

# Multi-State Tobacco Cessation Health Systems Change (HSC) Collaborative Initial Meeting (June 15, 2007)

Draft – Not for Dissemination

**Table 1: Identified Barriers to Health Systems Change at 3 Levels of the Ecological Model (E, S, O)**

## External Environment Barriers (E)

- Health insurers don't view tobacco dependence as a chronic disease that requires treatment/medication that should be reimbursable
- Limited JCAHO measure easily satisfied with only distribution of patient brochure
- Lack of state regulation or incentives to address tobacco cessation

## State Tobacco Control Program Barriers (S)

- Role definition of state health department regarding Medicaid coverage
- One size intervention does not fit all
- Behavior change takes lots of time to address this deeply engrained issue
- Little or no funds/compensation offered to health care facilities to participate in HSC – participation is voluntary rather than compensated
- Insufficient funding or too time-limited funding to effect systems change
- Intervention process is complex
- Working across widely decentralized Community Health Centers is complex and challenging
- Targeting only MDs is too narrow (need team approach)
- Asking/expecting too much time from providers to intervene

## Barriers at Health Care Organization Level (O)

- Many have paper forms only – no means of real performance reporting
- EMR limitations – text fields only, field data entry not required, etc. - affect performance analysis capability
- Health care facilities defer tobacco problem to public health to solve
- MDs don't understand addiction/chronic disease component of tobacco use - belief that tobacco use is not a medical problem or that availability of free-standing treatment cessation programs is sufficient (culture change needed)
- Definition of “tobacco dependence treatment” is not well understood by health care system. It is not simply providing a brochure
- Lack of champion or leadership/lack of consistent messages
- Staff training needs
- Low provider motivation
- Coding issues – diagnosis, billing, limits on entering codes
- Low patient acceptance of tobacco interventions and referral to counseling treatment
- When public health engages facilities in a change intervention without compensation:
  - Lack of commitment for the long haul to sustain significant changes
  - Lack of follow through by institutions after initial meetings with DPH
  - Lack of feedback to DPH on progress/unreturned calls from DPH
  - Limited time and resources /Lack of project manager & adequate staffing resources
  - Lack of continuity of staffing during intervention implementation

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**Table 2: Identified Strategies Currently Being Employed for Health Systems Change Categorized by EOS level (E=external;**

**S=State; O=health care organization) and by Push-Pull Model**

(Further study needed to determine which are most effective)

EOS	Push	EOS	Build Capacity to Deliver Intervention	EOS	Institution & Provider Pull/Demand
S	Set large goals & be willing to rock the boat	S	Formalize multi-state health systems change work group, find funding sources and invite them to participate, involve other states	S	Develop different approaches to delivering care that can be integrated with existing systems
S	Emphasize need for sustainability of health systems changes	S	Provide an evaluation framework and TA for health systems change grantees	S	Provide funding to motivate implementation of new policies and systems changes (contracts)
S	Base funding on deliverables, meeting objectives or on serving populations with highest vulnerability?	S	Academic detailing/follow up with practices or technical assistance available to implementing organizations/building institutional capacity	S	Subsidize a network of counselors in health care systems
S	Pay for performance (payment models? How much to pay? Who to pay – providers? HMO to raise awareness of services?) (incentives for assessing quit interest and discussing medication, referrals, etc.	S	Define tobacco use treatment/produce training materials for clinicians and staff	S	Subsidize the offering of free NRT to all smokers who enroll in counseling
S	Background research to identify targets (likely to succeed?). Work with those who are ready (providers, insurance companies, QI, etc.).	S	Use partnerships effectively – collaboratively developed interventions, project documentation, process evaluation (by S&O)	S	Understand targeted providers and start where they are with message campaigns and interventions proposed (providers & patients)
S	Focus on families with pediatric asthmatic issues, assessing tobacco use/exposure and quit interest	S	Organize kick-off/information-sharing meetings for community-based grantees implementing system changes	S	Use simple targeted messages
S	Invest in clinical outreach workers instead of advertising to motivate systems change (make cold-calls to practices, educate re: making appropriate referrals)	S	Use of outside experts to assist with implementation (quitline, media firm, consultants) when needed	S	Do niche marketing to providers
S	Develop marketing strategies that target clinicians (ex.: edgy media campaign targeted at clinicians who do not ASSIST their smokers to quit to make them aware this is their job)	S	Find ways to establish standards/consistency in diagnostic & billing coding. Diagnostic codes are not billing codes (only 15 of latter and tobacco codes not standardized)	S	Explore multiple points of access (to Health Center clinicians?)
S	Advocate for JHACO and enhancements	S	Provide office procedures for NRT ordering and distribution to practices – provide NRT samples directly to MDs – NRT incentives (via contractor like JSI)	S	Provide CME credits for learning/implementing PHS guidelines. Monitor implementation with participants
S	Coalition building (state and national?) Working with Health Care Quality Improvement Organizations (under contract) to develop relevant quality measures. Working	S	Adequate FTEs to facilitate changes (what level of effort is needed?)	S	Develop innovative models to facilitate referral to treatment (fax to quit)

<b>EOS</b>	<b>Push</b>	<b>EOS</b>	<b>Build Capacity to Deliver Intervention</b>	<b>EOS</b>	<b>Institution &amp; Provider Pull/Demand</b>
	nationally will result in a standardized model				
S	Influence insurance companies to have performance indicators that may be tied to bonuses	O	Effective champions/leadership (may need cultivation by S)	S	Make sure providers have a GOTO resource for referrals to help smokers quit
S	Advocate for national focus on uniform EMR systems for healthcare to include tobacco treatment	O	Adequate FTEs to effect changes (what level of effort is needed?)	S	Provide Community Health Center access to medications
S	Advocate for mandated commercial insurance coverage	O	Make EMR changes to support tracking of smoker identification, brief intervention and referral	S	States need to show results that health system partners can get behind
S	Advocate for providing reimbursable access to medications with no barriers to access	O	Collect baseline data and implement measurement capability		
S	Encourage smoke-free campus for health systems	O	Implement performance reporting for performance feedback/quality improvement	O	Health care institutions want to be on the cutting edge

