)

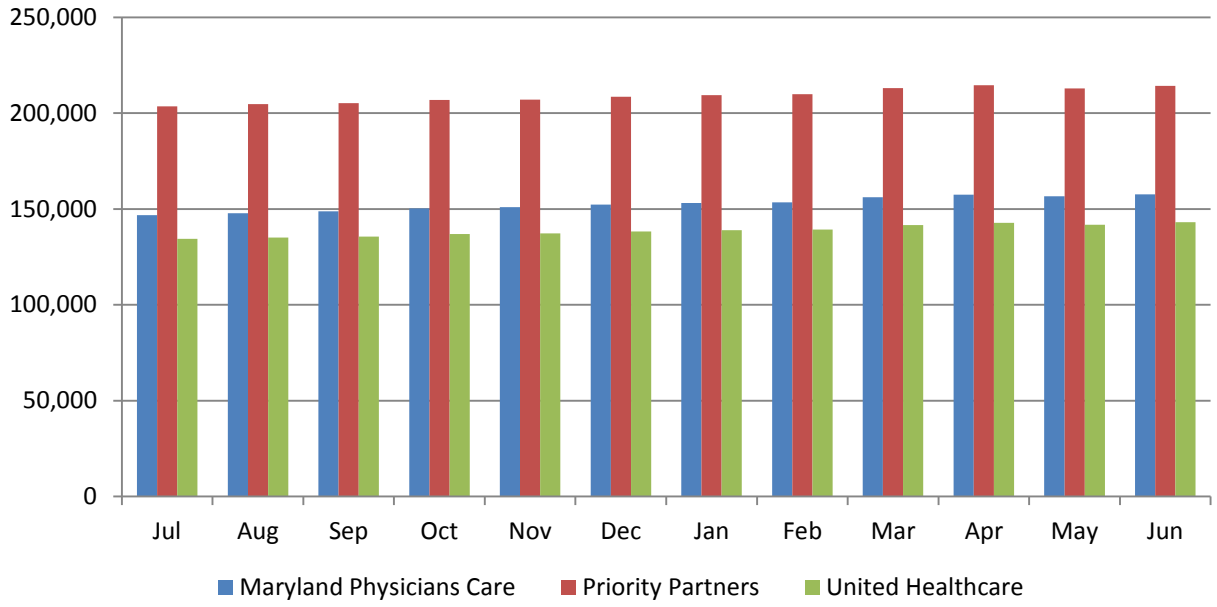


Table 1. Number of Potential Smokers that could be reached.

	Average enrollment	24% smoking prevalence	37.5% smoking prevalence	51% smoking prevalence
Maryland Physicians Care	152,599	36,624	57,225	77,826
Priority Partners	209,160	50,198	78,435	106,672
United Healthcare	138,763	33,303	52,036	70,769
Total # of Potential Smokers Reached		**120,125**	**187,696**	**255,266**

The bottom line is that, if we can reach even 50% of these smokers with brief, primary care cessation counseling and linkage to more extensive care, we can provide powerful motivation for cessation and increase the likelihood of quitting, benefiting not only the tobacco users but for entire State of Maryland. The National Commission on Prevention and Priorities (NCPP) has identified tobacco use screening and intervention for adults as one of the top three cost-effective prevention services that clinicians can provide (Maciosek et al., 2006). Maryland Quitline has consistently shown a 30% 7-day point prevalence quit rate at 3 months and primary care brief interventions can produce a 10 to 15% quitting success rate. Further, Maryland's direct health care expenditures for smokers' costs are over $2.2 billion per year (US Department of Health and Human Services, Centers of Disease Control and Prevention. *Sustaining State Programs for Tobacco Control: Data Highlights 2006.* Retrieved on October 9, 2012 from http://www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/pdfs/dataHighlights06rev.pdf). In 2006, the annual smoking attributable cost (direct medical expenses due to smoking) to the Maryland Medicaid program was approximately $476 million (ibid). It is estimated that for every $1.00 spent on providing tobacco cessation treatments, the average potential return on investment is $1.34 (Fiore, et al., 2008, Treating Tobacco Use and Dependence: 2008 Update). Using the conservative estimate of $1.34, and extrapolating that if 20% of all current smokers covered by Medicaid programs quit, the annual savings to Medicaid would be approximately $ 1.9 billion after 5 years, clearly is a win-win for both consumers and payees.

