

**Table 1: 4 groups by project focus**

State	Influencing Insurers	Motivating/Educating Clinicians and Practices to change behaviors	Systems Changes in institutions/practices involving medical chart/EMR changes to track interventions	Systems changes involving treatment of patients with co-morbid conditions
Colorado				
Iowa				
Maine				
Massachusetts		Implement QuitWorks in as many hospitals as possible	<ul style="list-style-type: none"> <li>• Increase documented brief interventions by Pedi/OBGYNs with women of reproductive age in practices and hospital since whole region uses same EMR</li> <li>• Implement/improve systems to promote tobacco dependence treatment; increase usage of Medicaid cessation benefit and QuitWorks referrals</li> </ul>	(Several CHCs are attempting systems changes in Behavioral Health Depts.)
Minnesota	<ul style="list-style-type: none"> <li>• Reduce barriers to QL use by health plan members</li> <li>• Increase employee coverage by self-insured employers</li> </ul>			
New Hampshire			Implement PHSG across entire community of providers on Dartmouth Hitchcock Medical	

			center campus/fax-referral process & referral to onsite cessation specialists	
<b>New York</b>		<ul style="list-style-type: none"> <li>• Edgy campaign via venues that target clinicians to improve attitudes &amp; beliefs about importance of assisting patients to quit smoking</li> <li>• AMA offers CME credits for program on office systems changes needed to PCPs via Cessation Centers</li> </ul>		
<b>Ohio</b>				Identify/evaluate strategies to integrate cessation interventions in MH/AOD systems
<b>Oklahoma</b>	Collaborate with state Medicaid agency to implement cessation benefits and with state to change its health benefit for state employees to include cessation benefits. Train community grantees to work with local employers to adopt the same benefit package	<ul style="list-style-type: none"> <li>• Work with U of O to improve medical school curriculum to include brief intervention and referral to Helpline</li> <li>• Conduct regional training events to train Medicaid providers on how to integrate new cessation benefit into their practices</li> <li>• Marketing campaign to change social norms</li> </ul>		Work with DMH and SAS to have facilities go smoke-free and to implement tobacco treatment concurrently with AOD treatment

		for tobacco use – targeted at providers and smokers		
<b>Oregon</b>				
<b>Rhode Island</b>		Motivate practices to adopt QuitWorks program		
<b>Vermont</b>		Motivate practices to intervene and refer to QL by providing free NRT to practices		Build capacity to intervene effectively with in-patient smokers
<b>Washington</b>			Test prior learnings about how to effect HSC in 3 pilot organizations in disparate rural populations in rural health clinics and hospitals (by adapting PDSA process to implement identification, intervention, and referral of smokers to quitline or internal resource)	
<b>Wisconsin</b>		Campaign to increase clinician/enrollee awareness & utilization of Medicaid cessation benefits		Integrate tobacco treatment with inpatient care in hospitals

**Table 2. Six Groups by target system type**

State	Influence Insurers	Motivate/educate Clinicians	Influence practices	Systems change in hospitals	Community Health Centers (CHC)	Systems changes in Mental health/AOD
Colorado						
Iowa						
Maine						
Massachusetts			Increase documented brief interventions by Pedi/OBGYNs with women of reproductive age in practices and hospital since whole region uses same EMR	Implement QuitWorks in as many hospitals as possible	Implement/improve systems to promote tobacco dependence treatment; increase usage of Medicaid cessation benefit and QuitWorks referrals	(Several CHCs are attempting systems changes in Behavioral Health Depts.)
Minnesota	<ul style="list-style-type: none"> <li>• Reduce barriers to QL use by health plan members</li> <li>• Increase employee coverage by self-insured employers</li> </ul>					
New Hampshire				Implement PHSG across entire community of providers on Dartmouth Hitchcock Medical center campus/fax-		

State	Influence Insurers	Motivate/educate Clinicians	Influence practices	Systems change in hospitals	Community Health Centers (CHC)	Systems changes in Mental health/AOD
				referral process & referral to onsite cessation specialists		
New York		<ul style="list-style-type: none"> <li>• Edgy campaign via venues that target clinicians to improve attitudes &amp; beliefs about importance of assisting patients to quit smoking</li> <li>• AMA offers CME credits for program on office systems changes needed to PCPs via Cessation Centers</li> </ul>				
Ohio						Identify/evaluate strategies to integrate cessation interventions in MH/AOD systems
Oklahoma	Collaborate with state Medicaid	<ul style="list-style-type: none"> <li>• Work with U of O to improve medical school</li> </ul>				Work with DMH and SAS to have facilities

