MaineHealth
Center for Tobacco Independence

A Case Study: Primary Care staff can achieve a 100% increase in referrals to tobacco quitline using 30-second intervention at every office visit.

From 2017 to 2018 MaineHealth told its clinical staff they were not expected to get patients to accept a referral -- and then it went on to achieve a 100% increase in referrals.

Who is MaineHealth?

MaineHealth is the largest health system in Maine and is organized in several Local Health Systems (LHS). In addition to operating 12 hospitals and dozens of ambulatory practices in 11 of the 16 counties in the state, it has always had a strong commitment to population health -- "Working together so our communities are the healthiest in the country."

The Goal

It is well known that tobacco use is the leading cause of preventable death and illness, and addressing it is important to population health strategy. In 2016 MaineHealth clinical leadership recognized there was more it could to address tobacco use in its service area. It set a target to reduce prevalence to <14% by 2020, with a general strategy to refer more tobacco users to the Maine Tobacco HelpLine (the state's tobacco quitline) for evidence-based treatment. It was determined to improve its system-wide referral rate from its 2017 baseline of 6% to 20% by the end of 2018.

The Team

A new team formed to support each LHS to achieve the referrals goal. Each LHS had a representative on the team – typically a quality or clinical leader – who would identify a strategy the LHS would use to reach the goal. A physician clinical champion vetted ideas for strategies to make sure they were clinically sound. An EPIC resource provided insight into what the system could do, and a data/reporting resource could develop reports to support the strategies. The team also included a quality improvement specialist and a performance improvement specialist to assist with testing new strategies and implementing change. A project manager from MaineHealth Center for Tobacco Independence (CTI) organized the team's work and meetings.

The team held regular one-hour telephone conference calls to brainstorm, discuss plans, update progress, and share experiences. For the first year the meetings were monthly, but in year two the schedule went to every other month because regular attendance was a challenge for some team members.

The Strategy – From Pilot to System-wide Implementation

CTI had conducted a survey of local providers and other clinical in 2017 staff to identify barriers to making referrals and ideas for improvement. This information collected from 98 respondents indicated there were three barriers having the most impact:

- Belief among staff that most of their patients are not interested in quitting or getting help to quit.
- Unawareness among staff of what the Maine Tobacco HelpLine does and the effectiveness of treatment.
- Feeling there is no time to engage in a conversation about tobacco in the space of an office visit.

Informed by the survey findings, CTI developed a presentation for Primary Care clinical staff. Where previous trainings about tobacco had been delivered in a one-hour "lunch-and-learn" format and gone into some detail about tobacco

addiction and treatment, the plan for this training was to be brief –15 minutes for content and 15 minutes for Q&A – and focus only on what was relevant to making a referral. This challenge was viewed as adaptive issue, that is, one related to beliefs and perceptions more than technique and knowledge.

3 Points of Focus:

1. Engaging patients about their tobacco use is important.
    - most people start using tobacco in their youth, they start thinking about quitting soon after, 70% are thinking about quitting, 50% will make an attempt, people make 30 attempts times to quit on average, 95% of the time without support, and "cold turkey" is rarely effective (3%-6%).
    - Positive effect just engaging on tobacco – patients with provider support do better, each intervention increases likelihood of quit attempt . . .
    - Downside of not engaging . . .
2. Staff can address tobacco and make a referral to the Maine Tobacco HelpLine in less than a minute.
    - Simple 3-part message: "I care about you; I think it is important to do something about your tobacco use; I can help, and I want to help – what do you think?"
    - If patient wants referral, EPIC referral takes 3 clicks
    - If patient does not, "I understand, but I'm going to offer help again next time I see you because we think it is important." and move on to the next subject.
3. Staff can refer to the HelpLine with confidence because it is an effective evidence-based treatment service.
    - Overall quit rate is 26% -- not 100%, but much better than 3%
    - 95% of users say they would use it again or recommend to family or friend.

In addition to the Power Point presentation, attendees would receive a folder with information deemed important to support the objective, but not as critical as what was addressed in the presentation itself. Materials covered open-ended questions, detailed information about the Maine Tobacco HelpLine (hours, criteria, etc.), the no-cost Nicotine Replacement Therapy medication available through the HelpLine, secondhand smoke, and third hand smoke.

CTI piloted this approach with Maine Medical Partners, MaineHealth's largest LHS. Throughout the month of September 2017, the training was delivered to clinical staff at 18 Primary Care practices including Internal Medicine, Family Medicine, and Pediatric sites. Attendees included providers, Medical Assistants, and RNs, and in some cases Social Workers, Patient Service Representatives, and receptionists.