Current Assessment of Need in Target Area

As we've seen, smoking among Medicaid enrollees is a big problem that affects a large number of people in Maryland. According to recent estimates, 15% of Maryland residents are enrolled in Medicaid (StateHealthFacts.org) and as shown in Table 1, an intervention could impact a great number of persons. However, while there are a variety of evidence-based best practices for treating nicotine dependence, including the 5 A's, the 1-800-QUITNOW Quitline, and medications (Nicotine Replacement Therapy [NRT] as well as prescription medications such as Buproprion or Varenicline), research has shown that both provider groups and enrollees often lack knowledge about these effective treatments.

Provider Groups Knowledge of Coverage & Treatment Options

Provider groups vary on coverage of pharmacotherapy and do not always provide clear information on access to tobacco cessation treatments. Chase et al. (2007) reported that only 9% of the Medicaid-enrolled smokers who visited a health care physician during the past year received all of the 5 As. Although MA providers asked (87%), advised (65%), and assessed (51%) many of their smoking patients, they were significantly less likely to assist (24%) them with quitting (i.e., provide medication or referral to counseling) or to arrange (13%) a follow-up visit (Chase et al., 2007), despite the finding that most smokers wanted to quit and wanted their physician's help (Quinn et al., 2005).

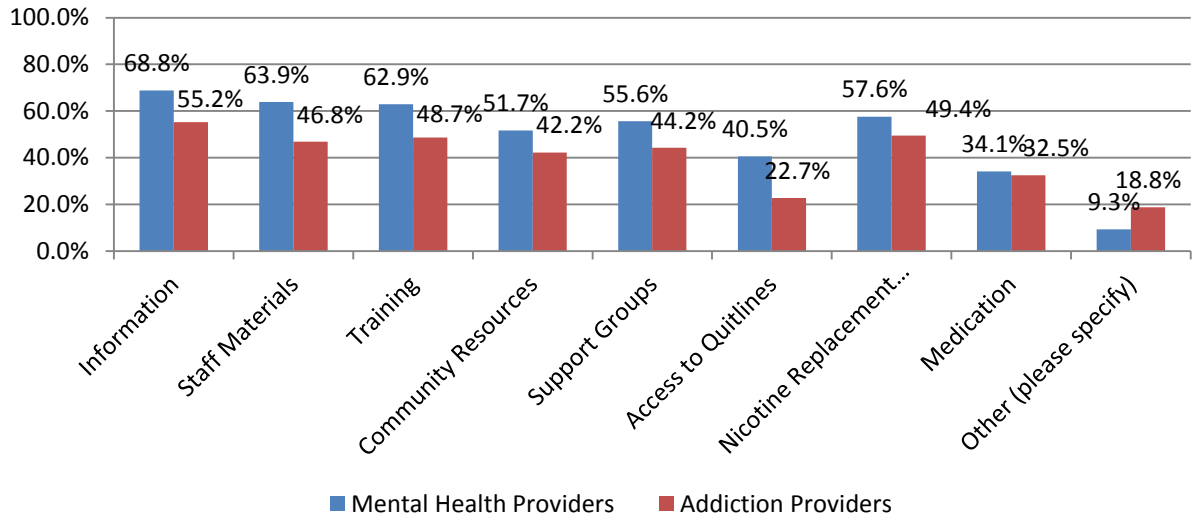
Even when there is coverage, knowledge of covered treatments for tobacco dependence among MA enrollees remains low. McMenamin et al. (2006) found that only 46% MA enrollees who were current smokers or recently quit were aware that their state MA program covered at least one form of treatment for tobacco dependence., while only 60% of Medicaid physicians knew that their state program covered tobacco-dependence treatments (McMenamin et al., 2004). A recent study by Li & Dresler (2012) found low awareness of tobacco-cessation services among both Medicaid providers and enrollees, with a key finding being that knowledge of coverage was positively correlated with the use of medications. Another disconcerting finding is that both Medicaid providers and enrollees do not perceive cessation treatments and interventions to be effective (McMenamin et al., 2006). Li & Dresler (2012) suggest that initiatives need to not only increase awareness of coverage, but also educate about evidence-based methods, the process of cessation, and interventions in order to increase utilization of tobacco cessation treatments.