State	Influence Insurers	Motivate/educate Clinicians	Influence practices	Systems change in hospitals	Community Health Centers (CHC)	Systems changes in Mental health/AOD
	agency to implement cessation benefits and with state to change its health benefit for state employees to include cessation benefits. Train community grantees to work with local employers to adopt the same benefit package	<p>curriculum to include brief intervention and referral to Helpline</p> <ul style="list-style-type: none"> <li>• Conduct regional training events to train Medicaid providers on how to integrate new cessation benefit into their practices</li> <li>• Marketing campaign to change social norms for tobacco use – targeted at providers and smokers</li> </ul>				go smoke-free and to implement tobacco treatment concurrently with AOD treatment
Oregon						
Rhode Island			Motivate practices to adopt QuitWorks program			
Vermont			Motivate practices to intervene and refer to QL by	Build capacity to intervene effectively with in-		

State	Influence Insurers	Motivate/educate Clinicians	Influence practices	Systems change in hospitals	Community Health Centers (CHC)	Systems changes in Mental health/AOD
			providing free NRT to practices	patient smokers		
Washington				Test prior learnings about how to effect HSC in 3 pilot organizations in disparate rural populations in rural health clinics and hospitals (by adapting PDSA process to implement identification, intervention, and referral of smokers to quitline or internal resource)		
Wisconsin		Campaign to increase clinician/enrollee awareness & utilization of Medicaid cessation benefits		Integrate tobacco treatment with inpatient care in hospitals		

**Barriers, Strategies and Lessons Learned for the 6 categories in Table 2**

**Working with health plans and employers**

**Barriers**

- Health plan policy change is slow and involves multiple depts. and processes (MN)
- Lack of state-specific ROI data for tobacco cessation (MN)
- Lack of access to health plan senior management (MN)

**Strategies**

- Work with major employers in state to adopt cessation benefits before working at the community level with small businesses (OK)

**Lessons learned**

- Need to make a ROI argument with insurance companies and their actuaries to support cessation benefit (OK)
- Importance of pairing policy work (tobacco-free workplace policies) and availability of effective services (Helpline) with changes in cessation benefits (OK)
- Difficulty of working with self-insured employers (MN)
- Buy-in of senior health plan management is necessary to effect health plan systems change [to reduce barriers to health plan QuitLine use – co-pay, prescription needed/no coverage for NRT] (MN)

### **Motivating/Educating Clinicians to treat tobacco use/utilize Medicaid benefits**

#### **Barriers**

- Clinicians not accepting importance of taking responsibility for treating tobacco dependence (NY)
- Gaining access to clinicians in primary care (NY)
- Working out details of campaign materials with Medicaid and HMO's (WI)

#### **Strategies**

- Identify a physician champion in medical schools to help promote inclusion of cessation interventions in curriculum (OK)
- Provide regional trainings for all Medicaid providers on new Medicaid cessation benefit, billing, the 5As and how to refer to the Helpline (OK)
- Provide materials and onsite training and TA for clinicians on cessation benefits provided by Medicaid (WI)
- Produce campaign to influence health care providers and citizens to take responsibility for cessation (OK)
- Produce edgy campaign in venues that target clinicians to improve attitudes/beliefs re: importance of assisting patients to quit (NY)
- Providing incentives (CMEs) to attract PCPs to AMA performance improvement program that instructs on tobacco use intervention and office systems change (NY)

#### **Lessons Learned**

- Make educational programs targeting PCPs more user friendly (NY)

### **Working with practices**

#### **Barriers**

- Hard to gain access to practices (VT)
- 5A's take too much time to be feasible (VT)

- Physician time required for training (RI)
- Clinician frustration with lack of insurance coverage for cessation (RI)
- Generally need to make changes to EMR to capture and report on information about tobacco use interventions (MA)
- Paper-based tracking of tobacco use interventions makes reporting on compliance difficult (MA)
- Insurance companies do not pay doctors for intervening with smokers (MA)

### **Strategies**

- TA (multiple interventions) for whole practice office to define practice system for intervening (VT)
- Give incentives to practices (free NRT) (VT)
- Work with vendor with QuitLine expertise ( RI, VT)