Attendees at every training were invited to complete a survey they would get via email within 24 hours and encouraged to share feedback. Also, training was delivered by presenter-assistant teams, and one important role of the assistant was to observe the audience and see which points resonated and which did not. Information from surveys and observations was used to fine tune the presentation, and it was revised several times.

This approach seemed to be effective. In the month before the training, these practices made 43 referrals combined, and in the month following the training they made 89.

On the strength of the pilot, CTI recommended this strategy to the Tobacco Team. The team agreed, and over the period of January through May every Primary Care practice received the training. In addition to the training, we reported monthly referral numbers and performance on the measure to every practice leader and to clinical leadership.

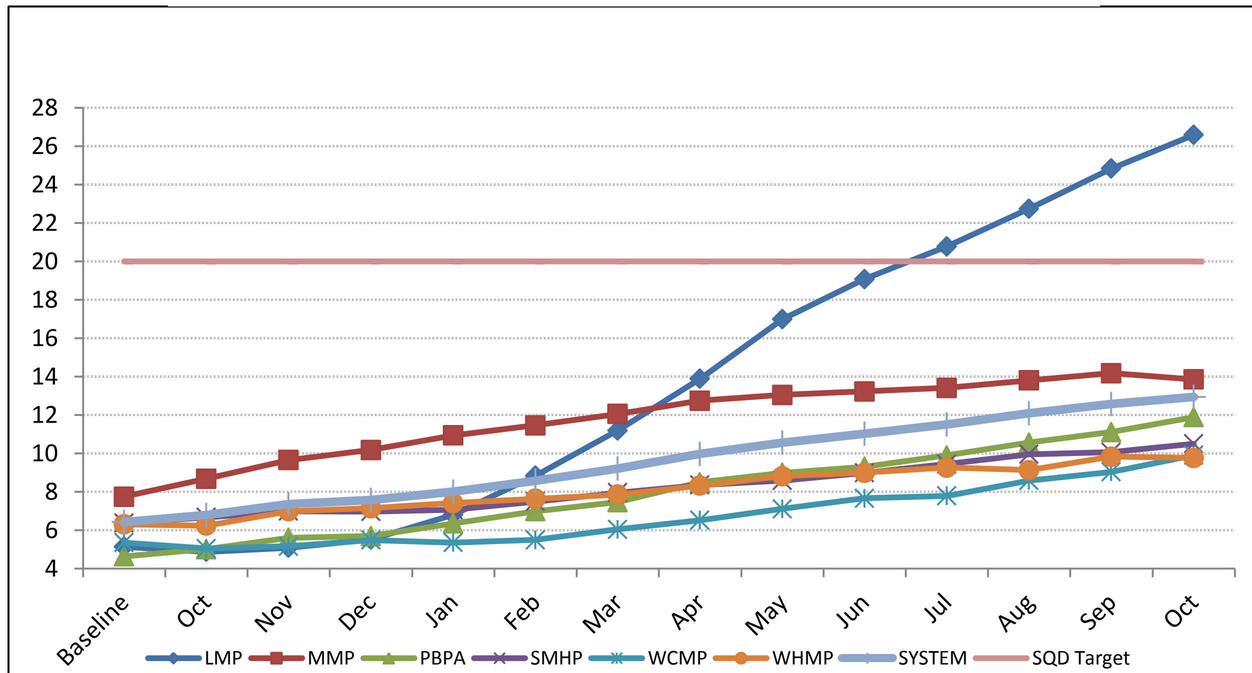
Results for Year 1

In the first year of the initiative, system-wide total referrals to the Maine Tobacco HelpLine went from 2,477 to 5,060. Referrals sent via EPIC increased from 2,047 to 3,221. The Dashboard Measure improved from 6.43 referrals for every

100 patients who use tobacco to 13.74. Every Primary Care practice increased the number of referrals submitted, and 55% at least doubled the number of referrals submitted the previous year.

Still, results varied from region to region within the system, and from practice to practice and provider to provider. Notably, a handful of providers that had made essentially zero referrals the previous went on to refer 50%-60% of their patients who use tobacco. Half of all referrals were coming from only 10% of the actively referring providers.