Gap Analysis

As part of our work with the Steering Committee of the Smoking Cessation Leadership Center (SCLC)'s Leadership Academy for Wellness and Smoking Cessation, we currently have a survey in the field assessing knowledge, attitudes and current practices at a variety of mental health (MH) and substance abuse (Addiction) clinics throughout the State of Maryland. We realize that not all of these mental health and substance abuse providers work with Medicaid enrollees; however we still anticipate that these providers will hold similar attitudes as some primary care Medicaid providers. We present these data for illustrative purposes. Relevant to this proposal, is the finding that many providers report needing additional support to help assist current tobacco users in their cessation efforts. Figure 2 presents the responses for MH and Addiction providers in terms of what resources their facility would need to get involved in tobacco cessation programming. For both MH and Addiction providers, the most popular "other" responses included funding, staffing, time (lack of), and "I don't know".

Most relevant to this initiative is the finding that almost two-thirds of Maryland MH and almost half of Addiction providers would like staff materials and training. In line with the research presented that providers aren't aware of services, two in five (40.5%) of MH providers and over one in five (22.7%) of Addiction providers do not realize that they can currently refer to the Quitline to obtain up to 4 calls and up to 4 week supply of FREE NRT for their patients.

Figure 2. What resources would your facility need to get involved in tobacco cessation programming (choose all that apply)?



Medicaid recipients when they access the Maryland Quitline (QL) increasing funding and potential reach. Examination of QL utilization during this past Fiscal Year (7/11 – 6/12) among the 3 Statewide MCOs reveals that less than 1,000 of the calls to the QL were from Medicaid enrollees from Maryland Physicians Care, Priority Partners, or UnitedHealthcare. This represents about 13.7% of the total callers. However, if we consider that these 3 Statewide MCOs have an average monthly enrollment covering 500,000 individuals, and that a conservatively estimated 30% smoke, we would have a potential pool of 150,000 smokers in these MCOs. Less than 1,000 calls from a potential pool of 150,000 smokers represent less than 1% of these Medicaid smokers reached; clearly we can do more to engage and support these smokers. Thus one of the key goals is to increase knowledge of the Quitline resources in these MCO providers and to link these resources to the 5 As to empower providers and provide interventions and follow-up for smokers. The current proposed project meets multiple needs of providers and smokers receiving Maryland Medicaid services.

Previous Research on Efficacious Training Interventions

We have several active SBIRT training and smoking cessation initiatives ongoing. Tobacco is included in the MD3 (Maryland MDs Making a Difference) SBIRT medical residency training project. Since 2010 we have trained over 400 medical residents from a variety of residencies. The training uses MI-informed techniques to help healthcare providers to assess how ready an individual is for change and to provide feedback and suggestions in a respectful, non-judgmental manner. The training teaches how to capitalize on teachable moments, such as health care-related events that influence motivational factors and increase the probability of behavior change. We have developed standardized patient protocols for training and evaluation, a training to assist faculty to oversee implementation, and consulted regarding clinic implementation in the various settings (Family Practice, Emergency Room, OB, and Pediatricians' Office). We are in the process of evaluating impact of the training on the residents and will use this knowledge to extend training and implementation to MA providers.

