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 America."

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 in its service area to <14% by 2020, with a general strategy to refer more people who use tobacco to the Maine QuitLink (MQL, the state's tobacco quitline, formerly known as the Maine Tobacco HelpLine) 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. MaineHealth uses EPIC as its EMR, and an EPIC resource provided insight into what the system could do. 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 monthly one-hour telephone conference calls to brainstorm, discuss plans, update progress, and share experiences.

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.
- Poor awareness among staff of what the MQL 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 –15-20 minutes for content and 10-15 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 MQL 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 MQL 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 MQL (hours, criteria, etc.), the no-cost Nicotine Replacement Therapy medication available through the MQL, 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.

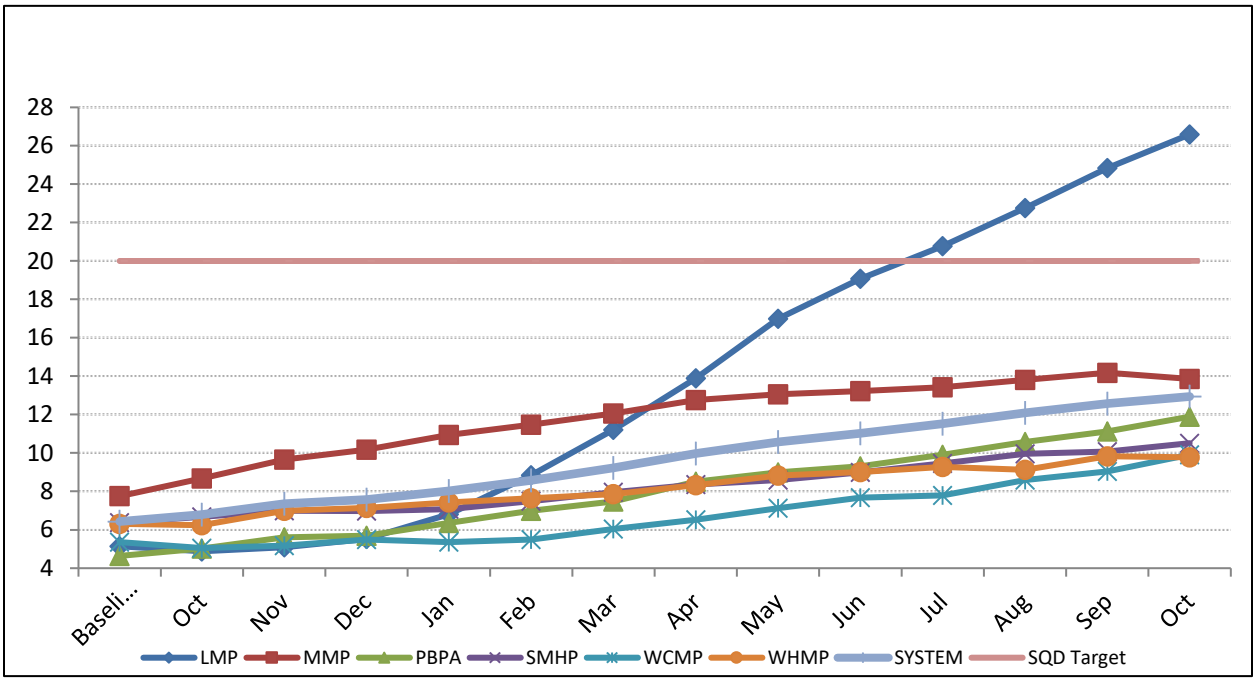
Results for Year 1

In the first year of the initiative, system-wide total referrals to the MQL went from 2,477 to 5,060. Referrals sent via EPIC increased from 2,047 to 3,221. Performance on 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 MQL, 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.
- The second most important lesson came after interviewing the clinical care teams that had submitted the most referrals. What did they have in common? Intending to refer every patient, they operated as if the default action was to refer, and they only did not refer if the patient declined the offer –which is appropriate.
- 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 the patient's knowledge and consent. We asked MQL 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 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.
- Year 1 closed with the system not achieving performance target. However, the system's rate of referrals was double the baseline with good improvement across the board and one LHS hitting the target, so MaineHealth clinical leaders extended the work for another year.

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 stated they 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 MQL. We thought training before they started working in the practices could head-off the adoption of misconceptions. We collaborated with one Local Health System, Maine Medical Partners (MMP), to meet every newly-hired MA (an others who would be rooming patients) and spend 30 minutes on tobacco referrals. This was well received by practice leaders. Other Local Health Systems said they would like to support newly-hired staff but they did not do the same sort of orientation as MMP. For some of these regions we delivered the training at MA Skills Fairs and via webinars.