### **Lessons Learned**

- Practices need to take systems-wide ownership of the issue (VT)
- Use as many communication venues with providers as possible (piggyback on education sessions/conferences, Physician Service Organization, etc.)
- Collaborate with other stakeholders to make the most of your time with physicians (RI)
- In order to track, need EMR or other means of collecting accurate information on interventions (MA)

### **Working with Hospitals**

#### **Barriers**

- Smaller rural health access hospitals have constraints that limit ability of TTS to deliver bedside services (VT)
- Logistics/staffing of cessation specialist for inpatients, specialty care patients, outpatients in clinic (NH)
- Logistics of the fax-referral process (NH)
- Time needed to gain approval within each dept. for detailing of change (NH)
- Turnover in hospital staff (MA)
- Loss of champion(s) in hospital (MA)
- No one wanting to own the implementation of the fax-referral system in the hospital (MA)

#### **Strategies**

- Provide consult at bedside that exceeds JCAHO requirements (Vt)
- Trainings that offer CEUs and TA for staff (NH)
- Detailed workplan methodically targeting all areas of hospital (NH)

- Work with vendor with QuitLine expertise (NH)
- Presenting fax-referral system to senior managers of hospital (MA)
- Providing TA in defining implementation details within each hospital (MA)
- Work with Hospital Association to develop/distribute materials re: treating hospitalized smokers to hospitals (WI)

### **Lessons Learned**

- It is unclear what the components of an effective bedside intervention are (VT)
- TA is critical and need ongoing education due to staff turnover (NH, MA)
- Need feedback on referrals and compliance and patient outcomes (NH, MA)
- Need to make contacts at multiple levels in system to successfully implement fax-referrals - a time-consuming, complex and intensive effort (MA)
- Hard to sustain integration of tobacco treatment with inpatient care once JCAHO is “done” (WI)

### **Working with CHCs and rural clinics/hospitals**

#### **Barriers**

- 8-month grant period too short (MA)
- CHCs have competing priorities and limited resources/staffing (MA)
- Time needed and logistics for training clinicians on evidence-based tobacco treatment and referral process (MA)
- No monetary incentives for participation (WA)
- Timing of capacity building re: models informing process (PDSA, Chronic Care Model) (WA)
- Project not a priority for all participating organizations (WA)

#### **Strategies**

- Grant funding and requirements (MA)
- Volunteer participation (WA)
- Recruitment via Rural Health Dept. listservs and Community agency listservs (WA)
- Use of TA model with regular interaction to develop workplan and evaluation process (MA)
- Use of cessation screening, intervention and referral model that can be customized to each CHC (MA)
- Use PDSA and Chronic Care Model to guide teams and inform systems change process (WA)
- Two cross-grantee meetings with CHCs to share learnings (MA)
- Require electronic documentation of interventions and performance reporting (EMR or PECS) (MA)

- Site teams composed of one clinical leader, one administrative leader and one leader knowledgeable of current tobacco cessation system (WA)

### **Lessons Learned**

- CHC must have a project manager dedicated to the project with authority to implement system-level changes (MA)
- Sustained contacts with TA providers are needed to promote successful implementation (MA)
- Time for approval and implementation of changes to EMR is usually longer than expected (MA)
- Small rural organizations are often more solutions oriented than process-oriented and want to implement without testing (WA)
- Need to teach the model for improvement (PDSA) up front
- Need to tailor systems change approach to organizational environment (WA)

### **Working with MH/AOD services**

#### **Barriers**

- Resistance of psychiatry staff to providing NRT due to health risk and safety concerns (OH)
- QL protocol not appropriate to individuals with serious mental illness (OH)
- Logistics of fax-referral process (OH)

#### **Strategies**

- Develop agency policies with involvement of staff related to tobacco use (progressing towards tobacco-free) (OH)
- Provide treatment to BH staff who smoke (OH)
- Partner with other community and state resources (OH, OK)
- Implement treatment using evidence-based psychosocial and pharmacological interventions unique to the needs of this population (OH)
- Encourage DMH and SAS to go tobacco-free in facilities and to implement tobacco dependence treatment concurrently with AOD treatments (OK)
- Facilitate the spread of tobacco interventions to BH departments in CHCs (MA)

### **Lessons Learned**

- Need to get buy-in from agency medical staff (OH)
- Has to be integrated with BH care to be effective (OH)
- Treatment protocol has to be adapted to the needs of this population (OH, MA)