Through a NIDA-funded grant, a previous research project examined a similar vulnerable population, smokers diagnosed with SMI. These smokers are at increased risk for the development of health problems as a result of their high rates of tobacco use and often are covered by Medicaid. Although there is evidence that more extensive treatments are needed for these smokers, the use of the TTUD recommendations for brief intervention when in contact with SMI populations in outpatient care had not previously been examined. This study (Dixon et al., 2009) tested whether successful implementation of the TTUD recommended 5 A's guideline could be implemented in psychiatric settings and if this implementation then reduces smoking among persons with SMI. We assessed the clinic-wide delivery of the 5 A's for all adult patients in three pairs of outpatient mental health clinics that treated at least 100 patients with Schizophrenia in the greater Baltimore area. Within each clinic pair, one clinic was randomly assigned to "immediate" implementation and the other to "delayed" implementation. Immediate implemented the 5 A's for 12 months whereas the delayed site of each pair implemented the 5 A's six months after a six month control period. The goal of the intervention was to ensure that each physician offering services utilized the 5 A's with each patient including Ask, Advise, Assess, Assist, and Arrange. Promotion of the intervention through the sites included pre-training publicity, psychiatrist training, provision of aids, provision of smoking cessation aids for staff, access to ongoing help from an in-person physician clinic liaison, and web-based mid-term booster training.

To assess fidelity, chart reviews of 20 charts from all patients were conducted every two months. Assessment included a review of how many of the 5 As were noted in the charts. Participants had to have an SMI diagnosis and be currently smoking. There were 156 and 148 participants in the immediate and delayed conditions and retention rates were 84% of the original sample at the six month follow-up and 77% at 12 months. While there was no evidence of a significant effect of the intervention from baseline to six month follow-up, there was modest support for the implementation of the 5 A's at community mental health centers when delivered for at least 12 months with an increased level of abstinence and reduced number of cigarettes smoked across time. After six months of the intervention, almost 69% and 41% of participants received one or more sessions that included either the 3A's or 5 A's, respectively. Analyses demonstrated that greater provision of the 5As increased stage transitions and progress toward cessation. A major conclusion was that incremental change is possible in this population but the brief interventions should also be linked to more intensive interventions.

Technical Approach, Intervention Design and Methods

We will offer state of the art training activities (website modules, in person interactive training, video modeling and assessments, practice opportunities online and in person) adapted to MA providers to enable them to provide a 5As/SBIRT intervention and empower them to link patients to more extensive treatments. Each group and practice has a unique culture and set of procedures to which we will tailor training and implementation. We will also encourage a continuous quality improvement approach to sustain the intervention as we have done in other projects. Thus we will focus on a more comprehensive system approach by providing evidence-based training to MA providers from different disciplines, offering multiple ways of connecting to cessation resources, and addressing needs of this challenging population of low-income,

hard to reach individuals often experiencing multiple problems including substance use and/or mental health issues. This project intends to improve upon current practices by training providers in SBIRT/5As as well as enhancing providers' use of effective readiness-based and Motivational Interviewing (MI)-informed practices for intervening with smokers. Furthermore, this project will consider the context/environment where SBIRT is delivered by assessing agency-level practices and offering solutions to implementation barriers. Finally we will offer some innovative ways to track implementation in charts (adding documentation to electronic medical records, stick on strips for paper charts) and link these to reimbursements. We have discussed with our Maryland Medicaid partners collaborating on ways to educate about payment codes and making sure that these codes are turned on for providers who are implementing this protocol.

In order to achieve the goals and objectives of this proposed project, we will engage three of the seven MCOs to work with on this initiative because they represent the only Statewide MCOs, namely UnitedHealthcare, Maryland Physicians Care, and Priority Partners. We are also collaborating with Medicaid to see how interventions could be billed and covered in Maryland.