At the end of Year 2 performance backslid to 12.01/100 and 3,207 referrals.

Comments from Year 2

- Overall performance started at 12.58 in October 2018 and by February 2019 it was 13.74. However, a slow summer brought steady decline and the system ended September at 12.1, below where we started the year.
- Two local systems stood out as they hit the target and their performance continued to improve. One adopted the strategy of making tobacco referrals a standing agenda item at monthly quality meetings, reviewing metrics and performance, and expanded the referrals training to specialty practices. The other was notable for its Chief Medical Officer standing up at a meeting of all the providers in the local system and clearly stating that they intended to refer every patient who uses tobacco to the MQL.
- It was noted that the local systems whose performance stayed flat or declined had either not hardwired the approach into their practice or lacked visible leadership commitment or both.
- 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 . . . "). However, we could not find a solution to the "opt out" question and instead continued to rely on the Best Practice Advisory and on staff acting on that BPA.
- Clinical leaders approved 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.
- It was a challenge to get consistent participation in our System Quality Dashboard team meeting, primarily because staff were struggling to juggle several concurrent initiatives.
- We noted that 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 trained staff at Cardiology, Oncology, Urology, General Surgery, and Women's Health practices.
- In order to reach tobacco users in the MaineHealth service area but who are not MaineHealth Primary Care patients, we piloted referrals from hospital Emergency Departments. Analyzing utilization reports, we found that in some of the system's hospitals
- We learned 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.
- On the strength of the commitment to the end goal, and encouraged by the improvement in some local systems, clinical leadership extended the work another year.

Year 3 Activities

The third year was notable for starting in October 2019 and ending in September 2020, 6 months into the global COVID-19 pandemic. We continued to advocate for training for Primary Care and Specialty practice care teams, and with executive support and local champions doing what they could we did have the opportunity to work with many teams, but not as many as we'd like, and not always in the systems that had the greatest room for improvement. One hopeful development early in Year 3 sprang from feedback shared by the CMO of the region with the poorest performance. In a large meeting of all that regions providers, many expressed skepticism about the efficacy of treatment, the value of offering referrals to patients who "were not ready", the suitability of the quitline treatment for rural patients . . . The list of concerns was long. We heard that they wanted to know that research supported this work, and they wanted to hear that from another provider, not someone associated with the quitline. With the support of that CMO and another physician, the Chief Quality Officer, we drafted a list of these concerns and provided responses including the research citations, and the CMO distributed this to all the providers at that had been at that meeting. This was so well received that we decided to distribute this document that our CMO dubbed "the Mythbuster" to all the Primary Care providers in the entire system. We subsequently made is a regular element of our training materials. Performance on the referrals measure improved so much in that region that local CMO and was invited to share the success story to the Board Quality and Safety Committee. We were making progress toward establishing this as part of our brand, i.e. that wherever a patient who uses tobacco goes in our system, it will be unquestionable that MaineHealth supports quitting and can help.

Then the pandemic hit, and energy that might have been spent at the practices on trainings and quality initiatives was reserved for simply meeting the most critical patient needs. Most of the activity on this measure stopped.

However, in the summer a Practice Manager of one low-performing Primary Care location reached out with a request for help to do better. We made a rough video recording of the training, and the manager showed it at a staff meeting the next week, emphasized the importance of tobacco referrals, and repeated that message at

meetings every week for the next two months. This practice became one of the highest-performing teams in the entire system and a model for the value of visible leadership buy-in.

At the end of year 3, actual referrals increased slightly (3,312) but the rate improved to 13.56/100, largely on the performance of those worst-to-best practices.

Comments from Year 3

- There were several learnings from Year 3.
- First, persistence is the key; this is the long game, and refusing to abandon the work despite slumps and even backsliding is important.
- Second, if people tell you what they need to hear to buy-in, and from whom, take that at face value.
- Third, while we initially believed that in-person training was the best way to address the adaptive challenge, a recorded training can be effective when supported by a dynamic champion, particularly if that person is a leader.
- While we were buoyed by the improvement, when it was time to consider extending the tobacco referral measure one more year, there was a lot of debate at the Clinical Leadership Council. After all, while some practices and local health systems showed hopeful progress, others had not improved and some were doing worse. The measure was approved for inclusion on the System Quality Dashboard for one more year, but leaders were told this was the last chance for the system to make the goal. It was expected that the Local Health Systems would lean in, make time for training, and express the expectation about consistent intervention repeatedly.

