



Multi-State Collaborative on Health System Change To Address Tobacco Use

Welcome!

**March 17, 2008
Cleveland Clinic**



Objectives for Today

- **Document and synthesize best practice learning among 13 states and share widely**
- **Establish scope of action (re: systems change) and major objectives for 2008-2010**
- **Clarify purpose and infrastructure required for this collaborative.**



Agenda

Morning

- **Welcome and Introductions**
- **Sharing Best Practices – 4 Panels and Discussion**

Lunch

- **Cleveland Clinic Presentation**

Afternoon

- **Partnering on National Objectives**
- **Action Plan**
- **Future of the Collaboration**



History of the Collaborative

Impetus

- **Share in-depth state experience** to promote or support *sustainable* changes in the healthcare system to address tobacco use
- Learn how each state has invested in health systems change, the scope of state-funded initiatives, and what has worked
- **First Meeting: June 15, 2007, Cambridge MA**
7 states: MA, RI, NH, VT, MN, NY, ME



History of the Collaborative

Products from June 15

- Potential Health Systems Push-Capacity Building-Pull Model
 - Documented facilitators and barriers across 7 states and organized by three levels: environment, state change agent, and health care organization
 - Identified 10 hot button issues
 - Submitted proposal to NTCC/CDC for support (Dec 4)
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- **NCTOH Breakfast: October 29, 2008, MN**
 - Invited 6 additional states: OK, CO, IW, OH, WA, MN
 - Invited CDC, NAQC, RWJ/AED, TCLN



History of the Collaborative

13-state Meeting: Cleveland, March 17, 2008

- Share best practices with focus on indicators of success
- Partner on national objectives that we agree can facilitate progress on addressing tobacco use in healthcare

Encourage new leadership

Identify partners –both “outside” and “inside” health care industry

Identify sources of support



Define Our Multi-Level Focus

- **External Environment and Policies** (JCAHO, Reimbursement, HCF, Grant Requirements)
- **Health Care Organization Factors**
 - Internal policies
 - Standards and performance measures
 - Goals, Champions
 - Clinician Attitudes, Knowledge, Skills and Behaviors
 - Patient care; standard of care
 - Electronic and paper systems
- **State Change Agency Policies and Capacity**



Guiding Questions for Panels

Each Panel Member Presents:

- What is your most significant best practices project?
- What indicators of success are you using or might use to evaluate the success of your project?

Whole Panel Discussion:

- What are the implications of these projects for a national action plan?
- What actions at the national level would benefit these initiatives?



Panel 1: Influencing Insurers and Employers

Barriers

- Health plan policy change is slow and involves multiple depts. and processes (MN)
- Lack of access to health plan senior management (MN)
- Lack of state-specific ROI data for tobacco cessation (MN)
- Health plan members prefer easier access state quitline intended for the uninsured over health plan quitline (MN)
- Lack of cessation benefit provided by self-insured employers (MN)
- Unable to influence small local businesses until major employers in state take first step (OK)



Panel 1: Influencing Insurers and Employers

Strategies:

- Schedule meetings with senior management of health plans (MN)
- Make it easier for QL to transfer callers back to their health plan helpline (MN)
- Collaborate with primary insurance buyers group in state to collect data from self-insured employers and present ROI data to them (MN)
- Work with major employers in state to adopt cessation benefits before working at the community level with small businesses (OK)



Panel 1: Influencing Insurers and Employers

Lessons Learned

- Buy-in of senior health plan management is necessary to effect health plan systems change (MN)
- Need to make a ROI argument with insurance companies and their actuaries to support cessation benefit (OK)
- Difficulty accessing self-insured employers (MN)
- Importance of pairing policy work (tobacco-free workplace policies) and availability of effective services (Helpline) with changes in cessation benefits (OK)



Panel 2: Motivating/Educating Clinicians and Practices

Barriers

- Lack of access to clinicians and practices (NY, VT)
- Competition for clinician focus and time (NY, OK)

Strategies

- Provide on-site and regional trainings (OK)
- Work through a physician champion (OK)
- Provide incentives to providers (e.g. CMEs, free NRT) and practices (NY, VT)
- Provide technical assistance for systems changes (VT, WI)



Panel 2: Motivating/Educating Clinicians and Practices

Lessons Learned

- Educational programs need to be clinician friendly (NY)
- System-wide ownership of change is critical (VT)
- Clinician awareness of cessation resources doesn't translate into utilization (NY)



Break



Panel 3: Policy, Protocol and IT Changes in Medical Institutions and Practices

Barriers

- Insurance companies do not pay doctors for intervening with smokers (MA, RI, WA)
- Time needed and logistics for training clinicians on evidence-based tobacco treatment and referral process (MA, RI)
- Community Health Centers have competing priorities and limited resources/staffing (MA, WA)
- Logistics of fax-referral process (OH, NH)
- Paper-based medical records make performance/compliance measurement difficult (MA)