Coordinator at each of the MCO Sites

We will support 100 hours of coordination at each of the three Statewide MCO groups over the period of this project. Our expectation is that we will be able to support/supplement a current staff member's salary and have this person assist the project manager in coordinating and facilitating all trainings of their providers and access to records. We envision having a coordinator at each of the three sites to assist us with identifying providers and potential scheduling availability. Another critical role the coordinator will fill is to assist us with our assessment of the implementation of services; as well as representing organizational needs and culture to the project staff and implementers.

Description of Intervention

We have expertise in creating trainings for a variety of healthcare providers in a range of healthcare settings and we will draw from all of our past experience to create a training tailored to Medicaid providers and how they can effectively address and encourage smoking cessation among their patients who are Medicaid enrollees.

Description of Training

All in-person trainings with Medicaid providers will last approximately 60 minutes. We anticipate having more time with some types of providers (nurses and social workers) and less with primary care doctors. However funding managers (Value Options) and provider MCOs have events for their providers and we will try incorporate trainings into these events. We will provide a brief overview of the problem of tobacco use among Medicaid enrollees, dispel common myths and discuss the efficacy of the 5 A's and SBIRT interventions. We will discuss the smoker's journey to cessation and promote core Motivational Interviewing (MI) techniques, such use of OARS (i.e., Open-ended questions, Affirmations, Reflections, and Summaries). We will allow time for role-playing exercises as we believe practicing how to discuss tobacco use

with patients is critical. We will also create brief online modules that can be used to retrain or train new providers once the project is over. We will promote recurring contact with providers and offer booster sessions in person for providers as well.

Description of Training Materials

We have had great success in our medical residency training grant with creating videos of brief (less than 5 minute) interactions with a physician and a patient and have received feedback that these tapes have been extremely helpful. We will adapt our MD3 training videos and create new videos that highlight interactions with a Medicaid provider and enrollee. As we have done with each of the residencies, we will solicit help from the three MCOs to help us identify what a "typical" Medicaid patient presents with in their practices to make the videos most relevant to the providers.

Training materials will include small reminder objects for the providers that can be kept on the desk or be useful for patient interactions (laminated cards outlining the 5 As with a printed readiness ruler, Quitline and resource cards, pens and other reminder aids). AS mentioned above we will include implementation strategies in our training and hopefully incentivize activities with reimbursement as ways to sustain the interventions post funding. Training is part of the ongoing mission of the MDQUIT Resource Center which has been funded continuously for over 6 years and provides educational and best practices support for providers and prevention specialists across the state. Thus the initiative will be housed in an ongoing center funded by DHMH increasing likelihood of sustained efforts and continued training options even after funding is complete.

Potential Pool of Providers to be Trained

There is a very large number of primary care healthcare providers (e.g., physicians, nurse practitioners, etc.) that we could potentially train. For instance, there are over 4,000 primary care providers just in one of the three Statewide MCOs alone. Assuming similar numbers of providers in the other 2 MCOs, we are anticipating a pool of potential providers to train is at a minimum 12,000 providers.

Delivery of Training

Recognizing the great number of providers in the potential pool to be trained and the realistic feasibility of this project to train as many providers as possible, we are proposing to reach providers in two ways: 1.) via in-person trainings and 2.) via online modules. For the in-person trainings, we propose to have trainings with at least 10 of the large practices (e.g., minimum of 50 practitioners) for each of the three MCOs, resulting in potentially reaching 1,500 providers (i.e., 10 trainings x 50 providers x 3 MCOs). In our MD3 SBIRT medical residency training project, we have been able to train the larger residencies (e.g., Internal Medicine) via online modules and we propose using this method as a way to reach as many providers in the smaller and/or individual practices as possible. We will create online versions of the trainings that are delivered in-person. We will host these online training modules on www.mdquit.org, linked to training and hopefully CME activities on Medicaid and MCO-related websites. We will monitor viewing of modules via analytics, where possible.

Evaluation Design

In order to assess how well our intervention worked, we will use the following target measures of success.