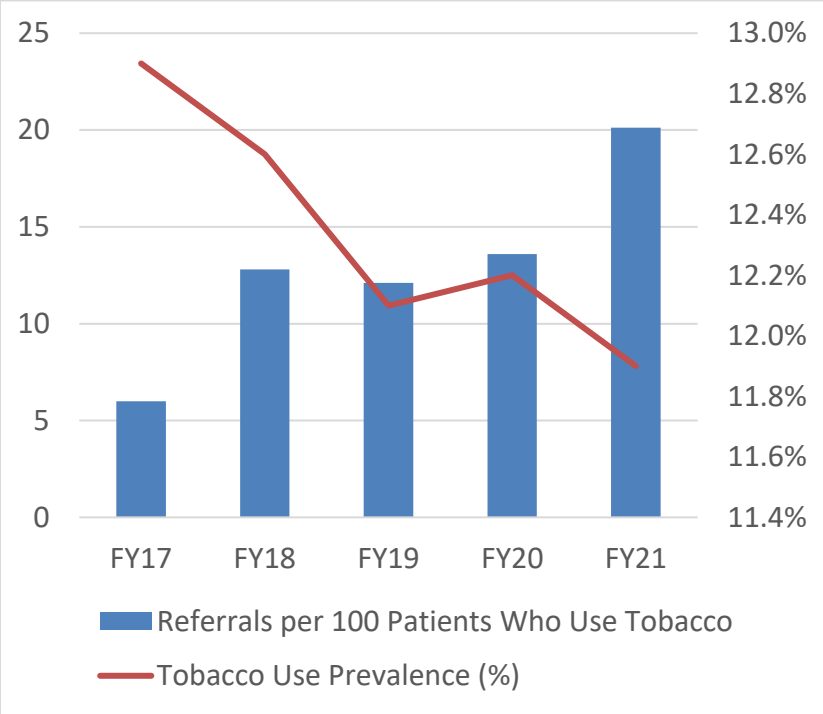
Year 4 Activities

Year 4 began with most practices still seeing few patients, allowing no outside training, but admonished to improve on tobacco referrals. The most notable development was the second-largest Local Health System making the measure a priority; their CMO stated that it would be the first agenda item of their clinical quality meeting every month until the goal was achieved. This was notable because this system's month-to-month performance had been in decline for 13 straight months. Our team partnered with their Population Health Manager to form a Steering Committee which included representatives (mostly MAs) from several Primary Care and specialty practices. The committee used quality improvement techniques to identify opportunities and plan interventions beyond the typical trainings. These strategies included more EPIC smartphrases, and new patient education materials and communication tools for patients and staff. Providers and care teams showing improvement were highlighted in newsletters. This LHS steadily improved, hit the target, and played a large role in the entire system ending the year successfully making 20.12/100 and 5,322 referrals.

Comments from Year 4 and beyond

- Year 4 was the culmination of everything that preceded it – a simple strategy, leadership involvement, flexibility but commitment to achieve the desired outcome – and the quality measure was retired from the System Quality Dashboard and replaced with a new, non-tobacco quality initiative.
- All of the training conducted was done virtually, either via ZOOM or Microsoft Teams or via a recording of the training. The recorded training was adapted to be 25 minutes long since it was our experience that trainings without a live, in-person facilitator seldom resulted in many questions. Items that frequently popped up in the Q&A portion of in-person trainings were incorporated into the content of the virtual training.

- One Local Health System sought to achieve the target using a different strategy: a nurse was tasked with reaching out to every tobacco-using patient on their panel and submitting a referral to those who consented. This did result in higher numbers: the LHS went from 5.0 per 100 to 45.9/100 and from single-digit referrals per month to >250 per month in 3 months However, as soon as that initiative was over, referrals dropped back to 7 per month. The LHS was still above the target at the end of Year 4, but clearly the change had not been hardwired.
- Since the tobacco quality measure was retired, many practices have continued to make referrals at the desired rate but some have slid back, so the Center for Tobacco Independence continues its efforts to engage practices.



Contact information:

David Spaulding, Sr. Program Manager, Practice Integration

MaineHealth Center for Tobacco Independence

110 Free Street

Portland, Maine 04101

David.Spaulding@mainehealth.org

207-662-7130

mainehealth.org

ctimaine.org