Panel 3: Policy, Protocol and IT Changes in Medical Institutions and Practices

Strategies

- Work with vendor with Quitline expertise (RI, VT, NH)
- Use PDSA and Chronic Care Model to guide teams and inform systems change process (WA)
- Provide trainings that offer CEUs and TA for staff (NH)
- Grant funding and requirements for community health systems - Require electronic documentation of interventions and performance reporting (EMR or PECS) (MA)
- Use of TA/academic detailing model with regular interaction to develop work plan and evaluation process/measures – (CO, MA)



Panel 3: Systems Changes to Policy, Protocols, IT Systems

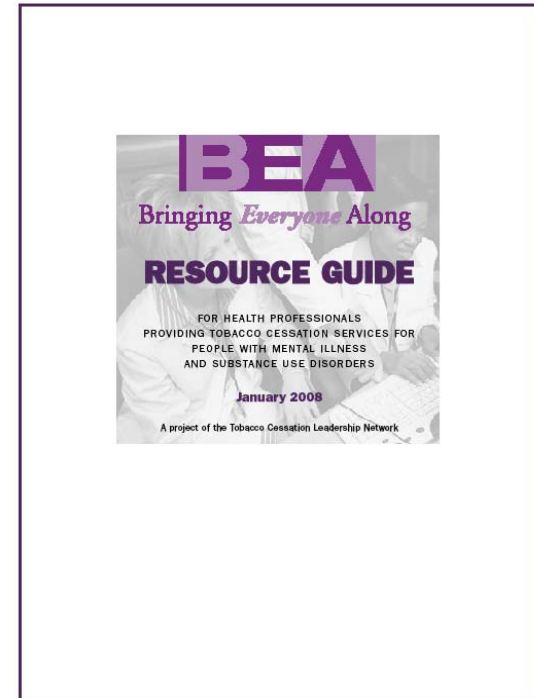
Lessons Learned

- Need to tailor systems change approach to organizational environment (MA, WA)
- Time needed for approval from all departments and/or for IT changes is lengthy (MA, NH)
- Small rural organizations are often more solutions-oriented than process-oriented and want to implement without testing (WA)
- TA is critical and need ongoing education due to staff turnover (NH, MA)
- Providers need feedback on referrals, referral compliance and patient outcomes to improve performance (NH, MA)
- It is unclear what the components of an effective bedside intervention are (VT)

Panel 4: Systems Changes in MH and SAS Systems

Barriers

- Resistance of psychiatric staff to providing NRT (OH)
- Quitline protocols not appropriate for individuals with serious mental illness (OH)
- Tobacco use by management and staff (OH)
- Logistics of fax referral process (OH)
- Organizational stage of change in MH/SA services facilities and tobacco use among staff (MA)





Panel 4: Systems Changes in MH and SAS Systems

Strategies

- Encourage (require?) DMH and SAS to go tobacco-free in facilities (OH, OK)
- Facilitate the adoption of tobacco brief interventions in BH units of community health centers (MA)
- Partner with other community and state resources (OH, OK)
- Provide tobacco use treatment for clinicians and staff in these systems (OH)
- Implement evidence-based treatment tailored to needs of these populations (OH, OK)



Panel 4: Systems Changes in MH and SAS Systems

Lessons Learned

- Need to get buy in from agency executives and medical staff (OH)
- Has to be integrated with Behavioral Health to be effective (OH)
- Treatment protocol has to be adapted to needs of these populations (OH, MA)



Lunch

Cleveland Clinic Presentation



Potential National Objectives

- Improve Joint Commission tobacco measures
- Consider promoting mandated insurance coverage for FDA-approved medication and counseling (or other ways to increase insurance coverage)
- Create uniform data system (standard ways to measure in EMRs)
- Create and implement marketing strategies that target clinicians; promote tobacco interventions as a “Standard of Care”
- Identify clinician education strategies, goals and standards (physicians, other), including incorporating tobacco dependence treatment into medical education
- Identify intervention techniques that can be applied with success in disparate populations and diverse communities.



Criteria for Selecting Priorities

- Things we can't do individually—that require collective effort for outcomes
- High impact objectives—things that would significantly amplify our work and/or remove barriers that impede progress for us in our state efforts
- Things that are realistic and achievable: Can we have impact here—really?



Three Break Outs 30 Minutes



Action Plan

Priority National Objective(s)

- To be determined by group

Sharing Best Practices

- Additional information gathering and final case examples
- Draft report with input from members
- Consultant-reviewers needed for report
- Final report via 2 Web Conference Calls with all states



Next Steps and Adjourn