The main outcomes of this study will be:
1.) number of Medicaid providers trained;
2.) number of provider practices and agencies reached;
3.) numbers and percentage of Medicaid smokers who call the Quitline (reach);
4.) cessation rates among MA recipients from the Quitline evaluations**;**
5.) changes in attitudes/perceptions pre to post training; and
6.) qualitative descriptions of implementation. Although we would like to evaluate cessation rates, individual follow-up is unfeasible and the period to evaluate population smoking cessation too short. We will continue to track population rates in the MDQUIT data analysis deliverables. These outcomes and how they will be assessed are outlined in further detail below.

Number of Medicaid Providers Trained

We will work with the Coordinators at each of the three MCOs to identify potential Medicaid providers to be trained. With our residency training grant, we use sign-in sheets to record and track all participants who attend and receive training online and in-person. We will create a database for tracking the number of providers trained and offer CE credit when possible.

Number of Agencies Reached

We will work with the coordinators at each of the three Statewide MCOs to identify key practices, clinics, FQHCs, and other provider options. We will create a database that will be used for tracking number of agencies trained.

Number and Percentages of Medicaid Smokers who Call the Quitline (Reach)

Through our work with MDQUIT, we have a great working relationship with Maryland's Quitline Provider, Alere Wellbeing and we receive monthly, detailed reports from the Quitline outlining services requested and received from all callers. We already know that approximately 13.7% of the callers to the Maryland Quitline are from one of the Statewide MCOs. We will work with Alere to not only track Medicaid callers to the Quitline, we will also create a custom "How Heard About" question with a response option that allows the QL to record if they "heard about" the QL through their Medicaid provider.

Cessation rates among MA recipients from the Quitline evaluations

As part of Alere Wellbeing's contract with the State of Maryland, an independent evaluation is also conducted on a yearly basis, which has as a key outcome, quit rates among a sampling of callers. As part of our work with MDQUIT, we receive this evaluation and will we be able to track the cessation rates among Medicaid enrollees.

Changes in attitudes/perceptions pre to post training

As part of our work with evaluating the MD3 SBIRT residency training, we conduct pre- and post-training surveys that assess knowledge, attitudes/perceptions and behaviors (KAB). These surveys have been valuable in identifying areas of weakness that we can address in our trainings. We will adapt these KAB surveys for use with Medicaid providers. We will obtain pre-surveys prior to the trainings. Depending upon preference of the providers, we will either have them complete the survey in-person prior to the training or use SurveyMonkey, an online survey collection site that we currently use for our MD3 project.

Qualitative descriptions of implementation

In our work with the Center for Community Collaboration (CCC), we've worked with agencies to implement SBIRT for mental health and substance use among HIV Care Services Programs. We will use the CCC framework as a model for assessing how well the 5 A's are being adopted and implemented in each of the MCOs (Gregory et al., 2012). We will assess organizational culture and context, the organizational stages of change as well as stage-based SBIRT implementation.

Evaluation Controls

In our evaluations we will use an historical control strategy to track increases in referrals to the Quitline and pre-post design for evaluation of trainings. Chart reviews will also use an historical control strategy examining a random sample of charts at the beginning of the project and then at 6 month intervals during the course of the 2 years of implementation of the project. We will then have trajectories over time to evaluate. We will also look for predictor of change in trajectories using organizational and training implementation dimensions (size of organization, implementation scope, participation in training, involvement of multiple types of providers).

Target Audience & Dissemination

Medicaid providers who receive the training and their patients will be our target audience. The direct benefit will be to the providers in terms of training and capacity building, and to the patients in terms of access to smoking advices and services. Medicaid enrollees who are tobacco users and receive care from the trained providers should be screened more effectively and provided with an array of resources to help them with their cessation (from pharmacology and advice to more intensive coaching and local health department groups, to the fledging Nicotine Anonymous groups currently being held in the state of Maryland. In terms of dissemination of SBIRT, this proposed project will enhance and extend one of our objectives/deliverables in our MD3 medical residency training grant. In the final year of that project (2014) we will work to disseminate our MD3 SBIRT trainings to other medical school residency trainings in our area (e.g., Johns Hopkins University) and to the broader community. We believe that this project with a focus on Medicaid providers fits nicely in with that MD3 initiative and that they will create some synergy since new Medicaid providers from both the University of Maryland and the Johns Hopkins University will be given the messages and resources related to the products and experiences related to smoking cessation in Medicaid populations as a result of this project.