Year 1 Referrals per 100 Active Tobacco User Patients by Local Health



Comments from Year 1

- One of the most valuable lessons learned in the first year was the importance of setting realistic expectations regarding referrals. Specifically, clinical staff were explicitly relieved to hear that despite their best efforts many if not most patients would still decline a referral to the HelpLine, but that as long as they were making a genuine offer of help to quit to every patient at every visit they could be sure they were doing everything reasonably within their power.
    - We called this Permission to get “No” for an answer. Expect patient to decline, and offer help anyway.
- The second most important lesson came after interviewing the clinical care teams – providers and MAs – who had submitted the most referrals. One thing they had in common was the intent to refer every patient. These teams operated as if the default action was to refer, and they only did not refer if the patient declined.
- There were a few clinical care teams that had made such an increase that we wanted to be sure the referrals were all done with knowledge and consent. We asked HelpLine staff calling referred patients to track instances of patients reporting that they had declined the referral or did not recall discussing referral. After two months we found that about 5% of patients from all referral sources stated they had either declined the referral or did not recall discussing referral; for practices that had been through our Provider Engagement training it was 4%, and for practices that had not gone through the training it was 6%. While the difference was determined to be insignificant, we were comforted that our training had not resulted in a spike in “inappropriate” referrals.

Challenges and Barriers

Staff turnover

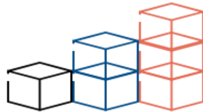
Staffing levels & availability to present and train

Competing initiatives and other priorities

Training & workflow variation in practices

Coordinating & convening initiative team meetings

Acceptance that significant change takes time


Objective & approach builds upon itself and requires deeper skills as phases go on

Internal reporting infrastructure needed to be developed to inform target measure

Year 2 Activities

In the second year the team's intention was to circle back to every Primary Care practice. We would have liked to talk with staff to get their perspective on what was working and what was not, to talk with staff hired since the initial training, and to share the new and improved elements of the training with everyone. However, most practices were unable to fit this into their agendas, citing other quality initiatives they were working on, staffing levels posing a challenge, or other obstacles.

Acting on observations from Year 1, specifically that MAs and other staff rooming patients played a key role and it was not uncommon for staff to have misconceptions and assumptions about patients who use tobacco, we set our sights on intervening with them as early as possible. In the MaineHealth System, MAs must go through a "Foundations" of clinical practice training in their first 6 months of employment, and then "Advanced MA Training" is available but not required and typically done in the first 6-12 months. The training does not address tobacco until the Advanced training, and then it focuses on clinical information about dependence, medications and treatment, and very little on making referrals to the HelpLine. We thought there was an opportunity to head-off the adoption of misconceptions before they started working in the practices. We collaborated with one Local Health System, Maine Medical Partners (MMP), to meet every newly-hired MA (an others who would be rooming patients) spend 30 minutes on tobacco referrals. This has been well received by practice leaders. Other Local Health Systems have said they would like to support newly-hired staff but they do not do the same sort of orientation as MMP. For some of these regions we have delivered the training at MA Skills Fairs and via webinars. We are monitoring these practices to see which approaches are easiest to maintain and produce the best results.

We continued to see wide variability in performance in the second year. Overall performance started at 12.58 in October and through July improved only to 12.7. At the regional level, 4 Local Health Systems improved 3 stayed level or backslid slightly.

We began planning how to handle referrals in EPIC so that the default action was referral, i.e. to make it harder to not make a referral than to make one. Besides making referral easier and faster, this change would underscore the position MaineHealth had taken and it was believed this would encourage some staff to persist ("We believe it is important to

help every patient who uses tobacco . . . "). This effort to build the "Opt Out" mechanism for referral is ongoing. In the meantime, we are rolling out a standard protocol for referral so rooming staff know they can and should submit a referral whenever appropriate and this does not have to be approved and submitted by the provider.

Comments from Year 2

- It has been a challenge to get consistent participation in our System Quality Dashboard team meeting, primarily because staff are struggling to juggle several concurrent initiatives.
- A few motivated people can have an impact. In one practice – which had shown the least improvement in 18 months – numbers improved quickly and significantly when a single MA championed the cause of increasing referrals. By discussing tobacco at every weekly huddle and staff meeting, she helped the practice submit more referrals in one month than it had in the previous 6. She went on to sponsor OPEX (quality improvement) projects to track referrals and use of EPIC SmartPhrases to attach tobacco information to every After Visit Summary, and the numbers continue to improve.
- While Primary Care practices have been the focus of our efforts, we recognized that other Specialty practices have opportunities to refer and to support the message that MaineHealth believes addressing tobacco is important. Accordingly, we have trained staff at Cardiology, Oncology, Urology, General Surgery, Emergency, and Women's Health practices.
- Leaders need to buy-in to the idea that improving tobacco referrals is a long game. Adopting improved practices will have some near-term results but the real benefit is the long-term effect of patients hearing over and over that their providers can offer effective help to quit.

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