E. Detailed Work Plan and Deliverables Schedule

The following table outlines the work plan for this project. If funded, this project will begin on December 1, 2012 and end on November 30, 2014. For ease of interpretation, we are presenting each year of the project in quarters. For instance, quarter 1 in the second column represents the time frame of December 2012 through February of 2013. The symbol ● denotes that the project objective or task will be achieved during that time period.

If funded, this project will begin in December, 2012. One of the initial key tasks will be hiring the coordinators at each of the three Statewide MCOs. Once we have these coordinators established, the project manager and project coordinator will work with the MCOs to schedule the trainings. We expect the hiring of coordinators to be completed in the first quarter of the project and we anticipate having these coordinators in place by end of winter and will continue to plan and schedule the trainings through early spring. At the same time as hiring coordinators, we will be also be concurrently adapting the 5 A's and SBIRT trainings to focus on special needs of Medicaid enrollees who are tobacco users. In quarters 2 and 3 of 2012-2013, we will develop the intervention and associated training materials and videos for both in-person and online delivery. The training of the MCO providers will begin in the quarter 4 of 2012-2013 and last the entirety of the last year of the project. Key tasks will include implementing the trainings both in-person and online. We are projecting that for the in-person trainings; we propose to train at least 10 of the large practices (e.g., minimum of 50 practitioners) for each of the three MCOs, resulting in potentially reaching 1,500 providers. We hope to reach as many providers as possible through our online modules. This project will require detailed tracking (e.g., smoking rates assessed via StateSTAT; calls to the Maryland 1-800-QUITNOW, and number of trainers trained), thus we have Data Tracking and Analyses tasks as occurring throughout the life of this project. Finally, in the last 2 quarters of this project, we will disseminate the findings, on our website, in presentations and in publications.

Project Tasks / Milestones	2012-2013				2013-2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Coordination @ 3 State-Level MCOs								
Hire coordinators @ Maryland Physicians Care, Priority Partners, and UnitedHealthcare	●							
Project Manager & Project Coordinator will work with Coordinators to schedule trainings	●	●						
Development of Intervention								
Adapt current 5 A's & SBIRT Trainings to focus on special needs of Medicaid enrollees who are tobacco users	●	●						

Project Tasks / Milestones	2012-2013				2013-3014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adaptation of MD3 videos to create new Brief Intervention Videos highlighting interactions of MA providers and MA tobacco users	●	●						
Develop Training Tools (e.g., PowerPoint Presentations, role-play exercises, pocket cards, etc.)		●	●					
Creation of online modules that mirror in-person training		●	●					
Conduct Trainings								
Deliver Trainings to 3 MCO Provider Groups via in-person trainings and online modules				●	●	●	●	●
Assess Delivery of 5 A's in MCOs				●	●	●	●	●
Data Analyses								
Track the # of Medicaid Providers Trained				●	●	●	●	●
Track the # of Medicaid Agencies Reached				●	●	●	●	●
Track the # of Calls to the MD Quitline from MA recipients	●	●	●	●	●	●	●	●
Assess cessation rates among MA recipients who called the Quitline	●	●	●	●	●	●	●	●
Assess pre-post training changes in attitudes / perceptions				●	●	●	●	●
Assessment of Adoption of 5 A's in each of the MCOs (chart review on subsample)		●		●		●		●
Dissemination of Findings							●	●

Q1=Dec., Jan., Feb.; **Q2**=March, April, May; **Q3**=June, July, Aug., **Q4**=Sept., Oct., Nov.